

## **Equality Impact Assessment final assessment for the revised Code of Practice (the Code) for the Mental Health Act 1983 as amended by the Mental Health Act 2007**

### **Summary of the purpose and aim of the proposed Code**

The Code of Practice (the Code) exists primarily to give guidance on the exercise of functions under the Mental Health Act 1983 (the 1983 Act). Producing the Code and revising it from time to time is a statutory requirement under S118 (1) of the 1983 Act.

The current Code was produced in 1999. The changes made to the 1983 Act by the Mental Health Act 2007 (the 2007 Act), plus advances in best practice, have been the catalyst for the Code's revision. The objective has been to issue a Code of Practice which will make a practical difference in promoting both the effective, lawful and appropriate use of the powers in the Mental Health Act 1983 and the effective, lawful and appropriate treatment of people who have mental disorders, but which will not restrict local flexibility to respond to the needs of patients and the public in the most appropriate way, nor hold back the development or adoption of innovative good practice.

For the first time the 2007 Act introduced a requirement that the Code include a statement of principles which should inform decisions under the Act. This is an important innovation, and in preparing the statement of principles it required us to address matters including *“respect for diversity generally, including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006)”* and *“avoidance of unlawful discrimination”* (s8 of the 2007 Act).

This requirement was included not only to reinforce adherence to equality legislation already applicable in mental health services and to the people who work in them, but to address particular stakeholder concerns.

In drawing up the revised Code, we reflected the Department's duties under relevant legislation, including the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005 and the Equality Act 2006. We also had regard to the Department's Single Equality Scheme.

We paid particular attention to the:

- concern about the impact of mental health legislation on BME patients;
- fact that many people affected by the 1983 Act could be considered disabled as defined by the Disability Discrimination Act 2005;
- differences in rates of mental disorder by age;
- different needs people of different gender, age, culture and religion will have in hospital.

### **Race Equality Impact Assessment (REIA) on Mental Health Bill (2006)**

It is important to note that a comprehensive REIA was carried out on the Mental Health Bill (which became the Mental Health Act 2007) between April and November 2006. This focused on the six items amending the Mental Health Act 1983 and the one item to amend the Mental Capacity Act 2005. This was in line with the requirement under the Race Relations (Amendment) Act 2000 to undertake a REIA on new policies and functions. The Department of Health undertook extensive consultation which included seven regional events, interviews with over 120 detained patients, a series of meetings with stakeholders, four consultation events with the BME Mental Health Network and a web-based questionnaire. The assessment was published on the Department of Health website, and a summary of the REIA is attached at annex A.

## **Consultation**

During the passage of the Mental Health Bill through Parliament we made an illustrative version of the draft Code of Practice available on the Department of Health website, to assist people to understand the effects of the Bill and to inform the debate. Whilst this was not a consultation draft we invited people to make comments.

In developing the draft Code, we consulted people working on improvements in mental health services in relation to older people, disabled people, gender, sexual orientation, race, religion or belief and children and young people. Their views were considered in the drafting.

The draft Code of Practice issued for formal consultation reflected the comments made during this part of the process. We provided examples of how issues of equality were being addressed in the Code, and whilst our view – based on the initial consultation - was that there was nothing in the Code that was likely to impact adversely in a disproportionate way on groups of people because of their race, religion, gender or age, we welcomed comments on the material, both as part of the general comments on the Code and through a specific consultation question on equality. The question we asked was:

*'Do you think that the Code has identified all the areas in which equality is a major issue? If not, what changes would you make?'*

The formal consultation invited comments on the Code of Practice from anyone with an interest and attracted a wide range of responses from different groups with over 160 written responses from individuals and organisations.

The majority of those who specifically responded to this question thought the issue of equality had been addressed well and in a more meaningful way than in the current Code, although there were some calls for a separate equalities chapter. There was support from some respondents for more references to disability in some areas. Some said the needs of transgender people had to be better acknowledged, and sexual orientation should be more prominent. Other respondents thought that there should be a requirement to take social factors into account. Cross-references to discrimination legislation and the Human Rights Act 1998 were felt by some respondents to be vital.

We have reflected these comments in preparing the final Code of Practice.

As well as seeking written consultation responses, we ran a series of workshops across the country. These workshops were run with colleagues in the Care Service Improvement Partnership (CSIP). They were open to a range of people and were attended by professionals working in mental health including ambulance and police services, and service users and carers. Across the workshops, there was representation from older people's services, learning disability services, children and young people's services, people from BME communities and advocacy services. The workshops invited comment on all aspects of the Code of Practice and were structured to address equality issues with a focus on the consultation questions. The workshops were attended by xxxx people

The comments and feedback from the workshops were considered as part of the overall consultation process to inform the development of the Code.

### **Guiding Principles for the Code of Practice**

As laid down in the Mental Health Act 2007, for the first time the Code includes a set of guiding principles which should be considered when making decisions about a course of action under the Act. One of those is the "respect principle" which says:

***'People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination'.***

In consultation editions of the Code of Practice the principles have been placed at the front of the code and have been referred to only infrequently in the body of the Code. In this version case scenarios which apply the principles have been woven into the Code at intervals, and whilst they do not form part of the code itself they illustrate how the principles might be considered in number of different scenarios.

### **Impact Assessment**

#### **Race**

Mental health legislation is known to be applied more frequently to people from some BME communities. The reasons are complex and are being addressed as part of the wider *Delivering Race Equality in Mental Health Care* programme – a comprehensive five-year action plan designed to secure improvements in BME communities' access to, and experience of, services, including care provided under the Mental Health Act. As already mentioned, the Mental Health Bill was subject to a detailed race equality impact assessment (see Annex A).

With the principles stressing respect for diversity and avoidance of discrimination and the emphasis on best practice, the Code has been designed to have a positive and favourable impact on the treatment of Black and minority ethnic patients. The guidance in the Code has been written to be applicable to people whatever their race, promoting

equality of opportunity and treatment, while recognising that race and culture are among the factors to be considered when making decisions under the 1983 Act.

In the text of the Code, there are a variety of references to race and culture, intended to highlight and particularise, in specific contexts, the implications of equality legislation and the statement of guiding principles.

For example, the chapter on mental disorder (chapter 3) makes clear the need to avoid allowing stereotypes of cultural difference to influence diagnosis. It states clearly that people cannot be diagnosed as having a mental disorder solely on the basis of their cultural beliefs, values or options.

The chapter on information for patients, nearest relatives and others (chapter 2) stresses that where an interpreter is needed that every effort should be made to identify one who is appropriate to the patient and that everything possible is done to ensure that information is provided to patients in a way that is accessible to them.

The chapter on assessment (chapter 4) outlines the importance of the need to be sensitive to the patient's cultural and racial background in setting up and an assessment under the Act. The chapter on appropriate medical treatment (chapter 6) specifies the need to take into account the patient's culture and ethnicity.

The chapter on the safe and therapeutic responses to disturbed behaviour (chapter 14) stresses the need for policies, educational material, training and practice initiatives relating the safe and therapeutic management of patient to be based on the need to demonstrate and encourage respect for racial and cultural diversity and recognise the need for privacy and dignity.

Guidance is provided to Approved Mental Health Professionals (AMHPs) in the chapter on supervised community treatment (SCT) (chapter 25) on not making assumptions about the suitability of SCT simply on the basis of the patient's ethnicity or social or cultural background.

## **Disability**

Disability is expressly referred to in the "respect principle. By definition, many people who have mental disorders are likely to be, as a result of those mental disorders, disabled as defined by the Disability Discrimination Act. As a result the Code will inevitably have a differential impact on the grounds of the disability of mental illness, whereas it will be of no relevance at all to the large majority of people who are not disabled, or who are disabled, but not because of mental disorder.

That aside, the Code has been designed to have a modest positive differential impact on people with disabilities because of the deliberate steps we have taken to provide additional guidance (in comparison with the current Code) on particular issues which arise in respect of people who are deaf, or who have learning disabilities or autistic spectrum disorders.

Learning disability and autistic spectrum disorder are the forms of disability most relevant to mental health care, in part because they can make other forms of mental disorder more difficult to diagnose. This is why the Code pays special attention to these

issues, with a specific chapter providing guidance on patients with learning disabilities, autistic spectrum disorders or both. (chapter 34).

The chapter was written following close consultation with key stakeholders and service users, including a workshop with people with learning disabilities. The workshop focused on particular aspects of the Code, including the underpinning principles. Views were also sought from professionals working with people with learning disabilities and, as with other consultation responses, these were fed in to the process to inform the final version of the Code.

As well as the specific chapter, the particular needs of people with learning disability are addressed throughout the Code. The chapter on mental disorder (chapter 3) gives guidance on the learning disability qualification and the chapter on applications for detention highlights the importance of having someone with particular experience of learning disabilities available wherever possible during the assessment process. Chapter 4 of the Code cross-refers to the Mental Capacity Act Code of Practice and there will be further guidance on mental capacity in the supplementary Code on the deprivation of liberty safeguards which will be published in due course.

Specific guidance on the particular needs of deaf people is provided in the chapters on applications for detention (chapter 4) and safe and therapeutic responses to disturbed behaviour (chapter 14). The importance of having regard to the physical health – and physical health needs - of people with mental disorders is also addressed at various points in the Code, in particular considerations for conveying patients (chapter 11) and factors for consideration in aftercare (chapter 27).

Given its subject matter, the Code does not provide an opportunity directly to encourage the participation of disabled people in public life.

## **Gender**

Men are more likely to be subject to compulsory measures under the 1983 Act than women - for example, of the 15,300 patients detained in hospitals in England at 31 March 2007, 66% were men. (Count Me In census, Healthcare Commission). It follows that the guidance in the Code will therefore be more often of relevance to men than to women.

The guidance in the Code has been written to be applicable to both men and women, promoting equality of opportunity and treatment, while recognising that gender is one of the factors to be considered when making decisions under the 1983 Act.

The need for decision makers to consider, and be sensitive to, issues of gender is made explicit in the statement of guiding principles and at many points throughout the Code. For example, the chapter on applications for detention in hospital (chapter 4) stresses the importance of considering the patient's gender in setting up the assessment. The chapter on privacy and safety (chapter 16) points to the importance of providing single sex areas. The chapter also stresses the importance of searches being carried out by a member of the same sex, wherever possible, to maintain the patient's privacy and dignity.

## **Transgender people**

The text of the Code has been amended to reflect consultation responses with the intention of better addressing the needs of transgender people, although we have no evidence suggesting that transgender people are more or less likely to be subject to compulsory measures under the 1983 Act.

The guidance in the Code has been written to be applicable to people regardless of their gender identity, promoting equality of opportunity and treatment, while recognising that gender identity is one of the factors to be considered when making decisions under the 1983 Act.

The “respect principle” does not mention gender identity specifically, but the principle calls for recognition of, and respect for, all the diverse needs, values and circumstances of patients and would therefore include issues of gender identity and could have a positive effect for transgender people.

The Code specifically references transgender issues in three places: in chapter 4 (in the context of the need to ensure, as far as possible, that assessments for possible detention under the 1983 Act, are carried out by the most appropriate people in the circumstances); in chapter 6 (as one of the factors to be considered in determining whether available medical treatment is appropriate for an individual patient); and in chapter 16 (in the context of sex segregated accommodation).

## **Religion or belief**

We have no reliable evidence on the extent, if any, to which religion or belief is correlated with the likelihood of being subject to compulsory measures under the 1983 Act. However, we are not aware of evidence suggesting, and consultation responses did not suggest, that the Code is likely to impact differently on people on the grounds of their religion or belief. The guidance in the Code has been written to be applicable to people regardless of their religion or belief (or lack of it), promoting equality of opportunity and treatment, while recognising that religion or belief are among the factors to be considered when making decisions under the 1983 Act.

The need for decision makers to consider, and be sensitive to, issues of religion or belief is made explicit in the statement of guiding principles and at many points throughout the Code. In addition, chapter 3 (mental disorder) expressly states that religion or belief (of any type) – even if they appear unusual or cause other people alarm, distress or danger – are no basis for compulsory measures under the 1983 Act unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind.

## **Sexual orientation**

We have no information on the extent (if any) to which people of different sexual orientation are more or less likely to be subject to compulsory measures under the 1983 Act. The Healthcare Commission’s Count Me In census of mental health inpatients asks for information about patients’ sexual orientation but the results do not provide evidence of differences in care.



However, the guidance in the Code has been written to be applicable to people regardless of their sexual orientation, promoting equality of opportunity and treatment, while recognising that sexual orientation is among the factors to be considered when making decisions under the 1983 Act.

The need for decision makers to consider, and be sensitive to, issues of sexual orientation is made explicit in the statement of guiding principles and at various points throughout the Code. The Code states unequivocally (in chapter 3) that homosexuality and bi-sexuality are not mental disorders for any purpose.

## **Age**

With the exception - explained below – of children, we are aware of no evidence to suggest that the Code is likely to impact differently on people of different ages. The guidance in the Code has been written to be applicable to people regardless of their age, promoting equality of opportunity and treatment, while recognising that age is one of the factors to be considered when making decisions under the 1983 Act.

The Mental Health Act 2007 requires the provision of age-appropriate environments for children and young people aged under 18. This is a response to deeply-held concerns that children and young people should not be treated in adult wards.

The Code reflects this requirement and emphasises the importance of the involvement of people with specialist expertise in child and adolescent mental health services in decisions about children and young people. It also emphasises, in several places, the importance of services and accommodation being suitable to the needs of children and young people. The deployment of specialist expertise and the provision of age appropriate services in a greater proportion of cases would represent a positive differential impact for children and young people, justified by their vulnerability and specific developmental needs.

In addition, the Code has been drafted to reflect a range of specific legal requirements relating to children. A separate chapter on children and young people under the age of 18 (chapter 36) has been included in the Code which offers guidance on particular issues arising in relation to children and young people. In addition to the individual chapter, the needs of children and young people are addressed in other parts of the Code, in particular in relation to assessment under the Act (chapter 4), the chapter on police powers and places of safety (chapter 10) and the needs of children and young people when visiting and being visited on wards (chapter 19)

## **Elimination of harassment and promotion of good relations between different groups of people.**

It cannot be claimed that the Code will, of itself, make a significant impact in helping to eliminate harassment or promoting good relations between people of different groups, but we judge its overall impact to be consistent with those aims.

## **Monitoring**

We have agreed changes to the Mental Health Minimum Data Set to monitor the changes made to the 1983 Act. We have commissioned research on three new provisions introduced by the 2007 Act and are considering others. We will continue engagement with stakeholders and specialist organisations, both on the changes to the 1983 Act and as part of the overall mental health programme. There is also a statutory requirement on the Mental Health Act Commission (and its proposed successor body) to monitor the operation of the 1983 Act and report biannually to the Secretary of State.

Any variation between ethnic groups in the way that the Act, and by extension the Code of Practice, are applied will also be assessed and examined by the Department's Delivering Race Equality in Mental Health Care action plan.

## ANNEX A

### MENTAL HEALTH BILL 2006: RACE EQUALITY IMPACT ASSESSMENT - EXECUTIVE SUMMARY

The purpose of mental health legislation is primarily to protect patients and others from harm that can arise from mental disorder. It sets out the procedures that must be followed when it becomes necessary to treat someone for their mental disorder without their consent and the safeguards and support there should be for the patient. It is important that these processes are seen to apply consistently to all people. But the Government recognises that the effects of mental health legislation apply disproportionately to some BME groups. Research evidence and data shows that disproportionate numbers of BME patients are subject to certain parts of mental health legislation, but there is no agreed explanation of why this is.

Some concerns identified through the REIA have already been addressed in the move from the draft 2004 Bill to the amending proposals and others addressed in the actions generated by the REIA. But we need to go further. We will build on the REIA with a new governance structure for ensuring that we deliver race equality across the health & social care sector and develop a comprehensive programme and action plan to:

- implement the actions stemming from this REIA;
- continue monitoring race equality in mental health services;
- continue addressing areas of adverse impact.

We are already addressing known disparities in the impact of the 1983 Act through Delivering Race Equality and we are committed to moving to a position where the operation of the Mental Health Act is further aligned with the positive general duties arising from the Race Relations Amendment Act 2000 to ensure that people from BME backgrounds are not adversely affected when using mental health services.

The Department of Health is particularly grateful to the Advisory Group on the REIA, chaired by Lord Patel of Bradford OBE. The Advisory Group devised an analysis tree to look at the impact of the amendments to the definition, SCT and professional role on other parts of the Act. The Advisory Group's membership is at Annex B.

The following list summarises the changes made to the legislative proposals and the draft Code of Practice as a result of this and the work done for the 2004 Bill, and further actions to take forward. We will work with BME stakeholders to implement the actions arising from the REIA, as part of the new governance structure for delivering race equality.

#### ACTION TAKEN

The REIA work for the draft 2004 Bill contributed to the Department's decision to adapt or not pursue the following policies:

- **adapted Supervised Community Treatment and introduced clauses in the amending Bill** that mean all patients must first be detained and assessed in

detention in hospital before they are placed on SCT and no one can be detained in a community setting. BME groups had suggested that there would be a lower threshold for using compulsory community treatment orders in the draft 2004 Bill and this could affect BME patients;

- **decided against** a separate condition for patients at substantial risk of causing harm to another person (BME groups felt their communities would suffer from stereotyping) and instead has largely **retained** the current structure for criteria for detention;
- **decided against** the policy that anyone should have **the statutory right to request** the relevant authority to consider an examination against the first four criteria for detention (initial examinations). BME groups felt that patients could be more likely to be subject to vexatious requests;
- **decided against** the policy that **Mental Health Tribunals** could sit with fewer than three members. Instead the current MHRT with three panel members will be maintained;
- **decided against** the policy that **police could enter premises without a warrant**. There was concern from BME groups that patients would be subject to 'urgent' entry of their premises;
- **decided against** the policy to **stop free aftercare services** for compulsory patients after 6 weeks. Instead we will maintain the status quo so that all aftercare services are free for people treated under compulsion.

As a result of the REIA work this year on the amendments to the 1983 Act, the Department has introduced into the amending Bill and the draft Code of Practice:

- **a regulation making power on Bournemouth safeguards** to allow for collection of data on patients for whom an application for a deprivation of liberty is made, including data on ethnicity, recognising BME groups' concerns that Bournemouth provisions should be monitored by ethnicity;
- **a clause that states** that AMHPs must always act on behalf of a Local Authority, to emphasise their independence from assessing doctors. Training for AMHPs will address the skills required for independent practice and the approval criteria will reflect this too.

### **Code of Practice**

The draft Code of Practice's first chapter is a set of guiding principles, including non discrimination on the grounds of race, ethnic, social and other criteria. The principles work together to provide for balanced decision making, and any decision maker

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should have regard to these principles in respect of any patient under mental health legislation.

The draft Code of Practice makes clear that in the absence of a mental disorder no-one may be considered to be mentally disordered because of their political or cultural beliefs, values or opinions; and that appropriate treatment takes account of all a patient's circumstances, including cultural, ethnic and religious considerations

### *Code re SCT*

- The draft Code sets out the importance of culturally appropriate treatment with respect to SCT. Services should involve family members in SCT to ensure treatment is appropriate and supportive to the individual.
- The draft Code addresses the use of the recall power in SCT.
- The draft Code makes clear that if the conditions of a SCT are broken the carer should, where possible, be informed.

### *Code re professional roles*

- The Code refers to the need for cultural awareness to be part of the training for both the Approved Mental Health Professional and the Responsible Clinician. This will also be reflected in the competencies for AMHPs/RCs.

## **FURTHER ACTION**

### **Monitoring/Research**

#### *Monitoring*

- The Department of Health (DH) and Welsh Ministers will work with the Mental Health Act Commission and the Health Care Commission to ensure there is proper local and national monitoring of the impact of the 1983 Act as amended.
- DH will ensure there is monitoring of SCT; the reasons for its use; its impact by ethnicity; and of those other parts of the Act that feed into SCT.
- DH will discuss with the NHS and Department of Constitutional Affairs (DCA) how best to gather details of the ethnicity of patients attending/applying to the MHRT to allow appropriate analysis.
- We will look at how DRE Census data is brought to the attention of more practitioners and used as a way of influencing behaviour and the way services are provided.

#### *Research/analysis*

DH will consider whether further research (possibly to look at the impact of the new definition and the changes to professional role) and/or analysis is required of the current differences in the experiences of BME groups under Mental Health Legislation and the possible solutions.

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### Delivery

#### *Training*

- DRE contains existing proposals for training in cultural capability for the whole workforce. We will look at the need to review training for responsible clinicians and section 12 doctors in England in light of the DRE training, to ensure that diagnosis is not inappropriately influenced by factors relating to patients' ethnicity.
- DH and the NAW will ensure that training on the operation of the Act as amended includes issues of culture, ethnicity, race and religion, building on recently established programmes on cultural competence and values based practice.
- DH will consider extending the current series of research seminars on values based and holistic approaches to psychiatric assessment and diagnosis, to explore their relevance to the over-representation of certain BME groups among those subject to compulsion.
- We will take forward work with the GSCC to strengthen AMHP training with respect to cultural diversity. Welsh Ministers will work with the responsible regulatory bodies including the Care Council for Wales to build on the current training to emphasise the importance of the social model of illness within a holistic assessment.
- DH and the Welsh Ministers will work together with the MHRT judiciary to develop a strategy for establishing the popular voluntary courses on Equal Treatment and Diversity, and Transcultural Aspects of Mental Health, as central components of the future training programme.

#### *Code of Practice*

- The draft Code chapters will be developed with the involvement of BME representatives.
- Both DH and Welsh Ministers will work to ensure that the final Codes of Practice promotes race equality by highlighting the importance of diversity and the need to treat a patient in a holistic manner when considering detention and treatment

#### *Nearest relative*

- We will discuss with DCA the production of an explanatory leaflet that explains the nearest relative process, and how people can apply to the County Court to displace their nearest relative.

#### *Bournemouth*

- The draft Code chapters in the Mental Capacity Act Code will be developed with the involvement of BME representatives.