

# Our advice to parliament: reforming the Mental Health Act

Westminster Hall debate, 25 July 2019, 1:30pm

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## Introduction

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The Equality and Human Rights Commission has been given powers by Parliament to advise Government on the equality and human rights implications of laws and proposed laws. This briefing provides our advice to parliamentarians on reforming the Mental Health Act 1983.

## Issue

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- The Mental Health Act 1983 (MHA) gives the state powers to detain, assess and treat people who have severe mental health conditions. There were more than 49,550 detentions under the MHA in 2017-18.<sup>1</sup> There are a number of concerns about the current legislation, including that people can be detained and treated against their will, that patients are not properly involved in decisions about their care, and that procedural safeguards are inadequate.
- The Government commissioned an Independent Review of the MHA to look at rising rates of detention, the disproportionate detention of people from Black and other ethnic minority groups, and concerns that the law is out of step with a modern mental health system. The Review reported in December 2018 and made 154 recommendations for reform along 4 key principles: patients should have greater choice and autonomy, the MHA's powers should be used in the least restrictive way possible, it should achieve a more therapeutic benefit, and people should be seen and treated as individuals.
- The last Prime Minister committed to new legislation to overhaul the MHA and confirmed that a white paper in response to the Independent Review would be published before the end of the year.<sup>2</sup>

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<sup>1</sup> NHS (2018), [Mental Health Act statistics, annual figures 2017-18](#). There were 49,551 new detentions under the MHA recorded in 2017-18, although the overall national totals will be higher as some providers did not submit data.

<sup>2</sup> See press release (17 June 2019), ['PM launches new mission to put prevention at the top of the mental health agenda'](#).

## Recommendations

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We recommend that the Government:

1. Ensure there are sufficient community-based alternatives to detention, and invest in preventative mental health services to support people before crisis
2. Ensure there is appropriate support to meet the needs of people with learning disabilities and autism within their communities, so these individuals are not detained in restrictive settings away from home
3. Ensure that people are not admitted to hospital and treated against their will where they have the capacity to refuse
4. Ensure patients are involved in decisions about their care, including through improved access to independent advocates and reform of the 'nearest relative' system
5. Create a statutory duty for providers to give people who are detained information about their rights
6. Ensure that people can access timely and meaningful detention reviews
7. Strengthen procedural safeguards for involuntary treatment
8. Take action to reduce the use of restraint and other restrictive practices
9. Ensure there are effective investigations into non-natural deaths of people detained under the MHA
10. Take action to address disproportionality in the use of the MHA including in relation to race

## Background

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### Investing in mental health services

We are concerned that some people are being detained because there are not enough community-based alternatives and insufficient early and preventative mental health services. Recorded detentions increased by 40 per cent between 2005-06 and 2015-16, while the rate of serious mental illness remained relatively static.<sup>3</sup> As the number of beds has declined, there are now proportionately more people in hospital involuntarily than those who are there by choice.<sup>4</sup>

Despite improvements in recent years, parity between physical and mental health services has not yet been realised and too many people are not getting the support they need.<sup>5</sup> The UN Committee on Economic, Social and Cultural Rights has highlighted concerns about inadequate resources for mental health services and urged the Government to ensure mental health care is available and accessible.<sup>6</sup> The UN Committee on the Rights of the Child has expressed specific concerns about the adequacy of therapeutic community-based services for children.<sup>7</sup> In signing the UN Resolution on Mental Health and Human Rights, the Government has acknowledged the need to invest in community-based services and tackle over-medicalisation and inappropriate treatment.<sup>8</sup>

### Meeting the needs of people with learning disabilities and autism

The Commission is concerned about the lack of suitable provision for people with learning disabilities and autism, who may be in restrictive institutional settings because there is insufficient community-based support. The Government failed to meet its minimum target to reduce the number of people with learning disabilities

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<sup>3</sup> Care Quality Commission (2018), [Mental Health Act: the rise in the use of the MHA to detain people in England](#).

<sup>4</sup> [Modernising the Mental Health Act: final report of the Independent Review](#) (2018).

<sup>5</sup> All-party parliamentary group on mental health (2018), [Progress on the five year forward view for mental health: on the road to parity](#).

<sup>6</sup> UN Committee on Economic, Social and Cultural Rights (2016), [Concluding observations on the sixth periodic report of the United Kingdom](#), paras 57-58.

<sup>7</sup> UN Committee on the Rights of the Child, [Concluding observations on the fifth periodic report of the United Kingdom](#), paras 60-61.

<sup>8</sup> Human Rights Council (2017), [Resolution on mental health and human rights](#).

and autism detained in inpatient settings, and at the end of March 2019 there were still 2,260 children and adults living in these institutions.<sup>9</sup> On average, they had spent almost 5 and a half years detained away from home.<sup>10</sup> There were more than 2,600 restrictive interventions recorded against inpatients with learning disabilities and autism in a single month, including physical, chemical and mechanical restraint, seclusion and segregation. Of these, 875 interventions were used against children.<sup>11</sup>

### **Ensuring people with capacity are not detained against their will**

The MHA allows for the involuntary admission and treatment of disabled people who have the capacity to refuse it. We share the concerns of the UN Committee on the Rights of Persons with Disabilities that this is discriminatory and runs contrary to article 14 of the Convention on the Rights of Persons with Disabilities, which requires that “the existence of disability shall in no case justify a deprivation of liberty”.<sup>12</sup> There is no comparative provision in physical healthcare, where the law allows a person with capacity to choose not to receive medical care in full knowledge that this will have serious consequences for their health. The MHA also allows the detention of people who are perceived to present a risk of harm to others without any such harm having been committed. Our recommendation to reform the MHA would require a revised approach to the capacity test for detention, taking account of the impact of the individual’s mental health on their decision-making.

We note that there are different considerations for people who lack capacity, and it may constitute a human rights violation *not* to provide healthcare in these cases. Where individuals lack capacity, we recommend efforts by Government to improve supported and advance decision-making.

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<sup>9</sup> The Government set a target to reduce detention in inpatient settings by 35-50 per cent by the end of March 2019, which would have meant no more than 1,700 people remained in detention - see NHS England (2015) [Building the right support](#). At the end of March 2019, 2,260 people with learning disabilities or autism remained in inpatient units - see NHS Digital (April 2019), [‘Learning disability services monthly statistics’](#), main report.

<sup>10</sup> NHS Digital (April 2019), [‘Learning disability services monthly statistics’](#), see Assuring Transformation dataset, reference table 8.

<sup>11</sup> Ibid, see Mental Health Services dataset, reference table 17.

<sup>12</sup> See [Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities](#), paras 6-9.

## Involving people in decisions about their care and treatment

We are concerned that the current MHA does not sufficiently empower people to be involved in decisions about their treatment. The Care Quality Commission reported that almost a quarter of mental health patients were not involved in their care-planning,<sup>13</sup> and there is evidence that advance decision-making is not used routinely or considered binding.<sup>14</sup> The Government has committed to introduce statutory advance choice documents, as recommended by the Independent Review, so that people can set out their preferences and wishes for treatment ahead of time.<sup>15</sup> The Review recommended a presumption that advance choice is followed even where the individual's preferences for treatment are considered by clinicians to be less than optimal.<sup>16</sup>

Supported decision-making is important in empowering patients to exercise their rights. Currently, people detained under the MHA are entitled to support from independent mental health advocates (IMHAs), but provision appears patchy and some groups are particularly likely not to access services.<sup>17</sup> The Independent Review recommended the IMHA role be extended to include support around advance choice for people who may be at risk of detention, and proposed an 'opt out' model where people would be provided with an IMHA unless they chose otherwise.<sup>18</sup> The family members or friends of people detained under the MHA can also play an important role in ensuring their will and preferences are respected. The Government has committed to reform the current outdated 'nearest relative' system, which restricts the ability of patients to choose their nominated representative and allows doctors and other medical staff to overrule their decisions. In some cases the current system may result in an inappropriate person being nominated, for example where there is a history of abuse in the relationship.

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<sup>13</sup> Care Quality Commission (2017), [Community mental health survey](#).

<sup>14</sup> Care Quality Commission (2018), [Monitoring the Mental Health Act in 2016/17](#).

<sup>15</sup> News story (6 December 2018), ['Government commits to reform the Mental Health Act'](#).

<sup>16</sup> [Modernising the Mental Health Act: final report of the Independent Review](#) (2018).

<sup>17</sup> Karen Newbigging et al, 'When you haven't got much of a voice: an evaluation of the quality of Independent Mental Health Advocate services in England', in *Health and Social Care in the Community* (2015) 313-324.

<sup>18</sup> [Modernising the Mental Health Act: final report of the Independent Review](#) (2018).

## **Providing patients with information about their rights**

Section 132 of the MHA requires hospital managers to ensure that people who are detained receive information about the legal basis for detention and their right to challenge it, as soon as practicable. However, evidence suggests many patients do not have their rights explained to them at the point of detention, or in the right format or at appropriate intervals throughout their treatment.<sup>19</sup> We recommend that the new MHA place a clear statutory duty on providers to notify patients of their rights under the MHA, the Human Rights Act and the Equality Act. This information should be provided prior to any assessment where a decision to detain may be made, and must be available in Easy Read or any other format as a reasonable adjustment. The Commission has developed a standard notification document which we expect to pilot later in the year.

## **Improving patients' ability to challenge detention**

We have concerns about whether people can effectively challenge their detention in line with the right to liberty and security protected by the Human Rights Act and in international human rights treaties. The first route to challenge detention is a hospital managers' hearing, in which an independent panel considers whether discharge is possible. The Royal College of Psychiatrists has submitted that these hearings are "meaningless" and "falsely raise expectations".<sup>20</sup> People who are detained can also apply for a mental health tribunal to consider whether they can be discharged, but there are barriers to doing so in practice. For example, people detained under section 3 of the MHA can only apply to the tribunal once within 6 months, and then only once within each renewed period of detention. Further, if there are no suitable places in the community there may be no practical option but to continue detention.

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<sup>19</sup> Care Quality Commission (2018), [Monitoring the Mental Health Act in 2016/17](#).

<sup>20</sup> Royal College of Psychiatrists (2018), [Submission to the Independent Review of the MHA 1983](#), p32.

## Strengthening safeguards for compulsory treatment

We are concerned about the lack of procedural safeguards for compulsory treatment (noting our concerns above about whether compulsory treatment is ever appropriate for people who have the capacity to refuse it). The powers under the MHA to treat without consent do not require a second opinion and there is no easily accessible, timely route to challenge the decision. In practice, the only options are likely to be judicial review (which the Independent Review called “both exceptionally difficult and rarely utilised”)<sup>21</sup> or a claim under the Human Rights Act. Ongoing treatment without consent requires authorisation by a second opinion appointed doctor (SOAD) but only after 3 months. The Independent Review has called for this period to be shortened.<sup>22</sup> Data from the Care Quality Commission for 2017/18 showed that less than a third of SOAD visits resulted in a change in treatment, which may suggest they do not currently operate effectively as a safeguard.<sup>23</sup>

## Eliminating ill-treatment

In a survey by the Mental Health Alliance, more than 60 per cent of people who had previously been detained disagreed with the statement ‘People are currently treated with dignity when detained under the Mental Health Act’.<sup>24</sup> We are further concerned that people detained under the MHA are subject to force or other restrictive interventions. There were a total of 99,609 restrictive interventions in England in 2017/18, including 10,881 uses of prone restraint and 8,805 instances of seclusion.<sup>25</sup> The Council of Europe’s Committee for the Prevention of Torture has found that some patients have been held in long-term segregation for years.<sup>26</sup> Further, in 2017 more than a third of NHS Trusts and private providers were rated ‘needs improvement’ in relation to providing a safe environment for patients.<sup>27</sup> The use of force may violate article 3 of the Human Rights Act - which absolutely

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<sup>21</sup> [Modernising the Mental Health Act: final report of the Independent Review](#) (2018), p26.

<sup>22</sup> Ibid, recommendations 7-10.

<sup>23</sup> Care Quality Commission (2018), [Monitoring the Mental Health Act in 2017/18](#).

<sup>24</sup> Mental Health Alliance (2017). ‘[A Mental Health Act fit for tomorrow](#)’.

<sup>25</sup> NHS Digital (November 2018), [Mental health bulletin 2017-18 annual report](#), reference table 7.3.

<sup>26</sup> European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2017), ‘[Report to the Government of the United Kingdom](#)’.

<sup>27</sup> Care Quality Commission (2018) ‘[The state of care in mental health services 2014 to 2017](#)’.

prohibits inhuman and degrading treatment - or may otherwise be unlawful if the means and duration are more than necessary to accomplish the intended aim. The UN Committee on the Rights of Persons with Disabilities has expressed concern about the continued use of restraint and other restrictive interventions on disabled people in healthcare settings, raising particular concern about the disproportionate use of such practices on people from Black and other ethnic minority groups.<sup>28</sup> The Independent Review also noted the disproportionate use of restraint on women and girls.<sup>29</sup>

In relation to non-natural deaths of those detained under the MHA, we are concerned that the Healthcare and Safety Investigation Branch (HSIB) cannot effectively exercise oversight for independent investigations. There are an estimated 9,000 avoidable deaths annually across the healthcare system, but the HSIB is only funded to conduct up to 30 investigations each year.<sup>30</sup> We therefore do not believe that the concerns about independent investigations we raised in our 2015 inquiry into deaths in detention have been adequately addressed.<sup>31</sup>

### **Tackling disproportionality**

There is significant racial disproportionality in the use of the MHA, with people from Black or Black British ethnic groups more than four times more likely to be detained than people from White ethnic groups.<sup>32</sup> Black Caribbean people experience particularly high rates of detention.<sup>33</sup> There is also evidence that people from ethnic minorities are more likely to be subject to restraint and other restrictive practices,<sup>34</sup> and experience disproportionate numbers of deaths in custody and/or mental health care.<sup>35</sup> The Government has committed to act on a number of the Independent Review's recommendations to tackle racial inequality

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<sup>28</sup> UN Committee on the Rights of Persons with Disabilities (2017), [Concluding observations](#), para 36.

<sup>29</sup> [Modernising the Mental Health Act: final report of the Independent Review](#) (2018).

<sup>30</sup> See news story (14 December 2017), '[NHS becomes first healthcare system in the world to publish numbers of avoidable deaths](#)'.

<sup>31</sup> Equality and Human Rights Commission (2015), '[Preventing deaths in detention of adults with mental health conditions](#)'.

<sup>32</sup> Office for National Statistics (2019), [Detentions under the Mental Health Act: ethnicity facts and figures](#).

<sup>33</sup> Ibid.

<sup>34</sup> NHS Digital (November 2018), [Mental health bulletin 2017-18 annual report](#), reference table 7.2.

<sup>35</sup> [Modernising the Mental Health Act: final report of the Independent Review](#) (2018).

in mental health, including the introduction of a race equality framework focussed on improving people's access to and experience of treatment.

Incomplete data and the lack of disaggregation make it difficult to determine how providers are making decisions about detention and treatment across the protected characteristics. No data is collected on gay, lesbian or transgender people, for example, although we know this group are particularly at risk of poor mental health.<sup>36</sup> The absence of data also makes it difficult for providers and commissioners to evidence compliance with the public sector equality duty. We therefore recommend that the Government take action to address gaps in data collection on the use of the MHA across the protected characteristics, to understand who is being detained and treated and in what circumstances, and identify any disproportionate impacts on particular groups.

## **The legal framework**

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The operation of the MHA must comply with domestic equality law and with the obligations of the European Convention on Human Rights (ECHR), enshrined in UK law by the Human Rights Act 1998.

### **Equality Act 2010**

The Equality Act 2010 protects people with protected characteristics from direct and indirect discrimination, failure to make reasonable adjustments for disabled people, discrimination arising as a consequence of disability, harassment, and victimisation. It also requires Government and public bodies - including NHS commissioners in England, service planners in Wales, and public services provided by private providers - to have due regard to the need to eliminate discrimination, promote equality of opportunity for people with protected characteristics, and foster good relations between people who share a protected characteristic and those who do not. Having considered these three aims, public

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<sup>36</sup> Equality and Human Rights Commission (2018), ['Is Britain fairer?'](#).

bodies need to consider how they could reasonably mitigate any adverse impacts that are identified for people sharing protected characteristics.

### **Human Rights Act 1998**

Article 2 ECHR protects **the right to life**. It requires the State and public bodies to protect life, act on positive obligations to protect life – for example, where a public authority is aware of a real or imminent threat to life or where the person is under the care of a public authority - and in particular circumstances to carry out official investigations into deaths, especially deaths in State institutions.

Article 3 ECHR **prohibits torture and inhuman or degrading treatment**. It requires the State and public bodies to: refrain from the most intrusive and risky forms of control and treatment used in care and treatment settings, such as the use of physical restraint and medication without informed consent; refrain from subjecting anyone to torture, treatment or punishment that is inhuman or degrading; act on obligations to prevent and protect those at risk from this type of treatment; and investigate allegations of torture and inhuman or degrading treatment.

Article 5 ECHR protects **the right to liberty and security**. It requires the State and public bodies to: ensure there is a clear procedure prescribed by law before authorising a deprivation of liberty (and permits a person to be lawfully detained if they are of "unsound mind"); ensure the deprivation of liberty is necessary and proportionate; provide for a speedy determination of the lawfulness of the detention by a court and compensation in the event of unlawful detention; and ensure there is a procedure for regular review of the necessity for the detention.

Article 8 ECHR protects the **right to respect for a private and family life**. It requires the State and public bodies to protect the right to personal autonomy, dignity, physical and psychological integrity, and ensure that any restrictions on these rights are limited to occasions where they can be legally justified. Acts undertaken in relation to the care and treatment of a person who lacks capacity to consent will almost invariably interfere with these rights sufficiently to engage Article 8, even if the acts are considered to be in the individual's best interests.

## **International human rights treaties**

The UK is further party to a number of human rights treaties which are legally binding under international law.

Under the **UN Convention Against Torture** the UK is expected to: ensure that any person who alleges they have been subjected to cruel, inhuman or degrading treatment has the right to complain to, and to have their case promptly and impartially examined by, its competent authorities (Article 13); and ensure victims of cruel, inhuman or degrading treatment are fairly compensated, including the means for as full rehabilitation as possible (Article 14).

Under the **International Covenant on Economic, Social and Cultural Rights** (ICESCR) the UK is expected to recognise everyone's right to the enjoyment of the highest attainable standard of physical and mental health and create conditions to ensure medical services provide for this (Article 12). Paragraph 8 of General Comment 14 on ICESCR states that the right to health includes "the right to control one's health and body (...) and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation".

Under the **UN Convention on the Rights of Persons with Disabilities** the UK is expected to: involve service user organisations in the development and running of services (Article 4(3)) and provide for peer support (Article 26); ensure disabled people are equally entitled as non-disabled people to all legal protections (Article 5); provide support to people who are disabled to ensure they can exercise their legal capacity (Article 12); ensure that the existence of a disability shall in no case justify a deprivation of liberty (Article 14); secure the right for disabled people to live independently as part of their communities (Article 19); and secure the highest attainable standard of health (Article 25).

Under the **UN Convention on the Rights of the Child** (UNCRC) the UK is expected to: respect and ensure every child can enjoy all UNCRC rights without discrimination (Article 2); ensure that the best interests of a child must be the primary consideration of all actions concerning children (Article 3); ensure that a

'mentally disabled child' should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community (Article 23); and recognise the right of a child who has been placed by the competent authorities for the purposes of care or health treatment to a periodic review (Article 25).

Under the **UN Convention for the Elimination of All Forms of Racial Discrimination** the UK is expected to eliminate racial discrimination and, when necessary, take steps to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full enjoyment of their human rights (Article 2).

Under the **UN Convention on the Elimination of All Forms of Discrimination Against Women** the UK is expected to take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure access to health care services on an equal basis for women and men (Article 12).

## **Further information**

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The Equality and Human Rights Commission is a statutory body established under the Equality Act 2006. Find out more about the Commission's work at [our website](#).

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