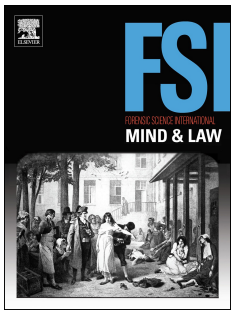

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PII: S2666-3538(21)00019-9

DOI: https://doi.org/10.1016/j.fsiml.2021.100062

Reference: FSIML 100062

To appear in: *Forensic Science International: Mind and Law*

Received Date: 29 March 2021

Revised Date: 25 June 2021

Accepted Date: 12 July 2021

Please cite this article as: Heym N., Mudholkar S., Sumich A.L. & Kumari V., The Mental Health Act reform – How proposed changes potentially impact personality disorder services, *Forensic Science International: Mind and Law* (2021), doi: https://doi.org/10.1016/j.fsiml.2021.100062.

The Mental Health Act reform – how proposed changes potentially impact personality disorder services

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In January 2021, following an ambitious programme to transform mental health care and an Independent Review (Wessely, 2018), the UK government released a White Paper (Dept of Health & Social Care, 2021) on Reforms of the 1983 Mental Health Act (MHA). This is aimed mainly at achieving higher quality, accessible mental health care, closer to home for an additional two million people by 2023-2024, as well as providing *voice* to people detained under MHA during the process and continuation of detention.

Some of the recommendations highlighted are to (i) change both law and practice to empower patients' choices to shape their care and treatment, and (ii) improve care for patients within the criminal justice system (CJS). The NHS England and Improvement (NHSEI) long-term plan for this transformation of mental health care envisages services with enhanced rights for patients through better crisis care, alternatives to detention and community care services. Consequently, the White Paper covers (i) proposals for reform and plans for legislative change, (ii) ongoing work to reform policy and practice to support the implementation of the new MHA, and (iii) the government's response to all 154 recommendations made by the Independent Review. Proposed changes are based on 4 principles:

1. **choice and autonomy** – ensuring that service users' choices are respected through statutory advance choice documents incorporated into care planning, including treatment refusals and preferences, and ensure legal protection for these documents
2. **least restriction** – ensuring the MHA is used in the least restrictive way including revision of the criteria around the risk of harm posed by the individual to themselves or others, so detention is only used when the risk is considered substantial, and must be explained to the patient and formally recorded including advance choices
3. **therapeutic benefit** – appropriate treatment is available in hospital with a focus on supporting recovery and discharge
4. **person as an individual** – ensuring patients are viewed and treated as individuals.

The details of all proposed changes and their merits are beyond the scope of this article. Here, we highlight the potential impact on key areas in Part III of the MHA 1983, dealing with mentally disordered offenders (MDOs) and interface with CJS. Detention is particularly relevant in personality disorder (PD) services as there has been a rich, long running debate around the issues of least restriction and therapeutic benefit in PDs, particularly in the context

as to whether to regard PDs as mental illness or disorder (see Kendell, 2002 for in-depth discussion). In brief, PDs are considered distinct from mental illness in their enduring long-term patterns of extreme deviations of behaviour rather than morbidity with concrete onset and time-course per se. Nevertheless, individuals with PDs are at increased risk of different mental disorders, and prognosis for these is poorer due to the coexistent PDs, which themselves have poor treatment outcomes. Given this complex relationship, PDs are relevant to clinical practice, and therefore, the MHA review. Moreover, the current position of the MHA, the ICD-10 and the DSM-5, alongside current legislations, is to treat PDs within the context of a broader definition of mental disorder. We, therefore, focus here on how the proposed reforms might impact detention and appropriate care for people with PDs within the CJS and community routes, with recommendations.

PD is common among criminal justice populations with prevalence rates significantly higher among sentenced prisoners compared to the UK general population (61% vs 4.4%; Joseph & Benefield, 2010); with a well-documented relationship with offending risk (Craster & Forrester, 2020). Several policy changes have directly affected management of PD offenders (PDOs) in prisons and hospitals over the past 20 years. The Dangerous and Severe Personality Disorder (DSPD) programme (2001) dealt with detention and management of high risk individuals with severe PD across four high-secure units (Dept of Health & Home Office, 1999), allowing indeterminate preventative detention for those posing a danger to the public independent of treatability of their condition. The treatability criteria of PDs - the so-called "treatability test" - were disbanded as the MHA 1983 was amended in 2007 (though see Sen & Irons, 2010 for further discussion). Despite substantial critiques, DSPD units continued but eventually decommissioned in 2017, mainly due to limited evidence around treatment efficacy, little therapeutic activity, excessive costs (£100k per bed/year), challenges with progression pathways to lower security, and ethical concerns around balancing public concern, preventative detention and treatment (e.g., Trebilcock, 2021; Tyrer et al., 2010). Nevertheless, this initiative led to significant service development for PDOs, and lessons learned paved the way for challenging the common view of "untreatability of those with severe PD". Importantly, it secured resource investment into supporting PD services more widely at all stages of health and CJS - through establishing the new national Offender PD Pathway (OPD) in 2011 within the prison and probation system offering interventions to the most high-risk and complex cases in prison (National Offender Management Service and National Health Service England, 2015a, 2015b), including development of National Institute of Care and Excellence guidelines for

Borderline and Antisocial PDs (NICE, 2009a, 2009b, 2015), but also beyond forensic services through establishment of Community-to-Community Pathway services post 2013 supporting clear progression routes and reintegration into community.

*The new reforms impact the detention of mentally disordered offenders***,** including PDOs, aiming to enhance the powers of Magistrates' courts to divert individuals to secure care at the earliest opportunity and to reform the "unfit to plead" issues. Every year, nearly 1000 prisoners across England and Wales become mentally ill and require transfer to mental health settings under the MHA. The proposals include reducing the time on remand for those who suffer from mental disorder (either new onset or relapse) and meet the criteria for detention to a maximum of 28 days from the point of referral to NHSE to ensure early treatment access. Judicial services are to work with medical professionals to enable direct transfer from court to appropriate healthcare services for defendants with acute mental illness rather than relying on prisons as 'places of safety' for these individuals. This will have implications on secure psychiatric service provision for PDOs.

That is, diversions from Magistrates' courts are usually for lower level offences (custodial sentences up to 6 months), who often do not meet criteria for thresholds of transfer to medium/high secure units, whereas more serious offences are referred through Crown court. High rates of referrals through Magistrates courts to low secure services might be hampered by logistic barriers. For example, referrals to high secure units can sometimes take several months - one of the reasons for delay in transfer of prisoners to psychiatric hospital is a complex referral process involving prison and probation services, NHSE, secure psychiatric providers and the Ministry of Justice (MoJ), as well as the "capacity issue" such as availability of appropriate secure bed and manpower to undertake assessments promptly. Currently the proposal does not address the complex issues encountered in different referral routes and logistic barriers to service provision. Whilst it is a welcome aim to limit the time patients spend on remand and courts are being offered more power of referral, in reality, further discussions are needed with stakeholders in facilitating speedy admission of patients to different secure settings. This might involve engaging low secure services within court liaison teams rather than them working in isolation. One solution might be to create specialist forensic intensive care units (FICUs) that support decision making and speedy admission. There is also consideration to have an independent person to authorise transfer of prisoners to secure psychiatric hospitals, rather than Secretary of State, but it is unclear who will be given this authority. One consideration is to delegate this responsibility to Approved Mental Health Practitioner (AMHP) or another person

independent from MoJ. There needs to be a serious thought into who will authorise such transfer as that person will be responsible for any failures resulting in risk of serious harm to public. Moreover, greater clarity is needed to support these decisions about appropriate transfer from prison to hospital to facilitate a coherent and consistent practice. A recent Delphi study indicated some consensus amongst professionals around criteria suitable for hospital admission – including (i) complexity (comorbid PD/severe mental illness, BPD/PPD); (ii) clinical characteristics such as psychiatric history, prior engagement with treatment and suicide risk; (iii) offence history; and (iv) high level of risk to others (Foyston et al., 2019). Nevertheless, heterogeneity in responses amongst the professional experts also highlight the diverse opinions regarding transfer and the importance of individualised care alongside structured and consistent guidance for the referral process.

In line with *the least restrictive principle, the criteria around the risk of harm* posed by individuals to themselves or others are revised, and detention is only to be used when the risk of harm is substantial. Here it is proposed to increase the frequency of patient reviews against these new criteria, making longer-term detention more difficult once the patient is no longer considered a significant risk and where treatment or detention ceases to have therapeutic value. Indeed, the likelihood of therapeutic benefit is particularly relevant in the context of PD care. As treatment of the core disorder (aka personality change) is not realistic, the aim is to provide more adaptive skill sets to enable patients to cope with their disorder and deal constructively with problematic interpersonal issues (see Sen & Irons, 2010 for discussion). As the therapeutic benefit is less clear upfront and may take much longer to show effects, it is crucial to have detailed assessment and monitoring strategies in place. Within the MHA, the hybrid order Section 45a allows a period of assessment to determine suitability for hospital or prison-based care and is often applied for PD patients. It is important to retain the provision of the hybrid order so that those who are unlikely to benefit from treatment can be remitted back to prison as otherwise secure hospital resources taken up with patients who are disengaged or untreatable. The reforms also improve patients' rights around challenging their "unjustified" detention. Here, proposed changes include that mental health tribunals receive statutory powers to transfer a patient to alternative hospitals and to grant leave, and streamlining the parole board and mental health tribunals for MDOs who are on indeterminate sentence for public protection (IPP) as well as prison transfer direction under Section 47/49 of MHA 1983. These proposals might be particularly advantageous to speed up the process of conditional discharge, considering that in the past, patients would have to wait a considerable period before parole board hearings

occurred. However, in terms of clinical reality there is still an issue revolving those who fall between CJS and MHA 1983 (amended 2007) referrals are not being attended due to their history of shorter sentences (<4 years) despite a strong likelihood of suffering from co-morbidities such as substance abuse, affective disorder and attention-hyperactivity-deficit disorder (ADHD). Thus, a significant proportion of PDOs do not receive access to service provision through either CJS or MHA route. This is a population that has been typically missed in the past and will likely continue to be missed under the reformed MHA.

Whilst maintaining a focus on public protection, rehabilitation and reduced re-offending, the current reforms also *shift the focus from reactive care to preventative measures and early intervention in the community*. Here, they aim to transform MH crisis care by making more emergency MH services available to prevent detention. The advantages of Community Treatment Orders to facilitate engagement with treatment to avoid detention have been considered previously (Sen & Irons, 2010). Indeed, established crisis teams in the community show early indications of working well. They improve access to community-based mental health support, including crisis care, to prevent avoidable detentions under the MHA. Community PD services have led to clearer care pathways and shown positive impact on well‐being through better health and life outcomes (employment, housing; Crawford & Rutter, 2007; Pidd & Feigenbaum, 2007). As part of the NHS long-term plan, an integrative care system (ICS) includes providers and commissioners of NHS services in a geographical area who collectively will have MH practitioners based in GP services. This will allow a more seamless service provision between secure and community services.

Nevertheless, for this to work, there is an urgent need to identify PD needs and responses within those preventative settings**.** Indeed, almost half of all psychiatric out-patients or people served by community mental health teams have mild-to-moderate levels of PDs, currently not adequately considered (Tyrer, 2020). Concerns have been raised around the lack of research on the complex needs of individuals with PD (e.g., comorbidities and offending risk) and formal assessment across services. This includes the efficacy of existing screening procedures for early identification to facilitate appropriate and speeded referral within community pathways or the CJS – as well as considering feasibility and logistical barriers to such delivery (see Craster & Forrester, 2020). One low cost and scalable method to achieve this could be through the routine use of valid self-report (or informer-based) digital screening/decision tools for PDs (Goorden et al., 2017) in all relevant settings, which, if indicated, could be followed up with more traditional assessments by a qualified mental health

professional and a referral made to appropriate services. One suggestion is the new classification systems offered by the DSM-5 Section 3 (PID-5), which is relatively easy and fast to administer (Tyrer, 2020). Whilst the recent Delphi study on expert consensus (Foyston et al., 2019) highlights some of the clear decision-making criteria that are needed for a more structured referral process to hospital settings, ongoing research needs to establish avenues for effective community screening tools. There may also be scope for developing digital interventions (e.g., Allemand et al., 2020) that can be used, alongside other services for PDs.

In conclusion, there are clearly merits of reforming the MHA in terms of empowering individuals in their choices and facilitating a person-centred approach. Nevertheless, whilst improving patients' rights is important and we acknowledge that the recommendations cannot be prescriptive across every diagnostic category, at the same time, one also needs to consider the broader issues relating to service provision and public protection. Our analysis of possible implications of the proposed reforms for PDOs highlights (i) the complexity around referral routes, logistics barriers and capacity issues within secure PD services that might hamper proposed speeded referral routes and raise concerns around assigning responsibility for authorisation of transfer to secure psychiatric hospitals in the context of risk of serious harm to the public, (ii) limitations where complex treatment needs of those with PD are potentially not being met by either CJS and MHA route as they fall through the system, (iii) the need for MH practitioners within the ICS to facilitate formal assessment across services, earlier routine screening within community settings, and identification of complex needs and support options for individuals with mild-to-moderate levels of PD, and (iv) a case for potential digital screening and interventions to optimise timely referrals and appropriate specialised care for PD.

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Highlights

- Mental Health Act reform potential impact on management of offenders with severe Personality Disorders (PD) in PD services
- Discusses criteria of least restriction, detention and therapeutic benefit for PD
- Highlights complexity around referral routes, logistics barriers and capacity issues within secure PD services
- concerns around speeded referral and responsibility for authorisation of transfers in the context of risk of serious harm to the public
- discusses the shift of focus from reactive care to preventative measures and early intervention in the community
- highlights the need for appropriate integrative services in the community to facilitate assessment and identification of complex needs and support options
- recommends earlier routine screening and potential digital interventions to optimise specialised care for PD.

AUTHOR DECLARATION TEMPLATE

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us.

We confirm that we have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing we confirm that we have followed the regulations of our institutions concerning intellectual property.

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