

Response to consultation on the Mental Health Act Code of Practice



Introduction

The Sainsbury Centre for Mental Health is a core member of the Mental Health Alliance and endorses the collective response of the Alliance to this consultation. Our individual response focuses on areas of especial concern to our work: on the criminal justice system and the employment prospects of people with mental health problems.

Places of Safety

Sainsbury Centre agrees with the Mental Health Alliance that a clear statement at the outset of this chapter would be helpful to guide practitioners towards the minimum use of force in implementing sections 135 and 136.

9.14 We strongly support this paragraph and would argue that it should be a requirement of local services rather than just 'good practice'. Lord Hunt stated in debate that police stations should be considered places of safety "only if such use is compatible with local agreements on the use of places of safety" (26.02.07). Protocols governing places of safety should be considered a necessity in all localities.

9.19 This paragraph should include a statement that "use of a police station is not appropriate where local agreements on the use of places of safety (as set out in para 9.14) are not in place."

9.23 This is an important point. It would be strengthened by a requirement upon commissioners to make resources available for the provision of sufficient staff to carry out assessments to meet local demand for section 135 and 136 work. This should be linked to provision for liaison and diversion services in courts and police stations: whose coverage is currently patchy.

9.38 Monitoring of the use of sections 135 and 136 is vital. Mental Health Act Managers should take primary responsibility for this. In addition, statistics detailing the use of police stations and other premises as places of safety should be provided to the Mental Health Act Commission and the Independent Police Complaints Commission annually and any concerns about the implementation of these sections should be investigated by those bodies.

Supervised Community Treatment

28.2 The purpose of SCT should be stated to be to facilitate a person's recovery and to be the least restrictive alternative for the individual. It should be clear that SCT should not be used where a viable and safe less restrictive alternative (eg discharge from compulsion with the support of a CRHT team) exists for that person. This is noted in 28.6 but should be stated clearly at the outset of this chapter.

28.6 A further consideration should be the impact of discharge onto SCT or otherwise may have on the person's everyday life and on their recovery. Mental health services should be assisting people on their personal journeys to recovery from the outset. Choosing to use SCT should not merely be a decision about symptoms and medications but about the person's life and their own wishes for their future. When assessing a person for discharge these considerations should, as part of the CPA process, play a part in determining whether SCT is appropriate for them.

The case example of John focuses almost entirely on assessments of risk. It does not address the wider factors that should determine how John is assessed. Does John, for example, have a job or is he in education? Risks can be positive as well as negative, for example the risk of John becoming more isolated and excluded if he is not supported to (re)gain his independence.

28.19 We are concerned about the prominence in this paragraph of "where the patient is to live." This is a highly limiting condition that could have an adverse impact on a person's recovery. A residence condition should only be imposed where it is clearly necessary in the person's case and should not be assumed to be a regular condition of a CTO. A paragraph could be added below 28.19 stating:

"Conditions over and above those relating to treatment can be imposed should be subject to the agreement of the service user and should be weighed up against the risk of that individual being limited in their ability to re-establish an ordinary life following a spell of detention in hospital. Any such conditions that are imposed should come with agreed support as part of the person's CPA care plan to ensure they are assisted to comply with those conditions and to get on with their life without undue restriction. Conditions which are no longer necessary should be removed from the CTO immediately."

28.22 In addition to monitoring a person's mental health and wellbeing, we would expect CMHTs to monitor their progress towards recovery and any impact the CTO conditions were having on that; and to adjust the CTO to assist them to regain independence.

28.26 We agree fully that care planning in line with CPA is essential. We suggest that making the CTO part of a coherent CPA care plan should be a requirement, not merely good practice. Nobody subject to SCT should be excluded from CPA.

28.37 In addition to the points made in this paragraph, we would note that attending a medical examination may be difficult for a person in work, training or education. Reasonable adjustments to appointments should be made around a person's commitments in order to enable them to get on with their lives.

28.48 In addition to noting the person's right to S117 after-care we would add an expectation that they will continue to have a comprehensive care plan under the CPA for as long as they continue to need it.

Part III of the Act

36.2 We strongly endorse comments from NACRO and others about the importance of this paragraph. The new Code of Practice is an opportunity to re-state a commitment to liaison and diversion and the importance of effective local services being available around the clock and for all age groups. Young people face an especial shortage of diversion services.

36.14 We would add to this paragraph that many offenders may be better supported in the community than in custody. The courts have the option of community orders (with or without a mental health treatment requirement) as well as prison and secure hospital and these should be considered in the medical assessment.

36.25 This paragraph should state that transfer to hospital should take place within 14 days of a request for an assessment of need for hospital treatment being made. In addition to the procedures recommended by NACRO in its response to the Code, we would add that all transfers that take more than 14 days to complete should be notified to the Mental Health Act Commission. All prisoners awaiting transfer should be offered the support of an Independent Mental Health Advocate during this time and again on arrival in hospital.

36.26 We would add to this paragraph that any person who returns to prison following a S47 or 48 transfer should be offered a CPA-compliant care plan for as long as they continue to need it. It is the responsibility of prison inreach teams to ensure any needs identified in this process are met while they are in prison. On release, responsibility for this should be passed on to an appropriate community-based mental health team.