General Psychiatry

Response to the white paper on MHA reform: marginalisation of patients detained under part III of the MHA

Sarah Markham

To cite: Markham S. Response to the white paper on MHA reform: marginalisation of patients detained under part III of the MHA. *General Psychiatry* 2021;**34**:e100524. doi:10.1136/gpsych-2021-100524

Received 08 March 2021
Revised 23 March 2021
Accepted 15 April 2021

Biostatistics and Health Informatics Department, Institute of Psychiatry, Psychology and Neuroscience, London, UK

Correspondence to
Dr Sarah Markham;
sarah.markham@kcl.ac.uk

In England and Wales, the Mental Health Act (MHA) 1983 provides the legal framework for the detention of individuals suffering from a mental disorder if they are judged to present a risk of harm to self or others. The MHA removes from certain psychiatric patients civil liberties otherwise inherent in our legal system. Through both statute and common law, it balances a patient's right to autonomy with psychiatrists' duty of care by reference to the health and safety of the patient. It also balances the civil rights of individual patients against the right of society to protection.[1]

The 2018 Independent Review of the Mental Health Act (1983) set out recommendations for the government on how the MHA and associated practice needed to change in its final report 'Modernising the Mental Health Act'.[2] This led to the development of the government's plans to reform the Act, together with the associated policy and practice, as set out in the white paper.[3] The proposals take forward the recommendations made by the Independent Review and the full government response. The government is now consulting on its proposals before bringing forward a bill to amend the act. This commentary highlights the white paper's marginalisation of patients detained under part III of the MHA.

As a member of the Independent Review's Department of Health and Social Care Topic Groups tasked with formulating recommendations for revision of the detention criteria and part III of the MHA, I am delighted that so many of our recommendations have been approved or are being given serious consideration by the government. However, I have substantial concerns about the white paper's differential approach to civil (part II) and forensic (part III) patients, specifically the exclusion of forensic patients from the proposed changes to the detention criteria in the MHA.

Part II of the MHA deals with patients who are detained in the hospital but have no criminal proceedings against them. These are referred to as civil sections. Part III of the MHA, known as the 'Forensic Sections', deals with patients who have been involved in criminal proceedings. The detention criteria are the fundamental justifications that allow approved clinicians to remove a person's liberty and give them treatment without consent. The criteria that must currently be met are that a person must be suffering from a mental disorder with symptoms severe enough to present a risk to themselves or to other people. This assumes a direct link between symptom severity and risk of harm to self and others. However, it has never been clinically proven that such a simplistic association necessarily exists at the individual patient level. Risk of harm to others is a multifactorial outcome, and the nature of the relationship between the various possible variables and presenting risk is dynamic, complex and differs at the individual patient level.[4]

Although it may be accepted that there are circumstances that necessitate the use of these powers, they should not be used lightly; these are strong state powers to detain people and deprive them of both their liberty and their right to make choices about their care and treatment. The white paper states that the government proposes to 'revise, strengthen and clarify the detention criteria to ensure that, in the future, detention only takes place or is sustained when it is absolutely appropriate'. It acknowledges that there must be 'better and more transparent decision making', when assessing whether someone meets the criteria for (continued) detention under the act, *unless the person concerned is a forensic mental health patient*. I posit that there is no moral, lawful or clinical reason for making such a distinction.

In the white paper, the government proposes, in accordance with the Independent Review's recommendations, that it must be demonstrated that the purpose of care and treatment is to bring about a therapeutic benefit; care and treatment cannot be delivered to the individual without their detention; and that appropriate care and treatment are available. The government further agrees that the current wording within the MHA that detention is lawful for the interests of the patient's 'own health or safety or with a view to the protection of other persons' is too ambiguous and may have contributed to growing risk aversion among some professionals, particularly regarding patients with a learning disability and autistic people. It is also proposed that for someone to be detained, it must be demonstrated that there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. The risk of harm posed by the individual must be evidenced and recorded and assessed on a case-by-case basis, documenting the specific risks that justify detention and how detention will deliver therapeutic benefit in the new statutory care and treatment plan, taking a positive approach to clinical risk management and regularly reviewing if the individual continues to meet the detention criteria on the grounds that they pose a substantial risk to themselves or others. Given the higher levels of perceived risks assigned to forensic patients, I would suggest that it is essential that at least the same degree of rigour is applied to such decision-making regarding forensic patients as the ostensibly less risky civil patients.

Part III of the MHA concerns the most stigmatised and restricted of patients, those detained in secure and forensic psychiatric hospitals and whose past behaviours retain salience not only in the present, but also potentially indefinitely, and wherein the concept of risk is omnipresent, dominating policy, procedure and practice.[5 6] The MHA provides the Crown Courts with a range of dispositions when convicting people of serious criminal offences in the context of a diagnosable and treatable mental illness. These measures include detaining a person for treatment (section 37) and restricting discharge if they are deemed to present an enduring serious risk to the public (section 41). The medical model views the crimes of forensic patients to result from their illness.[7] The criminogenic perspective, in contrast, assumes that offending is caused by a direct personal propensity, which may coexist with mental disorder.[7] Clinical and sociological research indicates that dynamic interaction of individual, social and contextual factors with clinical variables plays an important role as a determinant of violence.[8] It is the consultant forensic psychiatrists who make the risk judgements who are accountable to the Home Office for any harm enacted by their patients and who therefore have a strong professional and personal interest in ensuring their patients are restricted. Protecting themselves from blame is a strong motivator, one which may result in defensive and disproportionately risk adverse practice.[9] The chair of the Independent Review, Simon Wessely (a former consultant forensic psychiatrist), was very vocal throughout the review regarding defensive practice in mental health services, especially in secure settings, and wrote very candidly about this in the final report of the 2018 Independent Review of the MHA.[2] Psychiatrists are not necessarily indifferent to the impact of detention on their patients concerns but are themselves subject to imperatives of surveillance and control of so-called mentally disordered offenders.[2] 'Sometimes I think we try to change somebody's circumstances to deal with our own anxieties, rather than the concerns they have about themselves or the risks they actually present'.[10]

There is no moral, clinical or lawful justification for excluding forensic patients from these proposed changes. It is as just as important for forensic patients as for civil patients to ensure that they are only detained when there is a clear justification for doing so and that they are discharged as soon as that justification ceases to exist. Indeed, it can be argued that it is part III of the MHA to which the recommended changes are most needed primarily because of the pervasive nature of the disproportionate risk aversion practised in secure and forensic psychiatric hospitals, especially regarding the Ministry of Justice overseen 'restricted' patient cohort; patients who are categorised as having committed the most serious offence(s).[11]

It is not only forensic patients and their families who will suffer if they are excluded from the proposed recommended changes but also the tax-paying public. Forensic patients are detained in secure hospitals, high-cost, low-volume services that consume around a fifth of the overall mental health budget in England and Wales. The cost per patient in such hospitals ranges from £152 000 per year in a low secure hospital to £273 000 per year in a high secure hospital.[12] In spite of this, there is little evidence that forensic mental health services improve outcomes for this cohort.[13]

The white paper posits that patients in the criminal justice system have a unique risk profile; however, there is no clinical evidence to support this claim, especially given the clinical, social and behavioural diversity presented by the individual patients who receive a forensic section.[14] Furthermore, this contradicts the white paper's assurance that the new MHA will embrace the core principle of ensuring patients are viewed and treated as individuals. The White Paper states that it will be ensured that patients are viewed and treated as rounded individuals in accordance with the NHS Constitution's statement that staff should 'value each person as an individual, respect their aspirations and commitments in life and seek to understand their priorities, needs, abilities and limits'.[3] It would be not only be unwise and unjust, but also contradictory to not to include part III patients in the recommended changes to the detention criteria of the MHA.

The white paper also asserts that changing the detention criteria for part III patients would limit the scope for professional discretion or judgement regarding risk, and therefore compromise their ability to protect the public

from risk of harm from sometimes serious or violent offenders. Again, there is no evidence to support this claim; numerous research studies having found that clinical judgements regarding risk are no more reliable than those made by tossing a coin or by any non-expert.[15] It has been noted that 'risk perspectives of experts are privileged as objective and factual over those of lay people' whose perceptions are found wanting and contaminated by cultural influences.[8] Clinical perspectives are somehow regarded as immune from these very same influences. Clearly, in reality, this is not necessarily the case. As Simon Wessely clarified in the introduction to the final report, such discretion or judgement is often little more than the expression of a practitioner's subjective, self-protective anxieties.[2]

Part III patients, otherwise known as 'mentally disordered offenders' are seen as unpredictable and, by virtue of their previous actions, dangerous.[7] The predictive accuracy of assessing the risk of harm a patient poses to others is fraught with problems such that even the best actuarial tools perform below that which is commonly acceptable in other branches of medicine.[16]

Currently, a patient's detention can be sustained by a consultant psychiatrist's mere subjective, unexplained, unreasoned and non-evidenced opinion that risk is extant. Although Mental Health Review Tribunals (MHRTs) offer apparent rights of redress to detained patients, there is evidence that MHRTs, through their lack of governance by rules of procedure and evidence, fail to operate so as to protect the civil rights of patients as might be implied by the provisions of the Act itself.[17 18] The criticism includes concerns that MHRTs are overly influenced by the views of the doctors in charge of patients' care and that some tribunals amount to little more than 'glorified clinical case conferences' applying an odd mix of investigative and adversarial approaches.[19] In the context of an MHRT, panel members, including judges, will not necessarily challenge a treating psychiatrist's single-sentence statement that the risk of harm exists, let alone ask for a reasoned explanation or justification of their view.[20] While such practice persists, there remains huge scope for forensic patients to be detained for excessively long periods of time in isolating, minimally therapeutic locked settings. This is a potentially serious human rights issue and one that needs to be addressed.

Forensic patients are vulnerable to the potentially devastating double burden of mental health and criminal stigma due to past offending behaviour.[21] They may by default be viewed and treated, both by services and courts as inevitably and enduringly mad, bad and dangerous to know. Yet as individuals, this is not necessarily the case. In certain cases, forensic patients may present a long-term risk of harm to others, but this is not necessarily true of everyone who has committed an index offence, especially those whose sole index offence has been recognised in the courts as being an isolated incident and uncharacteristic of the individual concerned. It is those patients, civil and forensic, presenting with recent patterns of violent behaviour who are likely to present an ongoing risk of harm to others and to whom detention under the MHA may be clinically and lawfully relevant.[8]

Community forensic psychiatry services represent an evolving compromise between concern about overzealous control of those with mental disorder against the opposing concern about those discharged from secure hospitals receiving inadequate supervision of their risk to others from community psychiatric teams without forensic expertise. These services deal with 'restricted' patients: those discharged on a conditional basis under section 41 who are subject to supervision arrangements, such as adherence to a plan of care, permitting supervisory access to living locations and restrictions on travel or contacting specific individuals. The Ministry of Justice retains the right to recall individuals to hospital where concerns about risk behaviours are raised.[7] There is evidence that patients discharged from secure hospitals into such community forensic psychiatry services have lower offending outcomes than many comparative groups.[11] This may serve to offer reassurance to the public that patient risk can be managed in the community and thereby assuage prejudice and discrimination against people with mental disorders.

It is encouraging to see that the government agrees 'in principle' with the recommendation that 'there needs to be a concerted, cross-organisation, drive to tackle the culture of risk aversion'. It concurs with the review's recommendation that this will need to include the Chief Coroner, Care Quality Commission, the National Health Service, the Association and Directors of Adult Social Services, the Local Government Association, patients, carers and provider boards to understand the cultural drivers behind their different conceptualisations of risk and how they can be harmonised. However, this remains in stark contrast to the differential approach the rest of the white paper takes to part III patients and may lead to the non-evidenced simplistic and stigmatic discourses that pervade forensic psychiatric practice, for example, that patients present an enduring significant risk to the public, remaining unchallenged.[22] Even putting aside such concerns, to ensure that a forensic patient's risk is neither underestimated nor overestimated, it is crucial that at least the same degree of robustness and clarity, which it is proposed is applied to part II patients, regarding detention is applied to their part III peers. This is as much as to protect the public as it is to uphold the human rights of individual patients.

I am also concerned that patients who are detained in secure and forensic settings and who are therefore especially hard to reach and hear, with little if any access to the internet and other modern forms of communication, may not be given sufficient opportunity to participate in the current consultation on the government's white paper. The proposed changes in mental health legislation have the potential to impact significantly on all mental health patients' well-being, especially those such as forensic patients, who are subject to the severest

degrees of externally and internally imposed restriction. If patients are not to be detained unnecessarily, it is essential that there are safeguards to ensure that judgements are evidence-based, rather than based on pure clinical judgement, which has been demonstrated to be unreliable.[23] It is therefore of paramount importance that the proposed revision to the detention criteria include both civil (part II) and forensic (part III) patients.

I hope clinical practitioners, other healthcare staff and above all patients, together with their families and friends, will read and consider the implications of the white paper and take this rare opportunity via consultation, to act to protect all vulnerable patients' well-being and human rights.

Twitter Sarah Markham @DrSMarkham

Contributors SM is the sole author.

Funding The author has not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

ORCID iD

Sarah Markham http://orcid.org/0000-0002-8755-5935

REFERENCES

1 Eastman N. Mental health law: civil liberties and the principle of reciprocity. *BMJ* 1994;308:43–5.
2 Department of Health and Social Care. *Modernising the mental health act – final report from the independent review, published 6 December 2018 last updated 14 February 2019*. London, UK: Department of Health and Social Care Publications, 2019.
3 Department of Health and Social Care. *Reforming the MHA*. London, UK: Department of Health and Social Care Publications, 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951741/mental-health-act-reform-print.pdf
4 Sirotich F. Correlates of crime and violence among persons with mental disorder: an evidence-based review. *Brief Treat Crisis Interv* 2008;8:171–94.
5 Shattell MM, Andes M, Thomas SP. How patients and nurses experience the acute care psychiatric environment. *Nurs Inq* 2008;15:242–50.
6 Vatne S, Fagermoen MS. To correct and to acknowledge: two simultaneous and conflicting perspectives of limit-setting in mental health nursing. *J Psychiatr Ment Health Nurs* 2007;14:41–8.
7 Coffey M. A risk worth taking? value differences and alternative risk constructions in accounts given by patients and their community workers following conditional discharge from forensic mental health services. *Health Risk Soc* 2012;14:465–82.
8 Lupton D. *Risk*. 2nd edn. New York: Routledge, 2013.
9 Szmukler G. *Men in white coats: treatment under coercion*. Oxford University Press, 2018.
10 Norko MA, Baranoski MV. The prediction of violence; detection of dangerousness. *Brief Treat Crisis Interv* 2008;8:73–91.
11 Fazel S, Fimińska Z, Cocks C, *et al*. Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis. *Br J Psychiatry* 2016;208:17–25.
12 Durcan, et al. Unlocking pathways to secure mental health care. *Centre for Mental Health* 2011.
13 Maden A, Rutter S, McClintock T, *et al*. Outcome of admission to a medium secure psychiatric unit. I. short- and long-term outcome. *Br J Psychiatry* 1999;175:313–6.
14 Shepherd A, Doyle M, Sanders C. *Personal recovery within forensic settings – systematic review and meta -synthesis of qualitative methods studies*. London, UK: Criminal Behaviour and Mental Health, 2015.
15 Higgins N, Watts D, Bindman J, *et al*. Assessing violence risk in general adult psychiatry. *Psychiatric Bulletin* 2005;29:131–3.
16 Swanson JW. Preventing the unpredicted: managing violence risk in mental health care. *Psychiatr Serv* 2008;59:191–3.
17 Peay J. Mental health review tribunals: just or efficacious safeguards? *Law Hum Behav* 1981;5:161–86.
18 Peay J. *Tribunals on trial: a study of decision-making under the mental health act, 1983*. Clarendon Press, 1989.
19 Law Commission. *Mentally incapacitated adults and decision making, public law protection*. London: HMSO, 1993.
20 Richardson G, Machin D. Doctors on tribunals. A confusion of roles. *Br J Psychiatry* 2000;176:110.
21 Drennan G, Alred D. *Secure recovery: approaches to recovery in forensic mental health settings*. Willan 1st edn, 2012.
22 Vivian-Byrne SE. What am I doing here? safety, certainty and expertise in a secure unit. *J Fam Ther* 2001;23:102–16.
23 Bonta J, Law M, Hanson K. The prediction of criminal and violent recidivism among mentally disordered offenders: a meta-analysis. *Psychol Bull* 1998;123:123–42.

Dr Sarah Markham graduated from the University of Cambridge with a master's degree in Mathematics in 1996, and from the University of Durham with a PhD in Hypercomplex Hyperbolic Geometry in 2003. At present, she is a Visiting Researcher in the Department of Biostatistics and Health Informatics, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK. Her main research interests include risk-related discourses and practices in secure and forensic psychiatric services, the quality of practice in the First Tier Tribunals for mental health and the development and application of digital technologies to deliberation in Health Technology Assessment.