Royal College of Nursing Response to the Department of Health and Social Care: Reforming the Mental Health Act

With a membership of over 450,000 registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1. Introduction

1.1. As the main professional group implementing and delivering care under the Mental Health Act (MHA), alongside patients and service users', it is vital that the voice of nursing staff is heard throughout the development of these reforms.

1.2. The published consultation questions cover a wide scope of the proposed reforms set out in the department of Health & Social Care's (DHSC) the Reforming Mental Health Act white paper.[1] Feedback from members suggested that the RCN should provide a more concise summary of key areas most pertinent to the nursing workforce. The Royal College of Nursing (RCN) reviewed the 36 consultation questions, consolidating and organising key questions into eight themes[2].

1.3. This response has been developed in collaboration with a wide range of RCN members and staff. We have received contributions from multiple sources including the RCN Mental Health Forum, Learning Disability Nursing Forum, policy-makers, clinical nurses (NHS and independent sector), academic nurses (individuals and groups[3]), as well as people with lived-experience of mental illness.

1.4. This response was formed alongside our submission of written evidence to the Joint Committee of Human rights[4].

2. Guiding principles (*Consultation Question: 1*)

2.1. The RCN welcomes the importance of putting patients at the centre of decisions about their own care, promoting choice, equality and personal-recovery.

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[1] Open consultation: Reforming the Mental Health Act

[2] Reforming the Mental Health Act White Paper: feeding into the RCN response

[3] Mental Health Nurse Academics UK (swan.ac.uk) & University of Central Lancashire Mental Health Nursing Academics

[4] Royal College of Nursing - Evidence to the Joint Committee on Human Rights call for evidence on the reform of the Mental Health Act

2.2. The 'guiding principles' should be applied to all healthcare, social care and forensic settings, as well as all codes of practice and government guidance that directly influences NHS and non-NHS services who support people with mental health problems.

2.3. We explicitly recommend that the principles are added to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care[5]. This guidance is widely used in day to day commissioning and care provision, and would benefit from these additions.

2.4. Continuity of care is key to all four of the guiding principles, particularly choice and autonomy, least restriction and therapeutic benefit. One of the ways that this could be enacted would be to include patients and the public in the development of care pathways.

3. Care planning and choice (*Consultation Questions: 8, 9, 10, 11*)

3.1. Advanced choice, care planning and consent to treatment are key proposed reforms for the MHA. Nurses most often facilitate the formation and delivery of care plans with and for the people in their care.

3.2. We recommend that advance choice documents become a statutory requirement, aiming to ensure people receive the right care, in the right place, at the right time, with the right people supporting them (i.e. nominated person).

3.3. Advanced choice documents must provide a clear statement on when mental health services should engage and/or increase the intensity of care and treatment (i.e. through more frequent home-visits or via admission to hospital).

3.4. Some patients may have strong feelings about the pronouns that are used to describe them. As someone may be too unwell to articulate their preferences, these should be included in advanced choice documents.

3.5. There may also be family members, carers, or friends who patients do or do not wish to engage with when in crisis. Such choices should be made clear within advanced decisions. It is imperative that such a choice is regularly reviewed. A minimum timescale for review must be included.

3.6. A multi-disciplinary and collaborative approach to the formation of advanced choice documents must be followed. Patients must be enabled to fully participate in *their* care planning process. A person is more likely to engage with services if they perceive that the choices made meet their respective needs.

3.7. It is the patient's right to refuse treatments so long as they are fully aware of the consequences of that refusal. If young people (under 16) refuse treatment, their parents may consent on their behalf. In such instances, best practice should be to go through the Court of Protection. Within the code of practice, the right to refuse

[5] 20181001 National Framework for CHC and FNC - October 2018 Revised (publishing.service.gov.uk)

treatment for adults and young people must be made explicit to patients, carers and healthcare staff.

3.8. There will be circumstances where the need to protect the patient and others overrides a refusal to receive necessary treatment. There must be clarity regarding the judgement about what is and what is not a 'capable' refusal.

3.9. We need to examine the balance between the patient choice and therapeutic necessity. It is not a 'one size fits all', as diagnosis often shapes the treatment pathway via the notion of capacity. When in acute distress, someone with a diagnosis of personality disorder may be viewed as ineligible for inpatient mental health support as they are deemed to have capacity. Further examination into the role of 'capacity' for these individuals is essential.

4. Advocacy and patients' rights (*Consultation Questions: 4, 13, 15*)

4.1. The reforms aim to introduce the role of nominated person, while providing more powers to Independent Mental Health Advocates. Reduced timescales for which people are automatically referred to tribunal are also proposed.

4.2. The RCN welcomes the introduction of the 'nominated person', providing more choice, personalised care and support for patients.

4.3. It is vital that the legislation considers the statutory support available to those undertaking the nominated person role. The possibility of extending the statutory 'carers assessment' protocol within the Care Act (2014) must be considered.[6]

4.4. Noted by an RCN member with lived-experience of using mental health services, advocacy can be difficult to access if the patient has existing family support. It was further explained that a person in crisis can have strenuous relationships with family members. Support from a nominated person and/or independent advocate was seen as one way to help reduce carers' burden.[7]

4.5. There is now an opportunity to improve practices for people from BAME backgrounds[8]. BAME patients can experience disadvantage when admitted to inpatient settings. Including their carers and significant others in partnership working will help to reduce inequalities in mental health care. As the largest and most diverse professional group, the cultural expertise of mental health nurses must be overtly utilised.

4.6. The proposed reforms have kept Community Treatment Orders (CTOs) in place with changes intended to improve the equity of their application. For example, the provision for the new role of "nominated person" for those detained under the MHA to have the power to object to a CTO, while also increasing the frequency of

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[6] Care Act 2014 (legislation.gov.uk)

[7] Shah, A. J., Wadoo, O., & Latoo, J. (2010). Psychological distress in carers of people with mental disorders. British Journal of Medical Practitioners, 3(3). Available at: BJMP Online

[8] The term 'BAME' mirrors the language in the MHA White Paper. We are aware of the .gov guidelines for Writing About Ethnicity.

automatic referral to a tribunal during a CTO, from every 3 years to every 12 months.

4.7. Without increased investment in community services, the proposed changes will have implications on the nursing workforce, particularly the possible increased 'burden of risk'.[9] If unaddressed, this may negatively affect the provision of community care provided to people with serious mental illness.

4.8. There should be a framework to ensure those subject to the MHA are able to return home safely following treatment. This includes robust human rights-based tests, advocacy, peer support, a good range and spread of practical services and a minimum set of psychological support practice standards (not just requirements or orders). To ensure that this framework works, it should be coproduced with those with lived-experience.

4.9. Through better investment in custody and court liaison diversion models, we know earlier intervention (often by nursing staff working with police) leads to better outcomes for people; effectively reconnect people in the community rather than sending them to prison.[10]

5. **Capacity** (*Consultation Questions: 14, 17, 18, 19*)

5.1. The MHA must recognise the fluctuating nature of capacity for those who have mental health problems. Better definition or more consideration of the terms 'mental disorder' and 'capacity', within the MHA, would help to support delineation.

5.2. RCN members considered the implications of the title of the 'Mental Capacity Act', and felt 'Capacity Act' or 'Decisional Capacity Act' would be more appropriate to support the delineation of both Acts.

5.3. The MHA should explicitly emphasise the importance of training and education for all staff especially around Human Rights and the Mental Capacity Act. Nurses report that training is rarely focussed on human rights and patients' rights.

5.4. Members reported that Section 5(2) of the MHA is used relatively frequently on wards within acute hospital Trusts. It was argued that A&E staff must have a basic understanding of the MHA, as they often support people who are on Section 136 within their departments. All A&E staff should know what to do if a patient comes into their department in a mental health crisis, including the use of Section 5.

5.5. There is the argument that non-mental health and learning disabilities nurses may be expected to use the MHA without adequate skills and knowledge. All Liaison Services (LS) are expected to be Core 24 compliant soon. As a minimum, all Acute hospital trusts will have access to LS who can support non-specialist staff in the use of the MHA. Part of Core 24 is that LS will offer subject-specialist training to staff within acute hospital Trust's.

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[9] *Holding increased responsibility and accountability for patient safety and wellness*

[10] Bromley Briefings Prison Factfile (2021). Available at: Winter 2021 Factfile final.pdf (prisonreformtrust.org.uk)

5.6. Prior consent to be admitted as an informal patient is seen as being helpful; providing the person still has recourse to advocacy and other checks and balances. Admission and discharge, crisis management, carer and caring responsibilities, risk to others and the needs of carers must be considered.

5.7. If a person under 16 is deemed to have capacity, then they are seen as having the same rights as an adult and thus should be granted the right to request a nominated person. It is vital that the young person fully understands the implications of choosing a nominated person. This should include discussing the statutory rights of parents and carers so the young person is fully aware of their rights.

6. Therapeutic benefit and least restriction (*Consultation Questions: 2, 5, 23, 24, 25*)

6.1. We are concerned that the definition of therapeutic benefit: "ensuring patients are supported to get better, so they can be discharged from the act" is open to interpretation. The concept of "therapeutic benefit" is further complicated by conditions such as learning disabilities and autism where the approach is not to 'treat' these conditions, but to support people through an episode of crisis.

6.2. The historic and contemporary issues surrounding the concept of 'recovery' in mental health care, underpinned by power imbalances between patients and clinicians, must not be ignored. We recommend that the definition of 'therapeutic benefit' must be co-created with people that have experience of mental illness and those who use services, and have been detained under the MHA.

6.3. The biomedical model often persists as the primary treatment option under the MHA. The MHA should explicitly encourage practitioners to also consider other treatment approaches to mental health care (i.e. psychosocial interventions), offering greater choice to patients.

6.4. Therapeutic treatment is not always formal treatment, being therapeutic is a much broader concept.[11] Articulating the outcomes of care should be co-produced between professionals and patients. This needs to be genuine co-production, rather than treating patient-involvement with a tokenistic respect.

6.5. There remains a need to explore what is meant by "least restrictive" to ensure meaning and application is clear. The concept of "least restrictive" is a personal one. Some may prefer to be physically held rather than receive sedative medication. For others, touch may be painful or trigger memories of traumatic experiences, taking medication may be preferred.

6.6. We must avoid creating a globally applied hierarchy of "least restrictive" practices to most restrictive practices. The concept of "least restrictive" should be agreed at a personal level; explored and articulated through the care planning process.

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[11] Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. International journal of nursing studies, 102, 103490. Available at: Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance - ScienceDirect

Designing education around the use of the MHA, to ensure it is used in the least restrictive way, must involve a range of people with lived-experience.

6.7. The phrase "substantial likelihood and significant harm" holds a large amount of subjectivity and is open to interpretation; something that invariably leads to people being inappropriately detained or not detained when needed.

6.8. Uptake of statutory roles, such as Approved Clinician (AC) and Responsible Clinician (RC) has been limited among nurses and other professionals, compared to psychiatrists.[12] There is a clear value to multi professional opportunities in this area both for patient experience and outcomes, as well as professional development.[13] Likewise, the role of the Approved Mental Health Practitioner (AMHP) is most often held by social workers rather than mental health nurses and/or learning disabilities nurses.

6.9. Members who are nurse AC/RC have told the RCN how feedback from patients has been positive. Reporting more flexibility in their availability to meet with patients, building therapeutic relationships, while being more inclusive and holistic in their decision-making processes. There must be access to clinical supervision for those who hold more commensurate responsibility for the MHA. A minimum standard should be in place.

7. Learning Disabilities & Autistic People (*Consultation Questions: 26, 27, 28, 29, 31*)

7.1. Members welcomed that the contemporary and most appropriate terminology is being used ("learning disabilities" and "autistic people")[14] as previously ill-defined terms meant people often 'fell between the gaps'.

7.2. The needs of autistic people who do not have a learning disability may be very different to autistic people with learning disabilities. Merging the two groups together risks one or both groups not having the representation they need.

7.3. Environments within emergency departments (ED) need to be able to provide quiet and supportive spaces to promote safety and de-escalate situations that may lead to a detention. Our members are concerned about a lack of guidance for ED staff, psychiatric/learning disabilities liaison teams and hospital security on how they can maintain a patient's safety and alleviate their distress.

7.4. During the COVID-19 pandemic, more appropriate environments as alternative care pathways to ED were provided across the UK for people experiencing mental health

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[12] Veitch P and Oats J (2016), Strange bedfellows? Nurses as Responsible Clinicians under the Mental Health Act (England & Wales). Available at: Strange bedfellows? Nurses as Responsible Clinicians under the Mental Health Act (England & Wales) - Veitch - 2017 - Journal of Psychiatric and Mental Health Nursing - Wiley Online Library

[13] Oats J et al. (2021), Implications for mental health workforce strategy, professional training and supervision of more widespread adoption of the multi-professional Responsible Clinician role: Results of a qualitative inquiry. Available at: Implications for mental health workforce strategy, professional training and supervision of more widespread adoption of the multi-professional Responsible Clinician role: Results of a qualitative inquiry - ScienceDirect

[14] National Autistic Society - how to talk about autism

crisis.[15] These rapid changes show the ability of the system to respond to change when the needs arise. Despite using alternate pathways in recent months, those with mental health needs, a learning disability and autistic people, must continue to be welcomed by staff in ED.

7.5. It was strongly felt amongst nurses that people with a learning disability and autistic people have been detained under the MHA inappropriately and then remain in inpatient services for far too long. These issues highlight that the least restrictive option is not being used for these specific groups of individuals.

7.6. The ambition to decrease the number of people with a learning disability and/or autistic people being detained inappropriately and 'getting stuck in the system', may have unintended consequences. There is a risk that 'diagnostic shadowing' (of the LD/Autism) will occur. Some who require support, may be less likely to access the right mental health care, due to not being detained.

7.7. We strongly agree that the recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan. This change should ensure that there is more rigour and scrutiny brought to bear on care and treatment planning.

7.8. With regards to the application of the proposed changes to the MHA for those in the criminal justice system, we are mindful of unintended consequences; where a person with a learning disability and/or an autistic person may not receive adequate care.

7.9. Whether or not a person has a learning disability or autism, if a person needs mental health support they should be able to access services. To reduce these potential inequalities, the MHA must promote the continued investment in hospital, custody and court liaison and diversion models, with the aim for these to become statutory in every locality.

8. The impact on nurses and the role of CQC (*Consultation Question: 35, 36*)

8.1. The CQC will play a vital role in ensuring the guiding principles and new standards are put into place, maintain good practice, while offering the essential accountability for service to make improvements where required.

8.2. By increasing CQC monitoring powers, members are concerned that mental health services will be forced to extend their auditing documentation processes, taking nurses further away from direct patient care.

8.3. Currently, mental health accounts for 28% of the impact[16] of all illness in the UK but receives only 13% of NHS spending.[17]

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[15] Royal College of Psychiatrists (2020), Alternatives to emergency departments for mental health assessments during the COVID-19 pandemic available at: alternatives-to-eds-for-mental-health-assessments-august-2020.pdf (rcpsych.ac.uk)

[16] As measured through cost, mortality, morbidity and other indicators

[17] Centre for Mental Health (2020), Parity of Esteem. Available at: "Parity of esteem" | Centre for Mental Health

8.4. Mental health and learning disability services are already struggling to cope with chronic staffing shortages and a high turnover of staff as a result of pressurised working environments.[18] In quarter 3 of 2020/21 in England, the vacancy rate stood at 13.1%, the highest rate for any NHS nursing sector.[19]

8.5. With growing pressures and increasing number of people needing mental health care and support. The government must urgently take steps to remedy the supply, recruitment and retention of the nursing workforce in order to ensure that services can continue to provide safe and effective care.

8.6. Low levels of staff, unstable teams, and poor working conditions can lead to compassion fatigue and poor practice. Low staffing levels have been shown to increase the occurrence of restrictive practices, while negatively affecting patient outcomes[20]. Addressing these underlying issues will create the conditions for good care and allow advocacy to thrive.

8.7. We continue to call for the expansion of accountability for workforce planning and funding in law and investment into nursing higher education in England. A commitment in law is critical to provide assurance to our nursing community that our workforce shortages will be tackled.

9. Cultural diversity and Black, Asian and Minority Ethnic (BAME) (*No consultation question*)

9.1. The Final report of the Independent Review of the MHA 1983 highlighted how BAME groups are at a greater risk of compulsory detention than White majority groups (pp. 271). Although the consultation has not asked specific questions around the impact of the proposed reforms on people from BAME communities, the RCN is keen to ensure this is included in our response.

9.2. There are very concerning statistics regarding specific communities. For example, Black people are four times more likely to be detained under the MHA and twice as likely to be arrested under Section 136. They are put on Community Treatment Orders (CTO) eight times more frequently than white people.[21]

9.3. The overuse of restrictive interventions for some BAME communities, specifically black men, has remained unaddressed in the legislation. This disparity may be due to systemic and institutional forms racism and stereotypical views of black men being perceived as dangerous and violent when mentally ill. Services are not seen as

[18] CQC (2019), The State of Health Care and Adult Social Care in England 2018/19. Available at: THE STATE OF HEALTH CARE AND ADULT SOCIAL CARE IN ENGLAND 2018/19 (cqc.org.uk)

[19] NHS Digital (February 2021) England NHS quarterly vacancy statistics. Available at: Home - NHS Digital

[20] McKeown M et al. (2019) "Catching your tail and firefighting": The impact of staffing levels on restraint minimization efforts. Journal of Psychiatric and Mental Health Nursing. 26(5-6):131-141

[21] Mind (2019) Discrimination in mental health services. Available at: Discrimination in mental health services | Mind

accessible to all communities. Many black men find their first interaction with services via the police during a crisis.[22]

9.4. Culturally sensitive care is necessary when caring for individuals from diverse backgrounds with a range of traditions, languages faiths and cultural norms around mental wellness and ill health. It is important to avoid the 'one size fits all' approach. New and evolving approaches to transcultural care must be adopted in the code of practice to meet the varying needs of individuals from culturally diverse backgrounds.

9.5. Central to developing transcultural and culturally-sensitive or competent care is the need to consider the impact of intersecting identities on outcomes and experiences. There should be an explicit reference to intersectionality as it is core to shaping lived experience and outcomes. The proposed reforms would be significantly strengthened if they were more explicit and defined in how they intended to identify mechanisms to tackle this. It is vital that mental health services build their ability to design care pathways that recognise and effectively mitigate the impact that the range of protected characteristics, as defined by the Equality Act 2010, have on patient outcomes and experiences.

9.6. In addressing the disproportionate use of the MHA on certain BAME populations, specifically black men, the legislation must set out the need for mandatory training for all staff working under the MHA. It is imperative that staff receive high-quality, evidence-based training on human rights and equalities issues in the context of the MHA. Training must include the impact of systemic, institutional and interpersonal forms of racism and discrimination. Training must also incorporate how to demonstrably identify and tackle all forms of bias that impact on the delivery of services, as well as the outcomes and experiences of patients and carers. Monitoring of this training should be included in CQC inspection guidance under regulations 18(2)(a)[23] and 10(2)(c)[24].

9.7. People from BAME backgrounds are significantly overrepresented in terms of the number of people detained under the MHA, and yet underrepresented within the statutory MHA roles (i.e. AMHP and AC/RC). More must be done to develop a clear and flexible career pathway/programme for nurse AC/RC. It is imperative that the workforce is representative at every level and layer of the people we care for, which will help to turn the tide in terms of organisational culture. This representation must also be extended to the new mental health advocacy roles.

9.8. The RCN welcomes The Patient and Carer Race Equality Framework (PCREF) to support NHS mental healthcare providers and local authorities to improve access and engagement with the communities they serve. There should be a statutory

[22] Centre for Mental Health (2020), Racial disparity in mental health: challenging false narratives. Available at: Racial disparity in mental health: challenging false narratives | Centre for Mental Health

[23] Part of staffing regulation concerning the receipt by staff of appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

[24] Part of the dignity and respect resolution concerning due regard for protected characteristics

requirement for all mental health services to report on their duties as set out in the Public Sector Equality Duty,[25] linked to objectives reflecting the Patient and Carer Race Equality Framework.

9.9. The Final report of the Independent Review of the Mental Health Act 1983[26] highlighted that "LGBTQ+ patients also reported being stigmatised and not having their needs addressed". Discrimination was also reported for asylum seekers and refugees as well as Gypsy, Roma and traveller communities . In the context of the proposed reform, we note that there is little recognition of the mental health needs of Eastern European communities alongside perinatal mental health issues. The proposed reforms say little about promoting the mental health of men. The proposed reforms should state explicitly and in full how such disparities in outcomes and experience will be tackled and must view its tasks in tackling poor mental health outcomes across the diversity of communities as a priority for action, investment and research.

Stephen Jones, Professional Lead Mental Health
Stephen.jones@rcn.org.uk

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[25] The Equality Act 2010 (Specific Duties) Regulations 2011 (legislation.gov.uk)
[26] Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (publishing.service.gov.uk) (pp.158)