PRISON REFORM TRUST

Prison Reform Trust response to Reforming the Mental Health Act – April 2021

The Prison Reform Trust (PRT) is an independent UK charity working to create a just, humane and effective penal system. We do this by inquiring into the workings of the system; informing prisoners, staff and the wider public; and by influencing Parliament, government and officials towards reform. The Prison Reform Trust provides the secretariat to the All Party Parliamentary Penal Affairs Group and has an advice and information service for people in prison.

The Prison Reform Trust's main objectives are:

- reducing unnecessary imprisonment and promoting community solutions to crime
- improving treatment and conditions for prisoners and their families
- promote equality and human rights in the criminal justice system.

www.prisonreformtrust.org.uk

Chapter 8 – Caring for Patients in the Criminal Justice System

Consultation question 20
To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings we want to introduce a 28 day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?
Yes.

Consultation question 20a
Please explain your answer
• Transfer from prison under the Mental Health Act remains problematic. Despite best efforts, reviews continue to report lengthy delays for people who are acutely ill. For this reason, we propose that a timeframe should be included in the Act within which the statutory time limit for secure transfers is implemented. • Transfers for women and children (<18 years of age) can be even more problematic. Women and children represent minority groups within the prison estate and, as such, are often held far from home. These long distances are frequently replicated when secure or specialist beds are

sought, making it hard for family ties to be maintained. Specialist provision for women and children should be made available to avoid additional delays, and to reduce/eliminate their being placed long distances from home.

- A single competent assessment should be undertaken and, if transfer under the Act is deemed necessary, the individual should be found the nearest available bed, at an appropriate level of security. Many prisons have within their mental health staff teams adequately qualified and experienced forensic psychiatrists[1] who could provide a competent assessment that would demonstrate the need for transfer and at what level of security. Another option might be to have a locally commissioned rota of psychiatrists to provide rapid response as needed.
- The transfer rule (the first 14 day 'clock') should commence from the moment a formal referral for assessment for transfer is made. It is reported that some patients have considerable waits for assessment.
- Unlike Part II of the MHA, there is no description of urgency in Part III or in the Code of Practice. This can lead to people in prison being segregated and placed on constant watch while awaiting transfer. Being held in such conditions will be, for most people, exacerbating factors in any deterioration of their mental wellbeing. This is an area where reform of the Act itself should support parity of esteem between people in the community and people in the criminal justice system. (For example, for individuals in a community setting, s.140 MHA allows CCGs to commission emergency beds when a person is deemed to require an admission under S2/S3 MHA, but where no formal admission bed space is identified. An equivalent process should be available for NHS England, enabling them to commission emergency beds for patients in the criminal justice system in need of assessment and/or treatment, to prevent their being imprisoned due to a lack of mental health resources.)

Consultation question 21

We want to establish a new designated role for a person to manage the process of transferring people from prison or an Immigration Removal Centre to hospital when they require inpatient treatment for their mental health.

Which of the following options do you think is the most effective approach to achieving this?

- **Expanding the existing Approved Mental Health Professional (AMHP) role in the community so that they are also responsible for managing prison/ IRC transfers**
- **Creating a new role within NHSEI or across NHSEI and HMPPS to manage the prison/IRC transfer process**
- **An alternative approach (please specify)**

[1] Their expertise may not, however, include learning disabilities and/or autism, and additional input may therefore be necessary.

We have no views on options for the most effective approach to achieving this. In whatever way the new designated role is fulfilled, it will be necessary for them to have the powers to hold responsible officers to account, in real time, through access to designated ministers at the Department of Health and Social Care and the Ministry of Justice, and timely, comprehensive data on performance against the 28 day target.

Consultation question 22
Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of Social Supervisor could be strengthened?
Ideally, the Social Supervisor should have expertise in learning disabilities and autism; if they do not, the psychiatrist must have that expertise.

Consultation question 23
For restricted patients who are no longer therapeutically benefitting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty. Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?
We agree.[2]

Consultation question 23a
Please give reasons for your answer
• An option should be available that is less restrictive than hospital (or custody), which effectively combines necessary treatment and support, with public protection. • Some people with learning disabilities and autistic people will find it easier to learn to make positive changes in their behaviour in a community setting, rather than in the artificial environment of hospital. • Further, there is merit in considering this option being available to the courts as an alternative to detention. As the White Paper is written, the 'therapeutic benefit' test will not be applied to detentions under Part III. A reasonable alternative for individuals unlikely to benefit, therapeutically,

[2] For questions 23, 24 and 25, our response draws on a discussion paper produced following a 'round table' held at the Prison Reform Trust on enabling discharge of detained people with intellectual (learning) disabilities and/or autism, available at http://www.prisonreformtrust.org.uk/Portals/0/Documents/Consultation%20responses/Facilitating%20Discharge%20second%20paper.pdf

from detention is that they move directly from court to ‘supervised discharge’.

- It may be necessary to place a mandatory requirement on health, social care and justice to work together to create and provide the necessary package of care and support, which should be co-produced by the person concerned.

Consultation question 24
We propose that a ‘supervised discharge’ order for this group of patients would be subject to annual Tribunal review. Do you agree or disagree with the proposed safeguard?
We agree.

Consultation question 25
Beyond this, what further safeguards do you think are required?
There are several required safeguards, including: • Advocacy support to understand options and rights including, for example, how to complain and appeal. • Restrictions should be time-limited, with the option to renew, and reviewed regularly. • Clear criteria to justify restrictions in the first place and to guide regular reviews. Reviews should be undertaken by people who are appropriately qualified and bring together justice, health, social care and advocacy perspectives. • Tribunals should have expertise appropriate to the individual being reviewed, for example, in relation to learning disability and/or autism. • The individual's support should be person centred and co-designed with the individual concerned and collaboratively by people with appropriate expertise across justice, health and social care, and underpinned by joint training. • Community treatment and support services must be properly skilled and resourced so that neither the individual nor the service is set up to fail.

Chapter 9 – People with a learning disability and autistic people

Consultation Question 26
Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people?
We agree.

Consultation Question 26a
Please give reasons for your answer
• People on the autism spectrum and people with learning disability should not be detained under the Act on the grounds of disability alone; we support the additional behaviour 'qualification' (namely, 'when their behaviour is so distressed that there is a substantial risk of significant harm to self or others (as for all detentions) and a probable mental health cause to that behaviour that warrants assessment in hospital.'). • In closing the option of managing people with a learning disability and autistic people under the Act, it is essential that a new community framework for long term informed care, including strategies for respite and crisis management is put in place. • Many people on the autism spectrum and people with learning disability, especially those with complex needs and/or challenging behaviour, require lifelong support. The need for support may fluctuate over time, but access to services needs to be more than a series of interventions.

Consultation Question 27
Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?
We disagree.

Consultation Question 27a
Please give reasons for your answer
• In the absence of adequate community support and services for people with a learning disability and autistic people, their behaviour may become distressed, and they may experience poor mental health. This, in turn, may prompt consideration of detention under the Mental Health Act. The proposed reforms must, therefore, ensure provision of timely and

accessible services for people with a learning disability and autistic people, and their families (see response to Q26a).

- Another likely scenario is that due to a person's learning disability and/or autism, their capacity to understand a situation may be limited or compromised. This may reduce or negate their ability to understand that a specific act or omission will bring them into conflict with the law. If a person's capacity to understand is uncertain, and community support and services inadequate, a criminal justice response is likely.
- Any contact with criminal justice services, whether as a victim or suspect, should prompt a Care, Education and Treatment Review.
- We further recommend a thematic review, in line with UNCRPD, of how children and adults with learning disability and/or autism should be supported to live independent and productive lives in the community. The review should seek to ensure necessary support throughout a person's life and a reduction in the need for crisis care.

Consultation Question 28
Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act Applies to people with a learning disability and autistic people?
Yes.

Consultation Question 28a
Please give reasons for your answer
There is the risk that people with learning disabilities and autistic people may be criminalised to facilitate hospital detention.

Consultation Question 29
We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?
We disagree.

Consultation Question 29a

Please give reasons for your answer

- This approach will create a confusing and unhelpful distinction between civil patients and people caught up in the criminal justice system.
- If the reason for excluding people with learning disabilities and autistic people from the civil sections is because these disabilities are life-long and 'cannot be removed through treatment', it is unclear why this is not equally relevant to those involved in the criminal justice system.
- Removing the option for hospital admission would, of course, mean there is the risk that people with learning disabilities and autistic people receive a prison sentence – and such individuals are currently to be found in prison.
- Prisons are inappropriate environments for many residents, perhaps especially so for people with learning disabilities and autistic people. There are, however, many others for whom prison is an equally inappropriate environment, including for people with mental health conditions, brain injury, those who have experienced severe trauma, and many more with complex health and social care needs.
- Creating an anomaly, whereby the same person may be exempted from long term detention in civil proceedings yet may be subject to long term detention in hospital through the criminal justice system is an unjust solution. Hospitals should not be used for detention without therapeutic benefit.
- One alternative is to undertake reform of the criminal justice system alongside that of the Mental Health Act. For example, HM Inspectorate of Prisons is currently leading an *Evidence review on neurodiversity in the criminal justice system*, and the recent White Paper, *A Smarter Approach to Sentencing*, sets out the government's proposals 'for important changes to the sentencing and release framework in England and Wales.' It would surely make sense to 'join the dots', and endeavour to create a system that is integrated, flexible and coordinated – able to respond to the particular needs of the individual rather than 'shoe-horning' them into a service simply because it is there/already exists.
- Justice system reform alongside that of the Mental Health Act could, for example, include the creation of community sentencing options that meet the needs of people with learning disabilities and autistic people; improved provision of adjustments across the criminal justice system, including prison; and greater availability/use of problem-solving courts (see, *A Smarter Approach to Sentencing,* 2020). Examples do exist, including Restorative Justice and Circles of Support and Accountability.
- There is merit in considering a new mandatory requirement for health, social care and justice agencies to work together to develop the necessary package of personalised intervention and support when a person with learning disabilities and/or autism enters the criminal justice system. The court, for example, would mandate community health and social care interventions and support as an alternative to hospital – a 'supervised diversion'.

- It is unclear whether exclusion from the civil sections means that people detained under criminal justice sections could be excluded from S.17 leave from hospital and Care and Treatment Orders and S.117 aftercare on discharge, and this should be clarified and further consulted on.

  We strongly urge further consideration of this recommendation.

Consultation Question 30
Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people?
Yes, there is the risk that people with learning disabilities and autistic people may be criminalised to facilitate hospital detention.

Part 3: The Government's Response to The Independent Review of The Mental Health Act

We also wish to make the following points regarding this section of the consultation document.

Advocacy
Recommendation 22: The statutory right to an Independent Mental Health Advocate (IMHA) should be extended so that it includes: **a) All mental health inpatients, including informal patients;** **b) Patients awaiting transfer from a prison or an immigration detention centre;** **c) People preparing their advance choice documents (ACDs) that refer to detention under the Mental Health Act.**
We are disappointed to note and reject the reasons given for the delay in extending the statutory right to an Independent Mental Health Advocate for patients awaiting transfer from a prison or an immigration detention centre (22b). Extending the statutory right is complementary to, rather than dependent on the development of the new role for managing transfers from prisons and immigration removal centres (131). There is a strongly held commitment to provide equivalence of care for those detained in prison. We strongly urge that 22b is progressed with the same urgency as that for patients included under 22a and 22b.

Policing

Recommendation 124: By 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety in the Act and ensure that the majority of people detained under police powers should be conveyed to places of safety by ambulance. This is subject to satisfactory and safe alternative health based places of safety being in place.

We are pleased to note the Government's commitment to end the use of police cells as a place of safety and remove them from the definition of a 'place of safety' under the Act by 2023/24, and applaud progress made. The Government should, however, further commit to 'new capital funding', as required, to ensure satisfactory and safe alternative health-based places of safety where there are gaps in provision, and that the 2023/24 target is realised.

Recommendation 127: NHS England should take over the commissioning of health services in police custody.

We agree with this recommendation. It is over ten years since this recommendation was first made (Bradley Report, 2009), and repeated in 2017 by the Angiolini Report. The arguments for transferring commissioning and budgetary responsibility from the police to NHS England are clear and well-rehearsed – they need no further elaboration.

We strongly urge that NHS England take over the commissioning of health services in police custody at the earliest opportunity, and that budgetary considerations to enable transfer are addressed by the 2022 Spending Review.

Patients in the criminal justice system

Recommendation 129: Magistrates' courts should have the following powers, to bring them in line with Crown Courts: remand for assessment without conviction under section 35 of the Mental Health Act (MHA); remand for treatment under section 36 of the MHA; the power to commit a case to the Crown Court for consideration of a restriction order following an 'actus reus' finding; the power to hand down a supervision order following an 'actus reus' finding (where a person is not fit to enter a plea, but has been found to have committed the offence) under S1a of the Criminal Procedure (Insanity) Act.

This recommendation reflects wider reforms proposed by the Law Commission in their thoroughgoing report on 'Unfitness to Plead' (2016). Some five years on, the Government should commit to an early date by which this recommendation is addressed, alongside the wider reforms proposed by the Law Commission.

Amongst other things, these include measures that enable defendants' effective participation in court proceedings through individualised adjustments, such as statutory entitlement to a registered intermediary, and adjustments to court procedures for defendants with disabilities such as learning disability and autism, mental health and other needs.

Recommendation 130: Prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the Mental Health Act.

We are pleased the Government agrees with this recommendation, but strongly reject the delays inherent in the suggested course of action. Prisons are neither safe, nor a place of safety – as the high levels, and rising incidents of self-harm and self-inflicted deaths testify. The use of prison as 'a place of safety' should be abolished forthwith, and arrangements made to enable the timely transfer of people from court to a healthcare setting, as required.

The immediate removal of prison as 'a place of safety' should be considered alongside the removal of prison for a person's 'own protection' (Bail Act 1976); see Prison for their own protection: the case for repeal, APPG on Women in the Penal System (Howard League for Penal Reform, 2020).

How often prison is used as 'a place of safety' or for a person's 'own protection' is unclear – data are not routinely collected locally or at the national level. Early findings (as yet unpublished) suggest that numbers are relatively small; ensuring adequate provision is, therefore, not an onerous or unreasonable request, especially given the high risk of harm that prison can inflict on people in need of specialist healthcare and support.

System-wide enablers: Data

Recommendation 145: Data on police use of detention powers under the Mental Health Act (sections 135 and 136) should be published on a quarterly basis as close to real time as possible and include new data on delays.

We support this recommendation and refute the claim by the Home Office that 'the disadvantages of the administrative efforts involved would outweigh any potential benefits of a more frequent collection.' The benefits of quarterly publication of data, as oppose to annual, is necessary to progress the removal of police cells as a place of safety (recommendation 124; above), monitor progress made and share practice.

Data should be collected on people with learning disabilities and/or autism throughout the criminal justice system and used to inform service responses.