	APPENDIX 3	
Q Ref	**Consultation Question**	**SYSTEM RESPONSE TO DATE**
1	We propose embedding the principles in the MHA and the MHA Code of Practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?	Any applicable legislation under the MHA and Code of Practice, needs to be considered alongside the Children Act, this will reduce conflict between Health and LA's. The Principles of the Act should be at the forefront of all Department of Health and Social Care documents and policies that relate to the MHA - including the NHS Constitution. On a local level, the principles should similarly be embedded within all multi-agency 'policy statement' and introduction of all relevant policies, documents and training that guide mental health legislation and practice.
2	We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?	**AGREE but with caution- there has to be a balance between therapeutic benefit and management of risk.** Sometimes admissions have to be made primarily to keep the individual safe when specialist wards (that would provide the appropriate therapeutic input for the individual) have no capacity
3	We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person or the safety of any other person. Do you agree or disagree with this change?	**DISAGREE The criteria are too vague and open to significant interpretation**
4	Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal?	**AGREE but with caution. There are resource implications that need to be considered.**
5	We want to remove automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?	**AGREE**
6	We want to give the Mental Health Tribunal more power to grant leave, transfers and community services. We propose that health and local authorities should be given 5 weeks to deliver on direction by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount to time?	**LCC and CCG AGREE....LPFT DISAGREE** Concern from LPFT that Tribunals should recommend not enforce due to damage to the therapeutic relationship with clinicians.
7	Do you agree or disagree with the proposal to remove the role of the manager's panel in reviewing a patient's case for discharge from detention or a community treatment order?	**AGREE**
8	Do you have any other suggestions for what should be included in a person's advance choice document (ACDS)?	ACDs should be quickly and clearly identifiable within patient records, with regular review with patients. Need to be clear about the interface of the Mental Capacity Act (MCA) and the MHA here.
9	Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as in the case under the Mental Health Capacity Act?	**AGREE** The advance choice document (ACD) should depend on capacity as this aligns with current MCA legislation and guidance that they can make decisions.
10	Do you have any other suggestions for what should be included in a person's care and treatment plans?	Evidence based, NICE compliant, respectful of cultural sensitivities, health and social care alignment, proactive discharge planning, family and carer involvement. A focus on the persons full identity and understanding of impact of social stressors. For children, this needs to be considered alongside threshold criteria for support and relevant consents to treatment.
11	Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?	**AGREE- but ADVISE CAUTION ON THIS BECOMING A BLANKET APPROACH** This needs to be considered much more on an individual level, taking in to account the context of each decision, balanced against the nature and degree of the mental illness, and factors such as urgency of treatment and serious of suffering. The safeguard proposed (category 2) to seek two medical opinions should be backed by clear evidence of an MDT decision (to include relevant family / nearest relative / nominated person as appropriate). Seeking approval by court may lead to delays in decision making and potential impact on recovery. If someone has capacity and they fully comprehend the treatment being proposed and the pros and cons of the treatment then they should have a right to accept or refuse the treatment. There are many examples of a patient saying afterwards that they were glad that treatment was administered against there wishes to save their life and they are glad to be alive. Although difficult to predict accurately, the decision to withhold life saving treatment in order to respect a person's capacious wishes is a difficult one and should be taken very carefully and rarely.
12	Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?	DIS**AGREE** - there should be consideration of a 'full panel' decision, in line with that of a Tribunal, depending on the category and / or details of the specific treatment.
13	Do you agree or disagree with the proposed additional powers of the nominated person?	**AGREE** These additional powers provide support and a voice for the patient **as long as the nominated person is acting in their best interest**. There also needs to be consideration of factors such as coercion and control, given the powers that any nearest relative / nominated person may have. A clear process for over-riding this, for example where a nominated person is deemed not to be acting in the person's best interests, also needs to be in place.

14	Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?	**AGREE** This would need to be considered carefully and have sound reasoning for why someone with parental responsibility would not be suitable. We are concerned that this could be complex and could cause delays to treatment, especially if there is a need to 'override' the views of a person with parental responsibility.
15	Do you agree with the proposed additional powers of Independent Mental Health Advocates?	**AGREE**
16	Do you agree or disagree that advocacy services could be improved by:	**AGREE** All could improve advocacy services however the availability of advocates including diversity in the advocates to reflect the local population is paramount in improving their services (so as to cater for autistic people, those with learning disabilities and BAME).
	I. Enhanced standards	**AGREE**
	II. Regulation	**AGREE**
	III. Enhanced accreditation	**AGREE**
	IV. None of the above, but by other means	N/A
17	How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be subject to the powers which most appropriately meet their circumstances?	In practice, the current legislation and guidance is not very clear. The proposed dividing line that is based on whether or not a patient is lacking capacity is clearly objecting to detention or treatment could be a good starting point. Also a more appropriate principle could be considering the nature of the diagnosis, treatment and the need for safety.
18	Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the MHA and the MHA code of practice to make clear the availability of this right to individuals?	**AGREE** This needs to be considered much more on an individual level, taking in to account the context of each decision, including factors such as 'where' the individual will be admitted and treatment that will be provided / available. Decisions should already be made in the least restrictive way, with informal admission as a start point. Again, as noted, such decisions need to be clearly recorded and readily available.
19	We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do you think amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extent section 5 of the MHA?	**AGREE** An extension of Section 5 would be a great step towards parity of esteem between mental and physical health. Currently, if someone awaiting a mental health assessment leaves A&E, A&E departments do not have powers to stop them from leaving. If the police take a patient to A&E they have their powers to hold that person under S136 however if the police are not involved, A&E often uses hospital security to hold the individual despite not having the powers to do so. Section 5 would allow them to do this legally.
20	To speed up the transfer from prison or IRC 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 transfer?	Yes - given the extent of mental illness in the custodial system there needs to be adequate provision in that system and in the court diversion approaches. However, "The transfer and remission of adult prisoners under the Mental Health Act 1983: Good practice guidance 2019 (NHS England and NHS Improvement) already sets such targets. The issue remains lack of suitable (and local) secure inpatient services to meet the demand; and without significant investment in increasing this number such 'time limits' will remain arbitrary. Need close partnership working between Prison and Healthcare on both sides before transfer.
21	We want to establish a new designated role for a person to mange the process of transferring people from prison or an IRC to hospital when they require inpatient treatment for their mental health. Which of the following option is the most appropriate to achieve this?	Option I preferred- with suitable training and support .
	I. Expanding the existing approved mental health professional role in the community so they are responsible for managing prison/IRC transfers	
	II. Creating a new role within NHSEI or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison/IRC transfer process	
	III. An alternative approach	
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?	Clarity – and strengthening - of this role is well overdue - with better training and support with competencies and skills better defined.
23	For restricted patients who are no longer therapeutically benefiting 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?	**AGREE**

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?	**DISAGREE** An initial Tribunal review should be completed after 6 months, then again at 12months, and then annually.
25	Beyond this, what further safeguards do you think are required?	An option needs to be explored that such discharges are subject to renewal processes, similar to that of CTOs; so there is additional oversight from AMHPs in all stages of the process.
26	Do you agree or disagree with the proposed reforms to the way the MHA applies to people with learning disability and autistic people?	**AGREE** People should not be detained due to their LD/ASD, and that assessment needs to determine that it is due specifically to mental health concerns.
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?	**AGREE** The proposed reforms set out MHA assessments and detention under the act as the last resort for people with a learning disability and autistic people and would state that this needs to be a clear consideration as part of assessment..
28	Do you expect that there would be unintended consequences of the proposals to reform the way the MHA applies to people with a learning disability and autistic people?	**AGREE** As above, any such reforms need to be backed by robust community services, particularly where there is a substantial risk of significant harm to self or others
29	We think that the proposal to change the way that the MHA 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?	**AGREE** However, more clarity is needed. Impact of remaining in custody, vulnerability, context of offending behaviour, and issues of public protection also need to be considered.
30	Do you expect that there would be unintended consequences on the criminal justice system as a result of our proposals to reform the way the MHA applies to people with a learning disability and to autistic people?	Yes- There could be an increase in requests for Welfare Secure beds for children and young people and there is already a notable increase of people with a learning disability within the prison system. Changes to detention criteria that mean that people remain in prison for longer periods of time need to be avoided. Implementation of more robust court liaison and diversion services, alongside investment in community services, including crisis support will be needed.
31	Do you agree or disagree that the proposal that recommendations of a CTR for a detained adult or of a CETR for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?	**LCC and CCG AGREE-** Simplification and alignment of CTR alongside care and treatment plans will lead to 'joined up thinking' and facilitate better outcomes and shorter admission. But there is likely to be a conflict in the legislative requirements. There needs to be a clear process for any professionals to justify why a CETR recommendation is not appropriate, otherwise could be held to account for not implementing things which they believe could be harmful. E.g. recommending respite could be harmful to familial relationships . **LPFT DISAGREES** as there may be factors beyond the Responsible Clinician's (RCs) control that may prevent CTRs being implemented. Increases the burden on RCs without appropriate authority or control of the required resources.
32	We propose to create a new duty on local commissioners to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?	**AGREE**
33	We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?	**AGREE**
34	What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?	There needs to be an agreed joined up approach, current application is arbitrary the burden can fall to one service, this creates delays in Care Packages and transfer.
35	How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?	More inclusive involvement of AMHP's in reviews, including more thorough review of admission processes and barriers. Review of discharge processes and planning, including implementation of aftercare policy and procedures. A review of re-admission / re-detention to hospital would also help to understand where there needs to be improvement on joint working between inpatient and community services. It is so refreshing to see that EDI measures are now being reflected - everyone is treated equally and fairly and disparities experienced by individuals from black and minority ethnic backgrounds are tackled. Similarly, that individuals with a learning disability and autistic people are treated better in law and reduce the reliance on specialist inpatient services for this group of people.

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