Consultation response

Response to the white paper on reforming the Mental Health Act

Consultation details

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# Introduction

We welcome the Government’s white paper on reforming the Mental Health Act and the opportunity to respond to this consultation. Our strategic plan prioritises work to reduce the disproportionate detention and inappropriate treatment of people sharing protected characteristics in institutional settings. We engaged closely with the Independent Review and we are pleased that the Government has taken forward many of the key recommendations. We support a number of the specific proposals and consider they have the potential to drive a less restrictive, more person-centred approach to care that better upholds human rights. We look forward to continued constructive engagement on the legislation to implement these proposals.

# About us

The Equality and Human Rights Commission is Great Britain’s national equality body and accredited by the United Nations as an ‘A status’ national human rights institution. We operate independently as a statutory public body established under the Equality Act 2006. We have been given powers by Parliament to advise Government on the equality and human rights implications of laws and proposed laws, and to publish information or provide advice on any matter related to equality, diversity and human rights. Find out more about our work on our [website](http://www.equalityhumanrights.com/).

# About our response

We set out our response to the proposals relevant to our remit and our recommendations for taking them forward in legislation and policy.

Healthcare policy is devolved to the Scottish and Welsh Governments. Our response largely focuses on England, where the UK Government has competence. Where we make recommendations in relation to criminal justice, these would apply to England and Wales. We also recognise it is not uncommon for people to be detained and treated across borders and that there will need to be a coordinated approach between the nations. We are separately engaging with the Welsh Government on proposed changes to the operation of the Mental Health Act in Wales.

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# Summary

The Government has made welcome improvements to the mental health system in recent years, including a commitment to parity of esteem for mental and physical health[[1]](#footnote-1) and prioritising mental health in the NHS long term plan.[[2]](#footnote-2) The white paper on reforming the Mental Health Act presents a further important opportunity to help ensure people with mental health needs get the support they need.

The use of the Mental Health Act has significant implications for equality and human rights. Compulsory detention has been increasing in recent years,[[3]](#footnote-3) with an impact on the right to liberty[[4]](#footnote-4) and disabled people’s right to live independently as part of their communities.[[5]](#footnote-5) Restraint and restrictive interventions are widespread, and the Care Quality Commission (CQC) recently reported ‘many examples […] of care that was undignified, inhumane and that potentially breached people’s basic human rights’.[[6]](#footnote-6) Allegations of shocking physical and psychological abuse of people with learning disabilities and autism in 2019 raised serious questions about whether lessons had been learnt from the prior events at Winterbourne View.[[7]](#footnote-7)

People from Black ethnic groups continue to be detained and subject to community treatment orders (CTOs) at starkly disproportionate rates.[[8]](#footnote-8) Evidence suggests people from ethnic minorities, women and girls are at increased risk of restraint.[[9]](#footnote-9) While we know a number of groups sharing protected characteristics face inequalities in access to and outcomes from mental health services, including LGBT people,[[10]](#footnote-10) gaps in data on the use of the Mental Health Act make it difficult to identify the rates of detention and any differences in treatment.[[11]](#footnote-11)

We welcome the Government’s white paper on reforming the Mental Health Act and the important steps it is taking to safeguard the rights of people with mental health needs. We support a number of the specific proposals and offer our views on how these could be delivered to most effectively uphold equality and human rights. In some instances we support the principle of the proposals but recommend an alternative approach or identify areas for further development or clarification – for example, in relation to advance choice documents and proposals to improve access to community services.

There are some areas where we are disappointed that the Government has not taken forward the recommendations of the Independent Review or not yet committed to reforms pending decisions about funding. This includes proposals about access to the tribunal and improvements to advocacy. While we appreciate that the Government recognises the importance of some of these provisions in principle, we would like to see funding prioritised to ensure they can be delivered in practice.

We are also concerned that a number of reforms to the civil sections of the Mental Health Act would not apply to forensic patients. In our view, the essential safeguards should be brought in line for all patients.

We highlight throughout our response that realising the full potential of the white paper proposals will require achieving parity of esteem between mental and physical healthcare, and the provision of both therapeutic alternatives to detention and integrated community support for mental health – including housing, access to work and social opportunities.[[12]](#footnote-12) As we set out in response to the proposed new guiding principles, we consider that the package of reforms proposed in the white paper should have the express aim of reducing detention and coercion and supporting more people to live independently in their communities.

It is not yet clear how the coronavirus pandemic has affected the operation of the Mental Health Act or what the impact will be on mental health needs in the coming months and years. We share the CQC’s concern that reduced access to services in this period may have increased the risk of coercive pathways into mental health services, potentially exacerbating the overrepresentation of some Black and ethnic minority groups in detention.[[13]](#footnote-13) We understand that the coronavirus pandemic has inevitably delayed the development of the white paper. Following the consultation we encourage the Government to bring forward legislation at the earliest opportunity and take forward this crucial opportunity for reform.

# Recommendations

## The guiding principles

### Reducing detention and coercion

1. Mental health trusts should be required to report on trends in their use of the Mental Health Act, disaggregated by protected characteristics, and should provide an explanation and comprehensive action plan if they cannot demonstrate a year-on-year reduction in overall detentions and reduced disproportionality for groups sharing protected characteristics.
2. DHSC should publish annual national data on the use of the Mental Health Act, disaggregated for all the protected characteristics.
3. The proposed Mental Health Bill should include a requirement for the Government to report to Parliament within five years on the impact of the reforms in reducing detention and supporting more people to live independently as part of their communities. This should include the impact on reducing restraint and other forms of coercion, and the disproportionate treatment of groups sharing certain protected characteristics, particularly people from Black ethnic groups.
4. The CQC should monitor local detention rates as part of their inspections, with an expectation of overall reductions and a reduction in any disproportionate rates for groups sharing protected characteristics, and should assess how effectively health and care systems are enabling disabled people to enjoy their right to live independently.

### Embedding the principles in practice

1. The proposed Mental Health Bill should create a duty on all those who exercise powers under it to give the principles ‘paramount consideration’ in all decisions related to detention, treatment and the commissioning of mental health services.
2. DHSC should implement the recommendation from the Independent Review that clinicians should be required to demonstrate how they have considered the principles on all forms completed as part of the Mental Health Act process, formulated as a duty to show they have considered and acted on the principles to help ensure a positive impact on decision-making and practice. This should be monitored by the CQC.
3. The revised Code of Practice for the proposed new Mental Health Act should include clear and effective guidance on applying the principles in practice. DHSC should support this by developing standardised training and resources for commissioners, providers and staff at all levels, covering how the principles apply both to individual patients and in the wider planning and delivery of services. This should include requirements for monitoring and reporting on compliance.
4. DHSC should carry out or commission a future evaluation of the impact of the proposed guiding principles and take appropriate action if they are shown not to have led to a significant reduction in detention and improvements in patients’ experience.

### Addressing inequalities

1. The principle of the person as an individual should be defined on the face of the proposed Mental Health Bill to include meeting the specific needs arising from sharing protected characteristics.
2. The Code of Practice for the proposed new Mental Health Act should provide effective guidance on meeting the needs of different groups (including providing reasonable adjustments), addressing inequalities and preventing discrimination in decision-making and treatment, reflecting in particular the current disproportionate detention of people from Black ethnic groups.

## Criteria for detention

### The basis for detention

1. The Mental Health Act should be reformed to ensure that nobody who has a mental health condition but has the capacity to refuse treatment should be admitted and treated against their will. We recommend a revised capacity test that takes into account the impact of the mental health condition on their decision-making, and on the person’s rights and the Government’s positive obligations under articles 2 and 3 of the Human Rights Act. The criteria for determining whether a person without capacity requires treatment under the Act should focus on their best interests, enhancing their wellbeing and life chances, and enabling them to live a fulfilled life.

### Therapeutic benefit

1. DHSC should ensure there are sufficient high-quality, appropriate mental health services and pathways to meet the needs of all adults, children and young people across the protected characteristics, including therapeutic alternatives to detention, preventative support to minimise the risk of crisis, and wider community services that enable good mental health and recovery.
2. DHSC and NHS England should report on progress against the recommendations in the five year forward view for mental health and assess what further work is needed to improve access to high quality mental health care.
3. DHSC and NHS England should ensure that a robust assessment of mental health need at the local level is a priority for integrated care systems.

### Significant harm

If the Government is not considering reforming the Act in line with Recommendation 11 above, we recommend:

1. The Code of Practice for the proposed new Mental Health Act should set out clear standards and requirements for assessing risk of harm to ensure a consistent, evidence-based and unbiased approach. This should include standardised processes for making and documenting risk assessments, which should be scrutinised by the CQC as part of their inspections.
2. DHSC should develop training for professionals and other resources as needed to support a balanced approach to risk.

### Patients detained under part 3

1. We recommend that the proposals to strengthen the criteria for detention are extended to patients detained under part 3 of the Mental Health Act.

## Challenging detention

### Automatic referrals

1. We recommend that automatic referrals for conditional discharges take place every twelve months, in line with the recommendation in the Independent Review.
2. We recommend that DHSC assess the capacity of the tribunal system to manage more frequent referrals, and take steps to increase it as required to ensure the proposals are deliverable and lead to increased access to timely and meaningful detention reviews.

### Additional tribunal powers

1. We recommend that DHSC provide effective guidance in the Code of Practice for the proposed new Mental Health Act detailing the meaning of the ‘reasonable efforts’ a health and local authority must take when a tribunal directs the provision of community services.
2. We recommend that where local and health authorities are unable to provide community services as directed by the tribunal, they should be required to provide the tribunal with written evidence of the barriers, the steps they have taken to overcome these barriers and a clear, time-bound plan for making community services available. DHSC should consider what powers or discretion the tribunal should have to require authorities to report to the tribunal on an ongoing basis on their progress to secure community services.
3. We recommend that DHSC collect, analyse and publish data on how often the tribunal directs community provision, how often local and health authorities fail to follow the tribunal’s direction and the reasons for this, and the number of people considered ready for discharge who remain in detention due to a lack of community services and for how long. This data should be disaggregated by protected characteristic and by local area to allow comparisons. Local and health authorities should be required to take action to address any disproportionate outcomes.
4. We recommend DHSC clarify what rights and remedies patients, advocates and relatives will have if health and local authorities do not fulfil a tribunal’s direction.
5. We recommend that DHSC consider how to provide the tribunal with discretion to extend the five-week time limit for local and health authorities to respond to a direction to provide community services, where necessary to avoid prolonged detention.

### Hospital managers’ panel hearings

1. We recommend that DHSC assess the rate of requests to and outcomes from hospital managers’ panel hearings to inform a decision on whether their role in reviewing detentions should be removed. If their role is maintained, we recommend that mental health trusts be required to report data on discharge rates from hospital managers’ panel hearings on an annual basis, and the CQC should monitor this data alongside discharge rates from mental health tribunals.
2. DHSC should carefully assess the capacity of the tribunal system, and take necessary steps to increase capacity as required, before removing the power of a hospital managers’ panel to discharge a patient from detention.
3. We recommend that DHSC take forward the Independent Review’s recommendation for the independent ‘Hospital Visitors’ role in new legislation. Failing that, DHSC should work closely with the CQC to assess the ability and capacity of existing organisations to undertake the monitoring envisaged for the ‘Hospital Visitors’ role. If gaps are identified, DHSC should work with organisations to provide the support needed to enable effective scrutiny, including funding and resourcing.

### Statutory notification of rights duty

1. We recommend that the proposed Mental Health Bill place a clear statutory duty on all mental health wards to provide patients and their care network (which could include carers, nominated persons and family members) with standardised information about their rights under the Mental Health Act and under equality and human rights law. DHSC should produce a standardised resource for this purpose in consultation with stakeholders and using our notification of rights documents as a model. DHSC should ensure this resource is available in a range of accessible formats to meet individual needs, including Easy Read. Mental health wards should provide this information prior to any assessment where a decision to detain may be made.

## Choosing and refusing treatment

### Advance choice documents

1. We recommend a requirement for advance choice documents to be authenticated by a health or social care professional to help ensure the patient understands their choices and the implications, and to prevent any disputes about whether the patient had the relevant capacity and information at the time they made the decision. DHSC should introduce a process for authentication that works effectively and does not prevent people expressing choice or limit how that choice is respected. While we support a requirement for authentication, there should be scope for appropriate consideration to be given to advance choice documents that have not been authenticated by a professional.
2. We recommend that the CQC monitor the quality of advance choice documents and how they are followed.

### The right to refuse treatment

1. To achieve genuine parity between mental and physical health and safeguard people’s rights, we recommend that the proposed Mental Health Bill prohibit compulsory treatment for people who have capacity and are refusing, or who lack capacity but have made an express choice when they had capacity against such treatment, where that capacity is determined by a revised test that takes into account the impact of the mental health condition on their decision-making, and that takes account of the person’s rights and the Government’s positive obligations in relation to articles 2 and 3 of the Human Rights Act.

### Challenging treatment decisions at the tribunal

1. We recommend that DHSC clarify the following procedural issues to ensure advance choice documents have their intended effect in practice: which court or tribunal would adjudicate on disputes about compliance with advance choice documents; whether cases would be brought by the detained patient or on their behalf and if so by whom; and whether non-means tested legal aid would be available.

## Support during detention

###  Nominated person

1. We recommend that DHSC produce guidance on how the nominated person provisions will operate to place primary weight on the expressed views of the person detained under the Mental Health Act, and that all efforts are made to determine those views, including through supported decision-making, advance choice documents, and access to advocacy provisions.

### Children and young people’s right to choose a nominated person

1. We recommend that DHSC specify on the face of the proposed Mental Health Bill how parental rights will be maintained where a parent or guardian is not the child’s nominated person. These provisions should particularly address the rights of a person with parental responsibility to consent to treatment of a child detained under the Act and to receive information about their child’s treatment and discharge.

### Advocacy services

1. We recommend that DHSC expand the statutory duty to provide IMHA support to informal patients, make advocacy services ‘opt out’ by default for all patients, and commit to legislate for culturally competent advocacy in the proposed Mental Health Bill. DHSC should also set out a clear plan for how these improvements to advocacy services will be funded and resourced.

## Community treatment orders

1. DHSC should annually monitor the impact of its overall package of reforms for CTOs, and consider abolishing CTOs if the problems identified by the Independent Review are not ameliorated within the next five years. In addition, local mental health trusts should be required to explain rates of overall use of CTOs, including total length of time on a CTO, the nature of restrictions, and whether a CTO is renewed or extended, and take action to address any disparities for groups sharing protected characteristics, with a particular focus on people from Black ethnic groups.

## The interface between the Mental Health Act and the Mental Capacity Act

###  A clear dividing line between the two Acts

1. We recommend that DHSC ensure there are equivalent protections available under the Mental Health Act and Mental Capacity Act for detained people who lack capacity. This should include ensuring advance choice documents are treated in the same way, clarifying what constitutes objection (making clear that it does not require the person to expressly object and can be inferred from their behaviour), ensuring parity in provisions for after care, and introducing a statutory requirement for patients detained under the Mental Capacity Act to have a care and treatment plan.

### Advance consent for informal admission to hospital

1. We recommend that DHSC does not introduce provisions for people with capacity to provide advance consent to informal admission. In line with the wider proposals in the white paper, the emphasis should be on treating people in the least restrictive and most therapeutic way possible, strengthening the safeguards on detention and compulsory treatment, and improving people’s ability to express their wishes, including through greater access to advocacy.

### Supporting people with a learning disability or autism

1. DHSC should produce, publish and effectively oversee a new action plan to significantly reduce the number of people with learning disabilities and autism held in secure inpatient settings.

### Co-occurrence of mental health conditions

1. We recommend that DHSC ensure there are sufficient safeguards in the proposed Mental Health Bill to prevent people with learning disabilities and autism being inappropriately detained on the basis they have a co-occurring mental health condition, either because detention for assessment has led to a deterioration in their mental health, or because mental health professionals misidentify features of their learning disability or autism as a mental health condition.

### A duty to ensure appropriate community provision

1. We recommend that DHSC assess compliance with the current policy for local and health authorities to maintain ‘at risk of admission’ registers for people with learning disabilities and/or autism, and use this to inform a decision about whether to make this a legislative duty.

## Improving policy and practice around the proposed Mental Health Bill

###  Role of the Care Quality Commission

In addition to the recommendations we make to the CQC above (summarised in our response at paragraph 67), we recommend the following:

1. We would like to see an increased focus on monitoring and inspecting for coercion as part of any extension of the CQC’s current role and process, including the use of compulsory treatment, restraint, seclusion and other restrictive interventions, and CTOs.
2. We recommend that the resource we have developed to provide a standardised notification of rights under the Mental Health Act and under equality and human rights law could be used as part of the CQC inspections framework.
3. We recommend that mental health trusts’ attention to the PSED should be a specific focus for collaboration and intelligence sharing between our organisations. We would also support the CQC using PSED data published by mental health trusts as an indicator to trigger closer scrutiny, including inspections, of a particular local system.
4. We recommend that DHSC, NHS England and CQC work with us to explore a new approach for setting, measuring and monitoring progress on sector-based equality priorities and objectives, including for mental health trusts, in line with our overall recommendations to strengthen the PSED.

### Consultation process and impact assessment

1. When responding to this consultation, DHSC should set out clearly what steps it took to facilitate engagement from relevant groups, including disabled people with lived experience of detention under the Mental Health Act and particularly those from ethnic minorities, and what impact that feedback had on the consultation outcome.
2. DHSC should produce and publish an assessment of the cumulative impact of the white paper proposals on equality for people sharing different protected characteristics, including steps taken to mitigate any disproportionate impact on particular groups.

# The guiding principles

1. We welcome the proposed new guiding principles of choice and autonomy, least restriction, therapeutic benefit and the person as an individual. We support including these principles on the face of the proposed Mental Health Bill.

## Reducing detention and coercion

1. We consider that the guiding principles and wider reforms proposed in the white paper should have the express aim of reducing detention and coercion and supporting more people to live independently in their communities. Disabled people’s right to live independently is enshrined in article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD). It requires the Government to provide all means necessary so that disabled people can exercise choice and control over their lives, on an equal basis with others, and have the highest level of personal autonomy and self-determination.[[14]](#footnote-14) The growing number of compulsory detentions under the Mental Health Act raises serious concerns about whether this right is being upheld.[[15]](#footnote-15) We recommend that:
* **Mental health trusts should be required to report on trends in their use of the Mental Health Act, disaggregated by protected characteristics, and should provide an explanation and comprehensive action plan if they cannot demonstrate a year-on-year reduction in overall detentions and reduced disproportionality for groups sharing protected characteristics.**
* **DHSC should publish annual national data on the use of the Mental Health Act, disaggregated for all the protected characteristics.[[16]](#footnote-16)**
* **The proposed Mental Health Bill should include a requirement for the Government to report to Parliament within five years on the impact of the reforms in reducing detention and supporting more people to live independently as part of their communities. This should include the impact on reducing restraint and other forms of coercion, and the disproportionate treatment of groups sharing certain protected characteristics, particularly people from Black ethnic groups.**
* **The CQC should monitor local detention rates as part of their inspections, with an expectation of overall reductions and a reduction in any disproportionate rates for groups sharing protected characteristics, and should assess how effectively health and care systems are enabling disabled people to enjoy their right to live independently.**

## Embedding the principles in practice

1. The CQC and Independent Review have found that the current underpinning principles in the Mental Health Act have had limited impact and many providers lack understanding of how to apply them.[[17]](#footnote-17) To help ensure the new principles support real improvements in practice and in patients’ experience, we recommend that:
* **The proposed Mental Health Bill should create a duty on all those who exercise powers under it to give the principles ‘paramount consideration’ in all decisions related to detention, treatment and the commissioning of mental health services.[[18]](#footnote-18)**
* **DHSC should implement the recommendation from the Independent Review that clinicians should be required to demonstrate how they have considered the principles on all forms completed as part of the Mental Health Act process,[[19]](#footnote-19) formulated as a duty to show they have considered and acted on the principles to help ensure a positive impact on decision-making and practice. This should be monitored by the CQC.**
* **The revised Code of Practice for the proposed new Mental Health Act should include clear and effective guidance on applying the principles in practice. DHSC should support this by developing standardised training and resources for commissioners, providers and staff at all levels, covering how the principles apply both to individual patients and in the wider planning and delivery of services. This should include requirements for monitoring and reporting on compliance.**
* **DHSC should carry out or commission a future evaluation of the impact of the proposed guiding principles and take appropriate action if they are shown not to have led to a significant reduction in detention and improvements in patients’ experience.**

## Addressing inequalities

1. In its recommendation for a principle of treating people as individuals, the Independent Review reported that care and treatment often does not consider the different needs for groups sharing protected characteristics. It highlighted negative experiences for people from some ethnic minority groups, particularly Black African Caribbean men, and LGBT people, and noted the increased risk of vulnerability for children and people with learning disabilities.[[20]](#footnote-20) In line with the Review’s recommendations and the requirements of the Equality Act 2010 we recommend that:
* **The principle of the person as an individual should be defined on the face of the proposed Mental Health Bill to include meeting the specific needs arising from sharing protected characteristics.**
* **The Code of Practice for the proposed new Mental Health Act should provide effective guidance on meeting the needs of different groups (including providing reasonable adjustments), addressing inequalities and preventing discrimination in decision-making and treatment, reflecting in particular the current disproportionate detention of people from Black ethnic groups.**

# Criteria for detention

1. We agree that the criteria for detention should be strengthened and support the proposed new criteria in principle.

## The basis for detention

1. The CRPD – which is binding in international law and should be used by the UK Government to guide legislation and policy – requires that ‘the existence of a disability shall in no case justify a deprivation of liberty’.[[21]](#footnote-21) We share the concerns of the CRPD Committee that current mental health law discriminates against disabled people because it permits detention on the basis of impairment.[[22]](#footnote-22) The Committee does not accept that the requirement for risk of harm justifies detention, reflecting that our laws do not allow people without a mental health impairment to be detained on the basis that they pose a risk a risk of harm without any such harm being committed.[[23]](#footnote-23)
2. In our view, it is incompatible with human rights standards to justify the involuntary detention and treatment of people with capacity by reference to their mental health condition.[[24]](#footnote-24) We recommended to the Independent Review[[25]](#footnote-25) that:
* **The Mental Health Act should be reformed to ensure that nobody who has a mental health condition but has the capacity to refuse treatment should be admitted and treated against their will. We recommended a revised capacity test that takes into account the impact of the mental health condition on their decision-making, and on the person’s rights and the Government’s positive obligations under articles 2 and 3 of the Human Rights Act. The criteria for determining whether a person without capacity requires treatment under the Act should focus on their best interests, enhancing their wellbeing and life chances, and enabling them to live a fulfilled life.**
1. This remains our position. However, if the Government is not considering reforming the Act in this way, we broadly support the proposal to strengthen the existing criteria, subject to the considerations we set out below.

## Therapeutic benefit

1. We support the requirement that detention must provide a therapeutic benefit that cannot be delivered without detention. Realising this in practice will require the provision of appropriate mental health services in the community, including preventative support to reduce the risk of crisis.[[26]](#footnote-26) Without these alternatives, we are concerned that people will continue to be detained even if the criteria is not met; or that where detention would not be therapeutic but there is no alternative community provision either, people with acute mental health needs will not be able to access support.
2. Avoiding unnecessary detention will also require a number of other community services to be in place. As the CQC has reported, many people with mental health needs do not get the support they need in other areas of their lives including housing, financial support, employment and physical health, which can affect their condition and recovery.[[27]](#footnote-27) This has important implications for article 19 of the CRPD, which requires that the Government provide the full range of support services that disabled people need to live independently.[[28]](#footnote-28) We recommend that:
* **DHSC should ensure there are sufficient high-quality, appropriate mental health services and pathways to meet the needs of all adults, children and young people across the protected characteristics, including therapeutic alternatives to detention, preventative support to minimise the risk of crisis, and wider community services that enable good mental health and recovery.**
* **DHSC and NHS England should report on progress against the recommendations in the five year forward view for mental health[[29]](#footnote-29) and assess what further work is needed to improve access to high quality mental health care.**
* **DHSC and NHS England should ensure that a robust assessment of mental health need at the local level is a priority for integrated care systems.**

## Significant harm

1. We recognise that strengthening the requirements for risk of harm could help improve compliance with human rights standards. This should be implemented with clear standards to ensure a consistent approach, and with effective guidance and training to support professionals make appropriately balanced assessments and challenge unnecessarily risk-averse cultures.[[30]](#footnote-30)
2. Particular consideration should be given to appropriately assessing the risk to the individual (including the risks associated with detention) and the risk to others. Evidence suggests people with mental health conditions are much more likely to be a risk to themselves, or from others, than to pose a risk to others.[[31]](#footnote-31) There should also be a focus on preventing discrimination, particularly against men from Black ethnic groups, who may be subject to negative stereotypes and structural factors that lead to inappropriate risk assessments.[[32]](#footnote-32) We recommend that:
* **The Code of Practice for the proposed new Mental Health Act should set out clear standards and requirements for assessing risk of harm to ensure a consistent, evidence-based and unbiased approach. This should include standardised processes for making and documenting risk assessments, which should be scrutinised by the CQC as part of their inspections.**
* **DHSC should develop training for professionals and other resources as needed to support a balanced approach to risk.**

## Patients detained under part 3

1. We are concerned that the proposed changes to the criteria would not apply to patients detained under the forensic sections of the Act. We do not consider it appropriate that people who have been involved in criminal proceedings could continue to be detained where the criteria of therapeutic benefit and significant risk of harm are not met. While we recognise there may be different considerations of risk for this group, this should be managed in line with criminal justice provisions; otherwise, people are liable to be detained beyond the length of any sentence and without access to the safeguards and due process available in the criminal justice system. **We recommend that the proposals to strengthen the criteria for detention are extended to patients detained under part 3 of the Mental Health Act.**

# Challenging detention

1. We are pleased to see the focus on giving patients additional rights to challenge detention, in line with the right to liberty and security protected by the Human Rights Act[[33]](#footnote-33) and in international human rights treaties.[[34]](#footnote-34)

## Automatic referrals

1. We welcome the overall proposal to increase the frequency of referrals to the tribunal so that people can access timely detention reviews. The Independent Review noted that some patients may stay in detention or on a CTO for too long because they are not capable of making an application to the tribunal, sometimes because they lack the capacity to do so.[[35]](#footnote-35)
2. We agree with the direction of the proposed timetables for automatic referrals and support shorter time periods than those under the current law.[[36]](#footnote-36) However, we consider that for patients on a conditional discharge, the proposal for referrals to take place 24 months after the initial discharge and then every four years is still too long for effective oversight. **We recommend that automatic referrals for conditional discharges take place every twelve months, in line with the recommendation in the Independent Review**.[[37]](#footnote-37)
3. We recognise that more frequent referrals will incur an administrative burden on the tribunal system and implementation will require sufficient resourcing and funding. Without appropriate resources to increase the capacity of the tribunal system, more frequent automatic referrals may result in less meaningful oversight as the tribunal attempts to handle the increased caseload. **We recommend that DHSC assess the capacity of the tribunal system to manage more frequent referrals, and take steps to increase it as required to ensure the proposals are deliverable and lead to increased access to timely and meaningful detention reviews.**

## Additional tribunal powers

1. We welcome the proposal to extend the tribunal’s role by giving it the power to grant leave and transfers, but we are concerned about the effectiveness of the proposed power to direct services in the community.[[38]](#footnote-38) There is already evidence that people continue to be detained after they are considered ready for discharge because there is no available community support.[[39]](#footnote-39) The lack of community support will likely continue to be a barrier to discharge even with enhanced powers for the tribunal. Further, the tribunal may be reluctant to exercise its power if it is clear there are no services available, even where the criteria for detention are no longer satisfied.
2. Further details are needed about the meaning of ‘reasonable efforts’ to provide community services to ensure a shared understanding and standardised approach. A clear remit as to what is required will help health and local authorities take the right steps to provide support for people outside of restrictive settings. **We recommend that** **DHSC provide effective guidance in the Code of Practice for the proposed new Mental Health Act detailing the meaning of the ‘reasonable efforts’ a health and local authority must take when a tribunal directs the provision of community services.**
3. We also consider there should be a clear requirement on local and health authorities to demonstrate they have made reasonable efforts. **We recommend that where local and health authorities are unable to provide community services as directed by the tribunal, they should be required to provide the tribunal with written evidence of the barriers, the steps they have taken to overcome these barriers and a clear, time-bound plan for making community services available. DHSC should consider what powers or discretion the tribunal should have to require authorities to report to the tribunal on an ongoing basis on their progress to secure community services.**
4. To facilitate oversight for authorities’ response to the tribunal’s direction, **we recommend that DHSC collect, analyse and publish data on how often the tribunal directs community provision, how often local and health authorities fail to follow the tribunal’s direction and the reasons for this, and the number of people considered ready for discharge who remain in detention due to a lack of community services and for how long. This data should be disaggregated by protected characteristic and by local area to allow comparisons. Local and health authorities should be required to take action to address any disproportionate outcomes.**
5. Beyond the directive for health and local authorities to provide an explanation to the tribunal, it is unclear what rights people would have to challenge a failure to provide services. **We recommend DHSC clarify what rights and remedies patients, advocates and relatives will have if health and local authorities do not fulfil a tribunal’s direction.**
6. While we support the ability for the tribunal to direct timely provision of community services, we are concerned that the proposed five-week time limit could result in local and health authorities not making sustained efforts to provide community support, with the result that patients remain in hospital until the next detention review. In cases where authorities can provide community support within a longer time period, tribunals may need discretion to extend the five-week limit to help enable the patient’s discharge. **We recommend that DHSC consider how to provide the tribunal with discretion to extend the five-week time limit for local and health authorities to respond to a direction to provide community services, where necessary to avoid prolonged detention.**

## Hospital managers’ panel hearings

1. While we recognise there are concerns about the effectiveness of hospital managers’ panels in discharging patients from detention,[[40]](#footnote-40) we are not convinced that there is enough evidence at present to justify removing this role. There is no clear data on how often people successfully challenge their detention through a hospital managers’ panel. This makes it difficult to assess their effectiveness, if there are barriers to access, and whether there are any measures that would help improve them as a further safeguard alongside the tribunal. **We recommend that DHSC assess the rate of requests to and outcomes from hospital managers’ panel hearings to inform a decision on whether their role in reviewing detentions should be removed. If their role is maintained, we recommend that mental health trusts be required to report data on discharge rates from hospital managers’ panel hearings on an annual basis, and the CQC should monitor this data alongside discharge rates from mental health tribunals.**
2. Removing hospital managers’ panel hearings would mean that tribunals are the only way people can challenge their detention. If the capacity of the tribunal system is not increased to compensate, this may result in reduced access to challenge and unnecessary prolonged detentions. **DHSC should carefully assess the capacity of the tribunal system, and take necessary steps to increase capacity as required, before removing the power of a hospital managers’ panel to discharge a patient from detention.**
3. The Independent Review’s recommendation to remove panels’ power to discharge a patient from detention was made in conjunction with a recommendation to create a new independent ‘Hospital Visitors’ role.[[41]](#footnote-41) The main purpose of this role would be ‘to monitor day-to-day life in the hospital and ensure that patients are treated with dignity and respect, that they receive the treatment that they need, and that their rights are protected’.[[42]](#footnote-42) We are disappointed that this recommendation is not being taken forward. Without such scrutiny, services may be more likely to develop ‘closed cultures’, leading to a greater risk of abuse and human rights infringements.[[43]](#footnote-43)The white paper instead proposes that existing bodies such as independent mental health advocates (IMHAs), peer support workers and the CQC’s Mental Health Act reviewers and complaints team provide the scrutiny envisaged for this role. We are concerned that there may not be enough capacity across these groups and organisations to provide effective scrutiny for all patients, particularly advocacy services, which will need enhanced resources.
4. We are also not clear how IMHA and peer support workers would be empowered to provide effective scrutiny where service provision is inadequate. **We recommend that DHSC take forward the Independent Review’s recommendation for the independent ‘Hospital Visitors’ role in new legislation. Failing that, DHSC should work closely with the CQC to assess the ability and capacity of existing organisations to undertake the monitoring envisaged for the ‘Hospital Visitors’ role. If gaps are identified, DHSC should work with organisations to provide the support needed to enable effective scrutiny, including funding and resourcing.**

## Statutory notification of rights duty

1. In our view, the proposed Mental Health Bill should include more focus on providing patients and their advocates with information about their rights. The tribunal cannot work properly as a safeguard against inappropriate detention and treatment, regardless of how frequently it hears cases, without patients understanding their rights and the system in which they are detained.
2. 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,[[44]](#footnote-44) despite the existing requirement in the Code of Practice for hospital managers to provide information to patients both orally and in writing.[[45]](#footnote-45) We have previously called for a standardised notification of rights under the Mental Health Act and under equality and human rights law, and have developed a resource in collaboration with stakeholders (including patients, families, carers and staff).[[46]](#footnote-46) Evidence from the pilots we carried out suggested that a resource like this can help patients, families and advocates, as well as staff, better understand and realise people’s rights.
3. **We recommend that the proposed Mental Health Bill place a clear statutory duty on all mental health wards to provide patients and their care network (which could include carers, nominated persons and family members) with standardised information about their rights under the Mental Health Act and under equality and human rights law. DHSC should produce a standardised resource for this purpose in consultation with stakeholders and using our notification of rights documents as a model. DHSC should ensure this resource is available in a range of accessible formats to meet individual needs, including Easy Read. Mental health wards should provide this information prior to any assessment where a decision to detain may be made.**

# Choosing and refusing treatment

1. We support the overall proposals to strengthen patients’ right to express their wishes and be involved in decisions about their care and treatment. This is an important part of reducing coercion in mental health services and improving compliance with human rights standards.

## Advance choice documents

### Legal effect

1. We welcome the proposal to introduce statutory advance choice documents, but their legal effect should be clarified. The white paper states that patients will be able to document both preferences for treatment and decisions to refuse treatment. It is not clear whether clinicians would have the same obligations to follow preferences as they would refusals, or only a duty to consider them. Existing provisions for advance decision-making in the Mental Capacity Act do not relate to preferences and only refer to refusals, and current case law is clear that patients cannot require doctors to provide a particular treatment.[[47]](#footnote-47)

### Authentication

1. We disagree that advance choice documents should not need to be authenticated by a health professional. While there is no express requirement for authentication in the Mental Capacity Act, the courts have in practice required evidence that the person had capacity at the time they made the decision,[[48]](#footnote-48) particularly in cases where there is a mental health element and those involving refusal of serious medical treatment. In our view, authentication is the best way to create certainty about the status of advance choice documents and help ensure people’s choices are followed. To further support the principle of choice, we consider that social care as well as health professionals should be able to provide authentication.
2. We recognise that authentication could present administrative barriers. In our view, this could be mitigated by providing guidance to patients, carers and advocates on how to get an authentication, guidance to practitioners on how to provide one, and appropriate funding to ensure cost is not prohibitive. The guidance should make clear that authentication is required to confirm the person’s decision-making capacity but not any aspect of their expressed preferences, which are theirs to make. This should avoid the risk that professionals refuse to authenticate treatment choices by a person with capacity that they do not agree with or consider sub-optimal.
3. Advance statements that have not been authenticated could still be given appropriate consideration by clinicians. Patients could also be guided on how to provide evidence in case of future disputes if authentication by a professional is not possible - for example, recording explaining to a friend or relative the reasons for their choice.
4. **We recommend a requirement for advance choice documents to be authenticated by a health or social care professional to help ensure the patient understands their choices and the implications, and to prevent any disputes about whether the patient had the relevant capacity and information at the time they made the decision. DHSC should introduce a process for authentication that works effectively and does not prevent people expressing choice or limit how that choice is respected. While we support a requirement for authentication, there should be scope for appropriate consideration to be given to advance choice documents that have not been authenticated by a professional.**

### Governance and oversight

1. The recent CQC review of the use of ‘do not attempt resuscitation’ notices during the coronavirus pandemic has highlighted examples of inconsistent and concerning approaches to advance decision-making.[[49]](#footnote-49) These issues were already a concern prior to the coronavirus pandemic.[[50]](#footnote-50) In light of this evidence, we consider that advance choice documents should be supported by a clear governance framework to help ensure quality conversations, a consistent approach and an understanding of how decisions are being adhered to. **We recommend that the CQC monitor the quality of advance choice documents and how they are followed.**

## The right to refuse treatment

1. We agree there should be a more robust framework for involuntary treatment, including a right for patients with capacity to refuse treatment even where it is considered urgent (referred to in the white paper as a ‘right to choose to suffer’). It is a general principle in law and medical practice that people have a right to consent to or refuse treatment. Disabled people have an express right under article 19 of the CRPD to exercise choice and control over decisions affecting their lives with the maximum level of self-determination and autonomy. Involuntary treatment can in some circumstances violate the right to be free from torture and inhuman or degrading treatment and the right to a private and family life, which includes a right to physical and psychological integrity.[[51]](#footnote-51)
2. We consider that more clarity is needed about the status of advance refusals and their legal force. The white paper proposes a wide range of circumstances when patients’ refusals could be overridden, including where it is necessary to ‘prevent a serious deterioration of their condition’. This could in effect mean that doctors can justify overriding advance refusals in most cases. There is also potential for confusion about the status of advance refusals under the Mental Health Act and advance decisions to refuse treatment under the Mental Capacity Act, which are legally binding if they are established as valid. **To achieve genuine parity between mental and physical health and safeguard people’s rights, we recommend that the proposed Mental Health Bill prohibit compulsory treatment for people who have capacity and are refusing, or who lack capacity but have made an express choice when they had capacity against such treatment, where that capacity is determined by a revised test that takes into account the impact of the mental health condition on their decision-making, and that takes account of the person’s rights and the Government’s positive obligations in relation to articles 2 and 3 of the Human Rights Act.**

## Challenging treatment decisions at the tribunal

1. We support the introduction of a right to challenge treatment decisions at the tribunal. We are unclear, however, about access to the courts where a patient’s advance refusal has been overridden or is disputed. **We recommend that DHSC clarify the following procedural issues to ensure advance choice documents have their intended effect in practice: which court or tribunal would adjudicate on disputes about compliance with advance choice documents; whether cases would be brought by the detained patient or on their behalf and if so by whom; and whether non-means tested legal aid would be available.**

# Support during detention

## Nominated person

1. We are pleased to see the proposal to reform the nearest relative system, which we recommended in our submission to the Independent Review.[[52]](#footnote-52) International human rights standards support people being able to choose their preferred representative, and provide that medical professionals should give greater weight to the views of such representatives than they do currently, while always prioritising the expressed will and preferences of the person detained.[[53]](#footnote-53) We are also pleased that the nominated person provisions will be extended to people detained under the criminal justice sections of the Mental Health Act.
2. We agree with the new proposed powers of a nominated person,[[54]](#footnote-54) in addition to the powers currently held by the nearest relative. These additional powers are in line with the proposed guiding principles. However, to better support greater choice and autonomy, in our view there should an explicit emphasis on ensuring that nominated persons are always acting in line with a patient’s wishes, and that every effort is taken to identify a patient’s preferences on their treatment and care. **We recommend that DHSC produce guidance on how the nominated person provisions will operate to place primary weight on the expressed views of the person detained under the Mental Health Act, and that all efforts are made to determine those views, including through supported decision-making, advance choice documents, and access to advocacy provisions.**
3. As discussed in paragraphs 28-30, we recommend a clear statutory duty on all mental health wards to provide nominated persons with standardised information about detained people’s rights under the Mental Health Act and under equality and human rights laws**.** This should be a requirement, rather than just good practice, and is especially important for patients who may lack capacity to make decisions about their care.

## Children and young people’s right to choose a nominated person

1. We agree with the proposal that children aged 15 and under who are *Gillick* competent should be able to select their nominated person, who may not be their parent or guardian.[[55]](#footnote-55) We consider a distinction based on *Gillick* competence, rather than exclusively on age, is a more principled approach based in choice and autonomy, and will better respect children and young people’s human rights.[[56]](#footnote-56)
2. We consider additional clarification is needed as to how the law will navigate the possibility of overlapping obligations for nominated persons and a person with parental responsibility, where a child or young person chooses a nominated person who is not their parent or guardian.[[57]](#footnote-57) We are particularly concerned about the possibility for tension between rights in relation to treatment. There may be cases where a child is *Gillick* competent for the purposes of identifying a nominated person, but not *Gillick* competent in relation to consent to treatment. In this context, both the nominated person and the person with parental responsibility may have a right to be consulted.[[58]](#footnote-58) Clinicians may be confused about who to consult, and the nominated person and person with parental responsibility may offer conflicting views. Similar conflicts could arise in situations where clinicians are required to provide information about treatment and discharge to both a nominated person and a person with parental responsibility.
3. Without clarity on these points on the face of the proposed Mental Health Bill there is likely to be uncertainty and confusion in practice. In particular, we anticipate that clinicians may not consult parents at all if they are not the nominated person, even where parental rights still apply in common law. This could result in problems and delays with information sharing and potential implications for a parent’s right to a family and private life under article 8 of the Human Rights Act. **We recommend that DHSC specify on the face of the proposed Mental Health Bill how parental rights will be maintained where a parent or guardian is not the child’s nominated person. These provisions should particularly address the rights of a person with parental responsibility to consent to treatment of a child detained under the Act and to receive information about their child’s treatment and discharge.**

## Advocacy services

1. We agree with the proposals to expand the role of independent mental health advocates (IMHAs) to include the power to support patients take part in care planning and preparing advance choice documents, challenge a particular treatment if they believe it is not in the person’s best interests, and appeal to the tribunal on the patient’s behalf. However, in our view, the proposals do not go far enough to address the deficiencies in the system noted in the Independent Review.
2. Specifically, we are disappointed that the white paper does not commit to take forward an ‘opt out’ model for IMHA services (where people have an IMHA unless they choose otherwise), which the Independent Review recommended as ‘essential’.[[59]](#footnote-59) Instead, the white paper states it will consider the funding required for an opt-out model.[[60]](#footnote-60) The Independent Review heard evidence that in some areas, IMHA services were not consistently promoted or delivered,[[61]](#footnote-61) and evidence indicates that some groups are particularly likely not to access services.[[62]](#footnote-62) We share the CQC’s view that an opt-out model would better protect patients’ rights and reduce the risk of people being unable to access critical advocacy services in time for a meaningful review of their detention.[[63]](#footnote-63)
3. We are also disappointed that other significant reforms to advocacy services recommended by the Independent Review have not been adopted and are only being considered subject to funding. Specifically, we are concerned that there is no commitment to extend IMHA services to informal patients, or to legislate for culturally competent advocacy to be made available to detained patients. We consider that the Independent Review’s recommendations on these topics would significantly improve the quality and effectiveness of advocacy services. While we appreciate that the Government recognises the importance of these provisions in principle,[[64]](#footnote-64) we would like to see funding prioritised to ensure they can be delivered in practice.
4. **We recommend that DHSC expand the statutory duty to provide IMHA support to informal patients, make advocacy services ‘opt out’ by default for all patients, and commit to legislate for culturally competent advocacy in the proposed Mental Health Bill. DHSC should also set out a clear plan for how these improvements to advocacy services will be funded and resourced.**
5. The white paper asks about specific ways in which advocacy services might be improved, including enhanced standards, regulation and accreditation. We do not have a position on this but suggest that careful consideration is given to peer advocacy in forensic settings. In those situations, prospective advocates may be prohibited from providing valuable support as they may not be able to pass entry requirements for training or accreditation due to criminal records.
6. We also suggest a review of the advocacy services needed in rural areas, including the availability of services for patients who need to access advocacy in languages other than English or Welsh.

# Community treatment orders

1. As the white paper acknowledges, there are longstanding issues with CTOs. Evidence indicates that CTOs have not reduced hospital readmissions,[[65]](#footnote-65) and that they have been used significantly more often than originally intended.[[66]](#footnote-66) We share the concerns about CTOs reflected in the Independent Review and are particularly concerned about racial disparities. In 2019-20, Black or Black British people were over ten times more likely than white groups to be subjected to CTOs.[[67]](#footnote-67) This was a marked increase from the prior year, in which Black or Black British people were just over eight times more likely than white groups to be on a CTO. [[68]](#footnote-68)
2. While we are pleased to see that the white paper takes forward a number of recommendations from the Independent Review,[[69]](#footnote-69) we are disappointed that DHSC has not adopted the recommendations to commission IMHA services specifically for people on CTOs, allow tribunals to order changes to the conditions of a CTO, and mandate that all CTOs should end after twenty-four months. In our view, these recommendations are strongly needed and would significantly help to deliver the proposed guiding principles for a new Mental Health Bill. We are also concerned that there are no specific proposals in the white paper to reduce the disproportionate use of CTOs on Black or British people. We are further disappointed, given the significant concerns about CTOs, that the white paper does not seek views on the proposed reforms.
3. We welcome the commitment to monitor the effects of the reforms to CTOs over the next five years. This should include monitoring the impact on reducing the overall use of CTOs and reducing the disproportionate use on groups sharing protected characteristics, particularly people from Black ethnic groups. As overall rates of detention are reduced, DHSC must ensure that there is not a corresponding increase in the use of CTOs. **DHSC should annually monitor the impact of its overall package of reforms for CTOs, and consider abolishing CTOs if the problems identified by the Independent Review are not ameliorated within the next five years. In addition, local mental health trusts should be required to explain rates of overall use of CTOs, including total length of time on a CTO, the nature of restrictions, and whether a CTO is renewed or extended, and take action to address any disparities for groups sharing protected characteristics, with a particular focus on people from Black ethnic groups.**

# The interface between the Mental Health Act and the Mental Capacity Act

## A clear dividing line between the two Acts

1. We welcome efforts to address the current uncertainty about which Act should apply to patients who cannot consent to treatment and are not objecting, which has led to inconsistencies in practice.[[70]](#footnote-70) In our view, the primary objective should be ensuring all people detained in hospital who lack capacity have equivalent safeguards, whichever Act is being used. **We recommend that DHSC ensure there are equivalent protections available under the Mental Health Act and Mental Capacity Act for detained people who lack capacity. This should include ensuring advance choice documents are treated in the same way, clarifying what constitutes objection (making clear that it does not require the person to expressly object and can be inferred from their behaviour), ensuring parity in provisions for after care, and introducing a statutory requirement for patients detained under the Mental Capacity Act to have a care and treatment plan.** The introduction of new liberty protection safeguards under the Mental Capacity Act presents an opportunity to bring the current and proposed safeguards in the two Acts in line.

## Advance consent for informal admission to hospital

1. We disagree with the proposal that people should be able to give advance consent to informal admission to a mental health hospital. While we appreciate that informal admission may provide a less restrictive option than detention, it also deprives patients from accessing the procedural safeguards that would otherwise be available to them under the Mental Health Act or the Mental Capacity Act. This creates a risk of arbitrary detention, contrary to article 5 of the Human Rights Act which protects the right to liberty and security. Article 5 case law also makes clear that, where people have capacity, valid consent *at* *the* *time* *of* *detention* is required.[[71]](#footnote-71)
2. We remain concerned about whether people can genuinely consent to admission ahead of time. People cannot know the exact conditions they may be held in at the time they provide consent and could then be confined in settings they would not knowingly agree to. We are also concerned about the risk of coercion, and that alternatives to detention may not be considered for people who have given prior consent to admission. **We recommend that DHSC does not introduce provisions for people with capacity to provide advance consent to informal admission. In line with the wider proposals in the white paper, the emphasis should be on treating people in the least restrictive and most therapeutic way possible, strengthening the safeguards on detention and compulsory treatment, and improving people’s ability to express their wishes, including through greater access to advocacy.**

# Supporting people with a learning disability or autism

1. We have longstanding concerns about the inappropriate and prolonged detention of children and adults with learning disabilities and/or autism.[[72]](#footnote-72) There has been limited progress to reduce reliance on inpatient care despite Government commitments for a number of years.[[73]](#footnote-73) The CQC has recently reported that the use of restraint, seclusion and blanket restrictions in these settings is widespread.[[74]](#footnote-74) Allegations of shocking physical and psychological abuse at Whorlton Hall raised serious questions about whether lessons have been learnt from the prior events at Winterbourne View.[[75]](#footnote-75) **DHSC should produce, publish and effectively oversee a new action plan to significantly reduce the number of people with learning disabilities and autism held in secure inpatient settings.**
2. We support specific interventions to reduce the use of the Mental Health Act for people with learning disabilities and/or autism, which are lifelong conditions for which there is no treatment. Evidence suggests these people are typically detained because they demonstrate ‘challenging behaviour’, and not because they have needs that require detention or could not be delivered without detention.[[76]](#footnote-76) As we make clear throughout our response, we also support wider reforms to the Mental Health Act that will see a reduction in detention for all groups.

## Co-occurrence of mental health conditions

1. We broadly support the proposal to clarify the criteria for detention so that learning disability and autism are no longer grounds for detention on their own without a co-occurring mental health condition. However, we are concerned this proposal in isolation will not lead to a meaningful reduction in the number of people detained.
2. The Mental Health Act already provides that a learning disability should not be considered a ‘mental disorder’ for the purposes of the Act, unless it is associated with ‘abnormally aggressive or seriously irresponsible conduct’.[[77]](#footnote-77) The Code of Practice has made clear for a number of years that people with autism should only be detained as a last resort.[[78]](#footnote-78) In our view, it is primarily the lack of community support rather than the legislative framework that has resulted in continued detentions for this group. This is borne out by the latest Government figures which show more than a quarter of people with learning disabilities and autism in detention have been assessed as no longer needing inpatient care.[[79]](#footnote-79)
3. The white paper proposes that the detention of people with learning disabilities and autism will remain possible for assessment and where a co-occurring mental health condition is diagnosed. We are concerned that behaviour associated with a learning disability or autism, including coping strategies, could be interpreted as a mental health condition and used to justify detention. **We recommend that DHSC ensure there are sufficient safeguards in the proposed Mental Health Bill to prevent people with learning disabilities and autism being inappropriately detained on the basis they have a co-occurring mental health condition, either because detention for assessment has led to a deterioration in their mental health, or because mental health professionals misidentify features of their learning disability or autism as a mental health condition.**

## Statutory care and treatment reviews

1. We welcome the proposed introduction of statutory care and treatment reviews for adults, and statutory care, education and treatment reviews for children and young people. We note, however, that it is already policy for commissioning bodies to ensure these reviews are in place. There is also evidence to suggest that where reviews do take place, they do not necessarily lead to timely discharge from hospital.[[80]](#footnote-80)

## A duty to ensure appropriate community provision

1. We welcome the introduction of a new duty to ensure an adequate supply of community provision, although, as with other proposals we are not clear that it will necessarily drive meaningful change (there is arguably already an equivalent duty under the Care Act 2014[[81]](#footnote-81)). As we set out at paragraphs 18-23, we consider that a strengthened power for the tribunal to direct community provision would be more effective, along with more comprehensive action to address the under-availability of community provision, as we recommend at paragraph 10.
2. While we support the introduction of ‘at risk’ registers to support better planning for provision and avoid unnecessary detentions, we consider it would be helpful first to assess the extent to which the current requirement for ‘at risk of admission’ registers in NHS England policy is being complied with by commissioners.[[82]](#footnote-82) **We recommend that DHSC assess compliance with the current policy for local and health authorities to maintain ‘at risk of admission’ registers for people with learning disabilities and/or autism, and use this to inform a decision about whether to make this a legislative duty.**

# Improving policy and practice around the proposed Mental Health Bill

## Role of the Care Quality Commission

1. The white paper asks for views on how the CQC could support the quality of care by extending its monitoring powers.[[83]](#footnote-83) As we have noted in earlier sections of our response, there are significant ways the CQC can support the quality of care through such an extension. **Specifically, we have recommended that the CQC should:**
	* **Monitor local detention rates as part of their inspections, with an expectation of overall reductions and a reduction in any disproportionate rates for groups sharing protected characteristics, and should assess how effectively health and care systems are enabling disabled people to enjoy their right to live independently;**
	* **Scrutinise standardised processes for making and documenting risk assessments as part of their inspections;**
	* **If hospital managers’ panels maintain a role in discharging patients from detention, monitor requests to and outcomes from hospital managers’ panel hearings alongside discharge rates from mental health tribunals;**
	* **If DHSC does not implement a new independent ‘Hospital Visitors’ role, work with DHSC to assess the ability and capacity of existing organisations to undertake the monitoring role envisaged for the ‘Hospital Visitors’ role;**
	* **Monitor the quality of advance choice documents and how they are followed;**
	* **Monitor how clinicians have demonstrated they have considered and acted on the principles on all forms completed as part of the Mental Health Act process.**
2. We also consider that the CQC can continue to play a significant role in reducing the use of coercion and restraint at local levels. The CQC recently recommended that it should review its approach to rating providers who have people in prolonged seclusion or are using unnecessary restraint, and ensure that these providers are not rated as good or outstanding.[[84]](#footnote-84) **We would like to see an increased focus on monitoring and inspecting for coercion as part of any extension of the CQC’s current role and process, including the use of compulsory treatment, restraint, seclusion and other restrictive interventions, and CTOs**.**[[85]](#footnote-85)**
3. In addition, **we recommend that the resource we have developed to provide a standardised notification of rights under the Mental Health Act and under equality and human rights law could be used as part of the CQC inspections framework**. This would enable the CQC to take a more rights-based approach to their inspections and Mental Health Act reviews. For example, our resource contains a number of ‘interactive sections’ that patients can use to record information about their rights, including being involved in their care and treatment plan, and having reasonable adjustments put in place. One way the CQC could use this resource would be to check whether the document is being used in a specific mental health ward and, if so, what interactive sections patients have filed and what rights are being realised in practice.
4. We understand that the regulatory framework in England is increasingly focussed on evaluating how local systems (including integrated care systems) work as a whole, rather than individual providers.[[86]](#footnote-86) In our view, this potentially provides additional opportunities for the CQC to report and take action on key equality and human rights issues. We have recommended in our response that in line with the public sector equality duty (PSED), mental health trusts should be required to collect, analyse and publish disaggregated data on key aspects of the use of the Mental Health Act, including areas of disproportionality and any action needed to address inequalities. We recently signed a new memorandum of understanding with the CQC with the objective of strengthening our strategic partnership, in order to safeguard the wellbeing and rights of the public receiving health and social care in England.[[87]](#footnote-87) **We recommend that mental health trusts’ attention to the PSED should be a specific focus for collaboration and intelligence sharing between our organisations.** **We would also support the CQC using PSED data published by mental health trusts as an indicator to trigger closer scrutiny, including inspections, of a particular local system.**
5. We have separately called for the Government to review and amend the specific duties underpinning the PSED to ensure public bodies are required to focus on the most significant inequalities for people affected by their functions.[[88]](#footnote-88) We have developed proposals to strengthen the PSED, including that: Government departments should set and publish national equality priorities for the sectors for which they are responsible; public bodies within those sectors should set specific and measureable equality objectives to address these priorities; and that bodies with responsibility for regulating, inspecting or auditing public authorities should be required to oversee progress in relation to those published equality objectives.[[89]](#footnote-89) In the context of the Mental Health Act, this would mean that DHSC would publish equality priorities for the mental health sector, and the CQC would monitor progress against objectives set by mental health trusts to, for example, address inequalities in mental health detention. We would remain responsible for monitoring and enforcing compliance with the specific duties (i.e. the process duties requiring public bodies to set objectives). We maintain that the Government should bring forward proposals to reform the PSED specific duties in line with our proposals. In the interim, **we recommend that DHSC, NHS England and CQC work with us to explore a new approach for setting, measuring and monitoring progress on sector-based equality priorities and objectives, including for mental health trusts, in line with our overall recommendations to strengthen the PSED**.

## Consultation process and impact assessment

1. We have recently made recommendations to the Government on how it should actively involve disabled people in policy and decision-making.[[90]](#footnote-90) The consultation process on reforming the Mental Health Act must be informed by the views of people most affected by the proposals, including disabled people who have experience of being detained, their relatives and advocates. Given the evidence of racial disparities in in the use of the Mental Health Act, it is particularly important that ethnic minority communities are included in this consultation process.[[91]](#footnote-91) Under the CRPD, the State has an obligation to ‘consult with and actively involve’ disabled people, through their representative organisations in the development and implementation of legislation, policies and other decision-making processes relating to disabled people’s lives.[[92]](#footnote-92) The CRPD Committee makes clear that consultations with and the involvement of disabled people should be considered a mandatory step prior to the approval of laws, regulations and policies.[[93]](#footnote-93) **When responding to this consultation, DHSC should set out clearly what steps it took to facilitate engagement from relevant groups, including disabled people with lived experience of detention under the Mental Health Act and particularly those from ethnic minorities, and what impact that feedback had on the consultation outcome.**
2. Unless new legislation is fully informed by equality considerations, there is a risk that new proposals to reform the Mental Health Act may inadvertently entrench existing inequalities in its use. The PSED requires all public authorities to take active steps to consider equality when exercising their functions.[[94]](#footnote-94) We would have expected to see a full, cumulative equality impact assessment of the proposals in the white paper on groups sharing different protected characteristics, in line with the Government’s obligations under the PSED.[[95]](#footnote-95) We are disappointed that no such equality impact assessment appears to have been conducted or published.[[96]](#footnote-96) **DHSC should produce and publish an assessment of the cumulative impact of the white paper proposals on equality for people sharing different protected characteristics, including steps taken to mitigate any disproportionate impact on particular groups.**

1. See e.g. DHSC (January 2021), ‘[The NHS Constitution for England](https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)’. [↑](#footnote-ref-1)
2. NHS (January 2019), ‘[Long term plan](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf)’. [↑](#footnote-ref-2)
3. The Independent Review reported that compulsory detention rates had more than doubled since 1983, although emerging data suggested this trend may be changing. See Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 49. There were 50,893 recorded detentions in 2019-20 (the total will be higher as not all providers submit data). NHS Digital (October 2020), ‘[Mental Health Act statistics, annual figures 2019-20](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures)’. At the end of December 2020 there were 2,055 adults and children with learning disabilities and/or autism detained in inpatient facilities. See NHS Digital (January 2021), ‘[Learning disability services monthly statistics AT: December 2020, MHSDS: October 2020 final](https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-december-2020-mhsds-october-2020-final)’. [↑](#footnote-ref-3)
4. Article 5 of the Human Rights Act 1998. [↑](#footnote-ref-4)
5. Article 19 of the UN Convention on the Rights of Persons with Disabilities (CRPD). [↑](#footnote-ref-5)
6. CQC (October 2020), ‘[Out of sight – who cares?: Restraint, segregation and seclusion review](https://www.cqc.org.uk/publications/themed-work/rssreview)’, p. 46. [↑](#footnote-ref-6)
7. Triggle, N. (May 2019), ‘[Whorlton Hall: hospital ‘abused’ vulnerable adults](https://www.bbc.co.uk/news/health-48367071)’, BBC News. [↑](#footnote-ref-7)
8. People from Black ethnic groups are more than four times more likely to be detained under the Act and more than ten times more likely to be subject to a community treatment order. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act)’. Though current data on the use of the Act for groups sharing protected characteristics is limited, some patterns are observable. For example, while men are detained at higher rates than women, girls are detained at higher rates than boys. In 2019-20, almost 69 per cent of children detained were female. NHS Digital (October 2020), [‘Mental Health Act statistics, annual figures 2019-20’](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures) (see Mental Health Act Statistics Data Tables at table 1e). [↑](#footnote-ref-8)
9. See Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 56; UN Committee on the Rights of Persons with Disabilities (2017), ‘[Concluding observations](https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GBR/CO/1&Lang=En)’, para 36. [↑](#footnote-ref-9)
10. Equality and Human Rights Commission (2018), ‘[Is Britain Fairer?](https://www.equalityhumanrights.com/en/publication-download/britain-fairer-2018)’. [↑](#footnote-ref-10)
11. The current published data is limited to age, ethnicity and sex. [↑](#footnote-ref-11)
12. Article 19(b) of the CRPD requires that the Government provide the full range of support services that disabled people need to live independently. [↑](#footnote-ref-12)
13. CQC (February 2021), ‘[Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic](https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201920-mental-health-act-coronavirus-covid-19)’, p. 22. [↑](#footnote-ref-13)
14. See UN Committee on the Rights of Persons with Disabilities (2017), ‘[General comment No. 5 (2017) on living independently and being included in the community](https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsnbHatvuFkZ%2bt93Y3D%2baa2q6qfzOy0vc9Qie3KjjeH3GA0srJgyP8IRbCjW%2fiSqmYQHwGkfikC7stLHM9Yx54L8veT5tSkEU6ZD3ZYxFwEgh)’. [↑](#footnote-ref-14)
15. See footnote 3. [↑](#footnote-ref-15)
16. Current published data is limited to age, ethnicity and sex. [↑](#footnote-ref-16)
17. CQC (2019), ‘[Mental Health Act Code of Practice 2015: an evaluation of how the code is being used](https://www.cqc.org.uk/sites/default/files/20190625_mhacop-report.pdf)’, and Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’. [↑](#footnote-ref-17)
18. This follows the model of section 1 of the Children Act 1989, which requires that children’s welfare is the paramount consideration in decisions that affect them. [↑](#footnote-ref-18)
19. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, recommendation 3. [↑](#footnote-ref-19)
20. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 158. [↑](#footnote-ref-20)
21. CRPD Article 14. [↑](#footnote-ref-21)
22. In its most recent concluding observations on the UK, the CRPD Committee recommended that legislation providing for non-consensual involuntary, compulsory treatment and detention on the basis of actual or perceived impairment is repealed. See UN Committee on the Rights of Persons with Disabilities (2017), ‘[Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fGBR%2fCO%2f1&Lang=en)’, paras 34 & 35. [↑](#footnote-ref-22)
23. UN Committee on the Rights of Persons with Disabilities (2015), ‘[Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities](https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc)’, paras 13-15. One possible exception to the principle that non-disabled people cannot be detained only on the basis of risk is the provision for pre-trial detention for suspects of terrorism offences. [↑](#footnote-ref-23)
24. We recognise that compulsory detention and treatment may be necessary in some cases for people in mental distress who do not have decision-making capacity, in order to provide care and protect them from harm. Failing to provide care in these cases could violate the Government’s obligations to protect the rights to life and freedom from ill treatment under articles 2 and 3 of the Human Rights Act 1998. [↑](#footnote-ref-24)
25. Equality and Human Rights Commission (December 2018), ‘[Our recommendations to the Independent Review of the Mental Health Act](https://www.equalityhumanrights.com/sites/default/files/consultation-response-review-mental-health-act-updated-december-2018.docx)’. [↑](#footnote-ref-25)
26. See UN Human Rights Committee (2014), ‘[General Comment no. 35](https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsrdB0H1l5979OVGGB%2bWPAXjdnG1mwFFfPYGIlNfb%2f6T%2fqwtc77%2fKU9JkoeDcTWWPIpCoePGBcMsRmFtoMu58pgnmzjyiyRGkPQekcPKtaaTG)’, and UN Committee on the Rights of Persons with Disabilities (2015), ‘[Guidelines on the right to liberty and security](https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc)’. [↑](#footnote-ref-26)
27. CQC (November 2020), ‘[2020 community mental health survey, statistical release](https://www.cqc.org.uk/sites/default/files/20201124_cmh20_statisticalrelease.pdf)’. [↑](#footnote-ref-27)
28. CRPD Article 19(b). [↑](#footnote-ref-28)
29. Independent Mental Health Taskforce to the NHS in England (February 2016), ‘[The five year forward view for mental health](https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf)’. [↑](#footnote-ref-29)
30. The Independent Review reported that professionals need ‘supportive management, training support and supervision from their organisations and encouragement to adopt positive-/therapeutic risk-taking approaches, in line with the emerging evidence base. To do this will require a concerted, cross-organisation, drive to tackle the culture of risk aversion.’ Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 108. [↑](#footnote-ref-30)
31. See e.g. Royal College of Psychiatrists (May 2017), ‘[Rethinking risk to others in mental health services](https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr201.pdf?sfvrsn=2b83d227_2)’. [↑](#footnote-ref-31)
32. See e.g. Mind (2019), ‘[Discrimination in mental health services](https://www.mind.org.uk/news-campaigns/legal-news/legal-newsletter-june-2019/discrimination-in-mental-health-services/)’ [accessed 21 April 2021]. The Independent Review also stated that ‘[w]e are in no doubt that structural factors which engender racism, stigma and stereotyping increase the risk of differential experiences in ethnic minority communities’. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 20. See also p. 158. [↑](#footnote-ref-32)
33. Article 5 of the Human Rights Act 1998. [↑](#footnote-ref-33)
34. Including CRPD (Articles 14 and 19), the International Covenant on Civil and Political Rights (ICCPR) (Article 9 and General Comment no. 35), and the Convention on the Rights of the Child (CRC) (Articles 37(b) and 3(1)). [↑](#footnote-ref-34)
35. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, pp. 124, 188. [↑](#footnote-ref-35)
36. Table 1 of the white paper lays out the current and proposed provisions governing the frequency of automatic referrals. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#table-1)’, Table 1. [↑](#footnote-ref-36)
37. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 202. [↑](#footnote-ref-37)
38. The white paper proposes that, where a tribunal directs community services, health and local authorities would have an obligation to ‘take all reasonable steps’ to follow the tribunal’s decision within five weeks, and if they cannot, provide an explanation to the tribunal as to why. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act)’. [↑](#footnote-ref-38)
39. For example, at the end of March 2021, there were 85 people with a delayed discharge from inpatient units for people with learning disabilities and/or autism. The reasons include lack of social care support and lack of suitable housing. NHS Digital (April 2021), ‘[Learning Disability Services Monthly Statistics AT: March 2021, MHSDS: January 2021](https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-march-2021-mhsds-january-2021-fina)’, see LDA monthly statistics from AT data sheet, table 6. [↑](#footnote-ref-39)
40. The Independent Review noted that some service users found the hearings to be ineffective because managers were likely to agree with the responsible clinician. See Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 150. However, some stakeholders have reported to us that patients find hospital manager panels less intimidating and easier to access than formal tribunals. [↑](#footnote-ref-40)
41. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 151. [↑](#footnote-ref-41)
42. Ibid. [↑](#footnote-ref-42)
43. See CQC (September 2020), ‘[Our work on closed cultures](https://www.cqc.org.uk/publications/themes-care/our-work-closed-cultures)’ [accessed 21 April 2021]. [↑](#footnote-ref-43)
44. CQC (February 2019), ‘[Monitoring the Mental Health Act in 2017/18](https://webarchive.nationalarchives.gov.uk/20190301163936/https%3A/www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-report)’, p. 14. [↑](#footnote-ref-44)
45. DHSC (January 2015), ‘[Mental Health Act 1983: Code of Practice](https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983)’, paras 4.9, 4.10. The Code of Practice places the responsibility to produce information in accessible formats on local providers. We understand from stakeholders that there are often difficulties meeting this responsibility due to budget constraints. [↑](#footnote-ref-45)
46. Equality and Human Rights Commission (November 2020), ‘[Your rights when detained under the Mental Health Act in England](https://www.equalityhumanrights.com/en/publication-download/your-rights-when-detained-under-mental-health-act-england)’ [accessed 21 April 2021]. While DHSC has already compiled Easy Read factsheets on the rights of patients under the Mental Health Act, these resources do not include any critically important information on peoples’ rights under human rights laws. While there is some information on the Equality Act, in our view this resource lacks the specificity necessary to help patients understand their rights. NHS (June 2018), ‘[Mental Health Act (easy read)](https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act-easy-read/)’ [accessed 21 April 2021]. [↑](#footnote-ref-46)
47. See *Aintree University Hospital NHS Foundation Trust v James* [2014] AC 591, *R (Burke) v General Medical Council* [2005] EWCA Civ 1003. [↑](#footnote-ref-47)
48. *A Local Authority v E & Others* [2012] EWHC 1639 (COP). [↑](#footnote-ref-48)
49. CQC (2021), ‘[Protect, respect, connect – decisions about living and dying well during COVID-19](https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19)’ [accessed 21 April 2021]. [↑](#footnote-ref-49)
50. CQC (November 2020), ‘[Review of Do Not Attempt Cardiopulmonary Resuscitation decisions during the COVID-19 pandemic](https://www.cqc.org.uk/sites/default/files/20201204%20DNACPR%20Interim%20Report%20-%20FINAL.pdf): interim report’, pp. 4-5. [↑](#footnote-ref-50)
51. Compulsory medical treatment of a detained person with capacity may violate Article 3 if it reaches the threshold of severity required to engage Article 3, unless it can be ‘convincingly shown’ that it is a ‘therapeutic necessity’ and in conformity with accepted medical standards applicable at the time. See *Herczegfalvy vs Austria*, 10533/83 (September 1992) at §83, applied in *R(B) v Dr SS and others* 90 BMLR 1 [2006] EWCA Civ 28. [↑](#footnote-ref-51)
52. Equality and Human Rights Commission (December 2018), ‘[Our recommendations to the Independent Review of the Mental Health Act](https://www.equalityhumanrights.com/sites/default/files/consultation-response-review-mental-health-act-updated-december-2018.docx)’. [↑](#footnote-ref-52)
53. See, e.g. ICCPR General Comment no. 35 (which says that in cases where an individual might not be able to express their views, they should be guaranteed the support of a representative who is able to genuinely represent their preferences), and CRPD Article 12 (which requires the State to ensure that decisions regarding healthcare treatment, including possible hospitalisation, should ensure respect for the views and wishes of the individual). [↑](#footnote-ref-53)
54. Including the right to be consulted on statutory care and treatment plans, hospital transfer, and CTO renewals and extensions; the right to appeal clinical treatment decisions at the tribunal on behalf of someone who lacks capacity; and the power to object to the use of a CTO. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act)’. [↑](#footnote-ref-54)
55. The *Gillick* test is based on the decision on *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7, and involves considering whether the child has sufficient understanding, maturity and intelligence to fully understand what is proposed. [↑](#footnote-ref-55)
56. Including children’s Article 8 ECHR rights to personal development and autonomy, the right of the child to have his or her best interests taken as a primary consideration (Article 3(1), CRC), the right of children to express their views freely in all matters concerning them and on the obligation of the state to give these views due weight (Article 12, CRC). [↑](#footnote-ref-56)
57. For example, outside of the current nearest relative framework, a person with parental responsibility has a range of rights and responsibilities, including the right to consent to treatment on behalf of their child, provided treatment is in the child’s best interest (unless the child has attained *Gillick* capacity), and a right to apply to access the child’s health records. [↑](#footnote-ref-57)
58. Under the current framework, a nearest relative has a right to be consulted and given information about a child who is sectioned and can discharge a person from detention. Normally, the parent or person with parental responsibility would usually be contacted to give consent to treatment unless the child has gained *Gillick* capacity for treatment. [↑](#footnote-ref-58)
59. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 23. [↑](#footnote-ref-59)
60. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act)’. Responding to this recommendation, the white paper states that ‘We will consider making advocacy services 'opt out' and, as part of this, whether funding is needed or if there is capacity within the system to manage additional uptake of IMHAs among patients.’ [↑](#footnote-ref-60)
61. Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 91. [↑](#footnote-ref-61)
62. Newbigging K. et al. (December 2014), ‘[When you haven’t got much of a voice: an evaluation of the quality of Independent Mental Health Advocate services in England](https://www.researchgate.net/publication/269187506_%27When_you_haven%27t_got_much_of_a_voice%27_An_evaluation_of_the_quality_of_Independent_Mental_Health_Advocate_IMHA_services_in_England)’, Health and Social Care in the Community (23(3)). [↑](#footnote-ref-62)
63. CQC (February 2021), ‘[Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic](https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201920-mental-health-act-coronavirus-covid-19)’, pp. 53-54. [↑](#footnote-ref-63)
64. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act)’. The white paper states that the Government ‘plan[s] to extend the statutory eligibility to access an IMHA to informal inpatients, recognising how important it is for all patients to understand and exercise their rights in mental health inpatient settings . . . subject to securing funding’. While it commits to launch a pilot programme of culturally sensitive advocates to identify how to respond appropriately to the diverse needs of people from ethnic minorities, it states that legislation for this type of advocacy is only subject to appropriate funding and successful learning from the pilots. [↑](#footnote-ref-64)
65. Barkhuizen W. et al. (March 2020), ‘[Community treatment orders and associations with readmission rates and duration of psychiatric hospital admission: a controlled electronic case register study](https://bmjopen.bmj.com/content/10/3/e035121)’, BMJ. [↑](#footnote-ref-65)
66. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act)’; Independent Review of the Mental Health Act (December 2018), ‘[Modernising the Mental Health Act: final report of the Independent Review](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf)’, p. 132. [↑](#footnote-ref-66)
67. NHS Digital (October 2020), ‘[Mental Health Act Statistics, Annual Figures 2019-20](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures)’. From April 2019 to end of March 2020, known rates of CTO use for the ‘Black or Black British’ group (61.3 uses per 100,000 population) were over ten times the rate for the White group (6.0 uses per 100,000 population). [↑](#footnote-ref-67)
68. NHS Digital (October 2019), ‘[Mental Health Act Statistics, Annual Figures 2018-2019’](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures). From April 2018 to end of March 2019, known rates of CTO use for the ‘Black or Black British’ group (53.8 uses per 100,000 population) were over eight times the rate for the White group (6.4 uses per 100,000 population). [↑](#footnote-ref-68)
69. Including revising the criteria for CTOs in line with the new detention criteria, requiring the responsible clinician to demonstrate the evidence that a CTO is a reasonable and necessary requirement *to the individual*, are reviewed more frequently and by more professionals, and are time limited. DHSC (January 2021), ‘[Reforming the Mental Health Act](https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act)’. [↑](#footnote-ref-69)
70. See e.g. Gilburt, H. (February 2021), ‘[Understanding clinical decision-making at the interface of the Mental Health Act (1983) and the Mental Capacity Act (2005)](https://www.york.ac.uk/media/healthsciences/images/research/prepare/reportsandtheircoverimages/Understanding%20the%20MHA%20%26%20MCA%20interface.pdf)’, The King’s Fund. [↑](#footnote-ref-70)
71. *Storck v Germany* [2005] ECHR 406. [↑](#footnote-ref-71)
72. There were 2,035 people with learning disabilities and/or autism detained in inpatient units at the end of March 2021. The average length of stay was more than five and half years, and 735 people had been detained for five years or more. NHS Digital (April 2021), ‘[Learning Disability Services Monthly Statistics AT: March 2021, MHSDS: January 2021](https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-march-2021-mhsds-january-2021-fina)’, see LDA monthly statistics from AT data sheet, table 8. [↑](#footnote-ref-72)
73. In 2015 the Government committed that there would be no more than 1,300-1,700 people in inpatient care by March 2019. See NHS England (October 2015), ‘[Building the right support](https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf)’. This target has not been met and was pushed back to March 2024. See NHS (January 2019), ‘[The NHS long term plan](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf)’. [↑](#footnote-ref-73)
74. CQC (October 2020), ‘[Out of sight – who cares?: Restraint, segregation and seclusion review](https://www.cqc.org.uk/publications/themed-work/rssreview)’. [↑](#footnote-ref-74)
75. Triggle, N. (May 2019), ‘[Whorlton Hall: hospital ‘abused’ vulnerable adults](https://www.bbc.co.uk/news/health-48367071)’, BBC News. [↑](#footnote-ref-75)
76. See e.g. Joint Committee on Human Rights (November 2019), ‘[The detention of young people with learning disabilities and/or autism](https://publications.parliament.uk/pa/jt201919/jtselect/jtrights/121/121.pdf): second report of session 2019’. [↑](#footnote-ref-76)
77. Mental Health Act 1983, part 1, section 1 (2A), as amended by the Mental Health Act 2007. [↑](#footnote-ref-77)
78. DHSC (January 2015), ‘[Mental Health Act 1983: Code of Practice](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF)’. [↑](#footnote-ref-78)
79. NHS Digital (April 2021), ‘[Learning Disability Services Monthly Statistics AT: March 2021, MHSDS: January 2021](https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-march-2021-mhsds-january-2021-fina)’, see LDA monthly statistics from AT data sheet, table 6. [↑](#footnote-ref-79)
80. See e.g. Joint Committee on Human Rights (November 2019), ‘[The detention of young people with learning disabilities and/or autism](https://publications.parliament.uk/pa/jt201919/jtselect/jtrights/121/121.pdf): second report of session 2019’, p. 20 (evidence given by Rightful Lives). [↑](#footnote-ref-80)
81. Care Act 2014 s5. [↑](#footnote-ref-81)
82. NHS England (July 2015), ‘[Supporting people with a learning disability and / or autism who have a mental health condition or display behaviour that challenges](https://www.england.nhs.uk/wp-content/uploads/2015/07/ld-draft-serv-mod.pdf)’. [↑](#footnote-ref-82)
83. While this response focuses on the role of the CQC in England, we would also expect new legislation to consider similar responsibilities for equivalent bodies in Wales. [↑](#footnote-ref-83)
84. CQC (October 2020), ‘[Out of sight – who cares?: Restraint, segregation and seclusion review](https://www.cqc.org.uk/publications/themed-work/rssreview)’, p. 49. [↑](#footnote-ref-84)
85. We define restraint broadly as an act carried out with the purpose of restricting an individual’s movement, liberty and/or freedom to act independently, including chemical, mechanical and physical forms of control, coercion and enforced isolation, which may also be called ‘restrictive interventions’. Equality and Human Rights Commission (March 2019), ‘[Human rights framework for restraint](https://www.equalityhumanrights.com/sites/default/files/human-rights-framework-restraint.pdf)’, p. 4. [↑](#footnote-ref-85)
86. See DHSC (February 2021), ‘[Integration and innovation: working together to improve health and social care for all](https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version)’. [↑](#footnote-ref-86)
87. CQC (March 2021), ‘[Memorandum of understanding - Equality and Human Rights Commission (EHRC)](https://www.cqc.org.uk/about-us/our-partnerships/memorandum-understanding-equality-human-rights-commission-ehrc)’. [↑](#footnote-ref-87)
88. Equality and Human Rights Commission (September 2020), [Written evidence to the Lords Public Services Committee on ‘Lessons learned from Coronavirus](https://committees.parliament.uk/writtenevidence/9485/pdf/)’ paras 19-24 and Annex A; Equality and Human Rights Commission (August 2020), [Written evidence to the Lords COVID-19 Committee on ‘Life Beyond Covid](https://committees.parliament.uk/writtenevidence/10331/html/)’, paras 31-35 and Annex. [↑](#footnote-ref-88)
89. Ibid. [↑](#footnote-ref-89)
90. Equality and Human Rights Commission (February 2021), ‘[EHRC Briefing on Development of National Disability Strategy](https://www.equalityhumanrights.com/sites/default/files/210212_ehrc_submission_to_inform_the_national_disability_strategy.docx)’. We have called for the Government to a) establish long-term mechanisms for ensuring that disabled people and their representative organisations are fully involved in the development, delivery and evaluation of national policy-making across Government departments, and b) to develop, publish and promote guidance for Government departments on information accessibility standards and minimum standards for involving disabled people in policy consultations, in line with the CRPD. [↑](#footnote-ref-90)
91. As we noted in our recent section 31 assessment of the Home Office’s hostile environment policies, ‘engaging directly with groups representing people likely to be affected by policies or practices will help public bodies to better understand equality issues’. Equality and Human Rights Commission (November 2020), ‘[Public Sector Equality Duty assessment of hostile environment policies](https://www.equalityhumanrights.com/sites/default/files/public-sector-equality-duty-assessment-of-hostile-environment-policies.pdf)’, p. 25. [↑](#footnote-ref-91)
92. CRPD Article 4 (3). [↑](#footnote-ref-92)
93. UN Committee on the Rights of Persons with Disabilities (2018), ‘[General comment No. 7 on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention](https://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsnbHatvuFkZ%2bt93Y3D%2baa2pjFYzWLBu0vA%2bBr7QovZhbuyqzjDN0plweYI46WXrJJ6aB3Mx4y%2fspT%2bQrY5K2mKse5zjo%2bfvBDVu%2b42R9iK1p)’. [↑](#footnote-ref-93)
94. Section 149 of the Equality Act 2010 requires public authorities and those exercising a public function to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between those who share protected characteristics and those who do not. [↑](#footnote-ref-94)
95. See Equality and Human Rights Commission (October 2014), ‘[Meeting the Equality Duty in Policy and Decision-Making England (and non-devolved public authorities in Scotland and Wales)](https://www.equalityhumanrights.com/en/publication-download/meeting-equality-duty-policy-and-decision-making-england-and-non-devolved)’, p. 9 (noting that having ‘due regard’ to equality considerations across all of functions may involve assessing the impact on equality of decisions that are made together to understand the cumulative impact of these decisions). [↑](#footnote-ref-95)
96. The Women and Equalities Committee has noted that publishing equality impact assessments ‘help those most affected to help shape the Government’s plans to mitigate impacts’, and ‘allows those who may be particularly affected by a policy or legislation to better understand what might happen to them as a result’. Women and Equalities Committee (April 2020), ‘[Correspondence: Coronavirus Act: Equalities Assessment](https://publications.parliament.uk/pa/cm5801/cmselect/cmwomeq/correspondence/Letter-from-Chair-to-Liz-Truss-MP-re-Covid-19-equalities-assessment.pdf)’. [↑](#footnote-ref-96)