Written evidence submitted by the Equality and Human Rights Commission (MHB0014)

About the Commission

1. The Equality and Human Rights Commission (the Commission or EHRC) is a statutory body established under the Equality Act 2006. We operate independently to encourage equality and diversity, eliminate unlawful discrimination and protect and promote human rights. The Commission has a statutory mandate to advise Government and Parliament on matters relating to equality and human rights.

How we have approached this response

2. We have structured our response thematically. We have indicated which of the Committee's questions each section addresses. We have not addressed every question, nor every element of the draft Mental Health Bill. We have confined our response to matters of policy and procedure that have equality and human rights implications. In order to contextualise our responses and recommendations, we have set out at Appendix 1 some of the key relevant domestic and international equality and human rights legal obligations.

3. Our recommendations are addressed to the UK Government and they are equally applicable in England and Wales, since the draft Bill extends to both nations.

Executive Summary

4. The UK 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] and prioritising mental health in the NHS long term plan.[2] The draft Mental Health Bill (the Bill) represents a further important step towards better protecting people's rights and improving the treatment and support they receive. The Commission supports the Bill, and recommends some amendments to it that would help to fully achieve the Government's objectives to "give people greater control over their treatment and help ensure they receive the dignity and respect they deserve."[3] We also consider that some provisions would benefit from further clarity.

5. Helping ensure that reforms of the Mental Health Act 1983 (the Mental Health Act) better protect human rights and ensure equality in the use of compulsory powers is a priority for the Commission. We provided evidence to the Independent Review in 2018[4] and to the White Paper consultation in 2021.[5]

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[1] See e.g. DHSC (January 2021), 'The NHS Constitution for England'.

[2] NHS (January 2019), 'Long term plan'.

[3] DHSC and MoJ (June 2022), Draft Mental Health Bill 2022.

6. The use of the Mental Health Act has significant implications for equality and human rights under both domestic legislation (the Human Rights Act 1998 and the Equality Act 2010) and under international law (in particular the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)).[6] We set out more detail on the relevant legal framework at Appendix 1.

7. Compulsory detention under the Mental Health Act has increased in recent years.[7] Restraint and restrictive interventions are widespread, and in 2020 the Care Quality Commission (CQC) reported many examples of 'care that was undignified, inhumane and that potentially breached people's basic human rights'.[8] In 2022, the CQC found that not enough progress had been made to address these issues[9] and that Black people are more likely to be detained under the Mental Health Act, spend longer in hospital and have more subsequent readmissions than White people.[10]

8. The Commission's recommendations for improvements to the Bill therefore focus on four key aims:

I. Ending inappropriate detention

Inappropriate detention under the Mental Health Act should be ended, with sufficient community-based services for all who need them (and for whom they are appropriate).

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[4] Equality and Human Rights Commission (Nov 2018), Our recommendations to the Independent Review of the Mental Health Act.

[5] Equality and Human Rights Commission (April 2021), Response to the white paper on reforming the Mental Health Act.

[6] Whilst the UNCRPD has not been incorporated into domestic legislation, and is not directly enforceable in UK courts, its provisions represent legally binding obligations on the UK Government in international law, and can be used by UK courts as a tool to interpret rights under the European Convention on Human Rights.

[7] The Independent Review reported that compulsory detention rates had more than doubled since 1983. See Independent Review of the Mental Health Act (December 2018), 'Modernising the Mental Health Act: final report of the Independent Review', p. 49. There were 53,239 recorded detentions in 2020-21: see NHS Digital (October 2021), 'Mental Health Act statistics, annual figures, England 2020-21' (NHS Digital notes that the total will be higher as not all providers submit data). At the end of June 2022, there were 2,005 adults and children with learning disabilities and/or autism detained in inpatient facilities. See NHS Digital (July 2022), 'Learning disability services monthly statistics AT: June 2022, MHSDS: April 2022 final'.

[8] CQC (October 2020), 'Out of sight – who cares?: Restraint, segregation and seclusion review', p. 46.

[9] CQC (March 2022), Out of sight – who cares? Restraint, segregation and seclusion review, Progress report.

[10] CQC (2022), Monitoring the Mental Health Act in 2020/21.

9. We particularly focus on the need for sufficient community-based services, including therapeutic alternatives to detention, to support people before they reach crisis point, thereby reducing involuntary detentions. As set out in the latest CQC Monitoring the Mental Health Act Report, 'community services are key to reducing levels of detention in hospital.'[11]

10. With respect to people with learning disabilities or autism, we welcome the intention of the Bill to 'make it easier for people with learning disabilities and autism to be discharged from hospital',[12] and the changes introduced by the Bill so that learning disabilities and autism are no longer sole grounds for compulsory treatment under section 3 of the Mental Health Act. We recommend strengthening the new commissioning duty at Clause 2 (new section 125E) to provide community-based services so that people can be discharged with the support they need. We also consider that the Mental Health Tribunal power to recommend after-care should be strengthened (through amendments to Clause 38(2)(iii)) so that Mental Health Tribunals are able to specify particular services. We highlight the need for the Government to consider any necessary safeguards to ensure that people with learning disabilities or autism currently detained under section 3 are not simply moved to detention under the Mental Capacity Act, nor inappropriately detained on the basis of a co-occurring mental health condition.

II. Protecting people's rights

People detained or treated under the Mental Health Act should have their rights under equality and human rights law respected, with the support they need, the greatest possible control over treatment, and the ability to effectively challenge the use of compulsory powers.

11. Key to protecting patients' rights and enabling them to challenge decisions about detention and treatment is making sure patients are informed about relevant rights under the Mental Health Act, the Equality Act and the Human Rights Act. We recommend a standardised notification of rights procedure, using our Notification of Rights Documents as a model.[13]

12. We strongly support the new nominated persons provision which will better support patients. We recommend that the Government produce guidance on how the nominated person provisions will operate to place primary weight on the expressed

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[11] CQC, Monitoring the Mental Health Act in 2020/21.

[12] Prime Minister's Office (May 2022), The Queen's Speech 2022: Lobby pack

[13] See: EHRC (2020) Your rights when detained under the Mental Health Act in England, which includes both civil and forensic guides.

views of the person detained under the Mental Health Act. We also highlight that additional clarification is needed on 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.[14]

13. We welcome the provisions in Clause 11 of the Bill for consideration of advance decisions to refuse treatments. However, the opportunity to make an advance decision should be proactively offered to people who have previously been detained, as was anticipated in the White Paper.[15] We also consider that the provisions in the Bill set the bar too low for overriding advance decisions. It defines the 'compelling reason' required to override advance decisions as where there is no alternative medical treatment, or where there is alternative medical treatment available but the patient has not consented or lacks capacity to consent (new section 57A(4)). In order to meet the requirements of Articles 3 and 8 ECHR, the 'compelling reason' should in addition include a test of therapeutic necessity.[16] In applying a test of necessity, the State's positive obligations to protect people under Articles 2, 3 and 8 ECHR would need to be taken into account.

14. Clause 15 of the Bill amends section 62 of the Mental Health Act to remove the power to administer urgent treatment to alleviate serious suffering to patients who have the relevant capacity and are refusing. It is a general principle in law that people have a right to consent to or refuse treatment, even if that results in their suffering. We therefore welcome this provision but consider that, in order to avoid unlawful discrimination contrary to Article 14 ECHR, it should also apply to those who now lack capacity but have made a valid and applicable advance decision.

III. Addressing disproportionality

Disproportionality in detention of ethnic minority groups, particularly Black people, should be addressed.

15. People from Black ethnic groups continue to be detained and subject to community treatment orders (CTOs) at disproportionate rates. In 2020-21, amongst the five broad

[14] For example, outside 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* competency), and a right to apply to access the child's health records.

[15] DHSC (2021), Reforming the Mental Health Act: summary.

[16] 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.

ethnic groups, those in the Black or Black British group were over four times more likely to be detained than those in the White group. Rates of community treatment order (CTO) use in 2020-21 for the Black or Black British group were over ten times the rate for the White group.[17] The CQC recommended in its 2021 Monitoring the Mental Health Act report that urgent action is needed to address these longstanding inequalities.[18]

16. We recognise that, as explained by a May 2022 Parliamentary Office of Science and Technology report, "The reasons for disparities are complex and are driven by wider inequalities both within and beyond the mental health system."[19] We welcome the commitments from the Government in this area, such as for culturally appropriate advocacy for different groups, including for ethnic minority groups.[20] Legislative options could also help the Government to meet its aim of addressing disparities in the use of the Act.[21] These include a new duty in the Bill to require local mental health trusts to explain overall rates of use of CTOs and take action to address disparities, and our recommendations to increase transparency and accountability, set out below.

IV. Increasing transparency and accountability

Transparent data on the use of the Act should be collected, monitored and used to improve accountability and inform policy-making in line with obligations under the Public Sector Equality Duty (PSED).

17. The use of compulsory detention and treatment powers under the Mental Health Act impacts on fundamental human rights – the right to liberty and security (Article 5 ECHR), and the right to be free from cruel, inhuman and degrading treatment (Article 3 ECHR). The changes this Bill makes to the Act seek to protect these and other rights.

18. To ensure the Bill has the positive impacts intended, the changes it proposes must be accompanied by provisions to ensure better data, transparency and accountability. This can be achieved through reporting requirements on mental health trusts, monitoring by CQC and through post-legislative scrutiny. In particular, as part of post-legislative scrutiny, the Government should report on the impact of the reforms on reducing restraint and other forms of coercion, the detention of people with learning

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[17] Figures are from DHSC (January 2021), 'Reforming the Mental Health Act' and NHS Digital (2021), Mental Health Act Statistics, Annual Figures - 2020-21.

[18] CQC (2021), Monitoring the Mental Health Act in 2020/21.

[19] UK Parliament POST (May 2022), Mental Health Act Reform - Race and Ethnic Inequalities.

[20] DHSC (January 2021) Reforming the mental health act: Government response.

[21] HM Government (May 2022), Queen's Speech Briefing Pack.

disabilities and autism, and the disproportionate treatment of groups sharing certain protected characteristics, particularly people from Black ethnic groups.

19. We also consider the Guiding Principles should be included in the Act, as recommended by the Independent Review, and that the CQC has an important role as statutory regulator of the Mental Health Act.

Summary of recommendations

Throughout our response are recommendations addressed to the UK Government or relevant public bodies. We hope they are helpful to the Committee in formulating their own recommendations. For ease of reference, we have listed these recommendations thematically below.

Ending inappropriate detention

Criteria for detention and risk assessment

(1) The Government should – in line with the aims of the UNCRPD and recommendation of the Independent Review[22] – ensure that there are sufficient, high-quality, appropriate, community-based mental health services and pathways to meet the needs of all adults, children and young people (including those with protected characteristics). These should include therapeutic alternatives to detention, preventative support to minimise the risk of crisis, and wider community services that enable good mental health and recovery.

(2) The Code of Practice for the revised Mental Health Act should set out clear standards and requirements for assessing risk of harm to ensure a consistent, evidence-based, unbiased approach. This should be informed by research on what constitutes best practice in the assessment of risk[23] and include standardised processes for making and documenting risk assessments, which should be scrutinised by the CQC as part of their inspections.

(3) The Government should develop training and other resources for professionals to support a balanced approach to risk.

People with learning disabilities and autism

Co-occurring mental health conditions

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[22] DHSC (2018), Modernising the Mental Health Act, p.13.

[23] See e.g. National Confidential Inquiry into Suicide and Safety in Mental Health (October 2018), The assessment of clinical risk in mental health services.

(4) Responsible clinicians and other relevant staff should be given appropriate training and support to ensure that behaviour associated with a learning disability or autism, including coping strategies, are not interpreted as a mental health condition and used to justify detention. We note and welcome the new duty in section 181 Health and Care Act 2022 for mandatory training on learning disability and autism for staff employed in CQC-regulated providers, but recommend that Government consider whether further specific training on this issue is required.

Risk register and commissioning duties

(5) The Government should conduct a public consultation on any risk factors to be listed in regulations under new section 125D (introduced by Clause 2 of the Bill), and in particular ensure that they consult with affected patients and their families. We assume the reference to 'people' in section 125D includes children. If so, the process of giving consent for children ought to be set out in legislation for clarity.

(6) We recommend that the commissioning duty in Clause 2, new section 125E, is strengthened as follows: integrated care boards should be required to ensure, so far as reasonably practicable, that sufficient services are available so that the needs of people with autism or a learning disability can be met without detaining them under the Mental Health Act.

Clause 38 Tribunal power to recommend aftercare

(7) We recommend that the tribunal power to recommend after-care be strengthened (through amendments to Clause 38(2)(iii)) so that Mental Health Tribunals (MHTs) are able to specify particular services.

(8) The MHT should be given the power to require (as opposed to merely recommend) that a section 117 needs assessment be carried out within a specified period and, where appropriate, an assessment for eligibility for NHS continuing healthcare and/or further Care Act assessment for needs that falls outside the scope of section 117.

(9) The MHT should then have the power to make equivalent recommendations as to how the needs identified by any further assessments will be met.

Avoiding unintended consequences: Mental Capacity Act, and new Liberty Protection Safeguards (LPS)

(10) We recommend that the Government consider what safeguards are necessary to prevent people with a learning disability and/or autism currently detained under section 3 (or who, in the future, would have been able to be detained under section 3 but for the changes brought in by the Bill), being instead detained under the Mental Capacity Act and the Liberty Protection Safeguards.

Protecting people's rights

Challenging detention

(11) Clause 35 should be amended to place a duty on hospital managers to take reasonable steps to ensure that patients are informed about their relevant rights under the Mental Health Act, the Equality Act 2010 and the Human Rights Act 1998. The Government should produce a standardised resource for this purpose in consultation with stakeholders and using our notification of rights documents[24] as a model. This resource should be made available in a range of accessible formats, including Easy Read, to meet individual needs.

Support during detention

Nominated persons and parental rights

(12) The Government should 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 to ensure that all efforts are made to determine those views, including through supported decision-making, advance choice documents, and access to advocacy provisions.

(13) We recommend that the Government specify on the face of the 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.

Choosing and refusing treatment

Advance decisions

(14) Guidance should be included in the Code of Practice to ensure that people who have been previously detained are proactively offered the opportunity to make a valid and applicable advance decision.

(15) New section 57A(4) (introduced by Clause 11 of the Bill) should be revised such that advance decisions may only be overridden where there is both no alternative medical treatment and a test of therapeutic necessity (which takes into account the State's positive obligations to protect people under Articles 2, 3 and 8 ECHR) is met.

(16) The Bill should provide clarity on:

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[24] See: EHRC (2020) Your rights when detained under the Mental Health Act in England, which includes both civil and forensic guides.

- which court or Tribunal will adjudicate on disputes relating to compliance with advance decisions;
- how cases will be brought (by the detained patient or on their behalf, and if so, by whom); and
- whether people will have a right to non-means-tested legal aid to challenge a refusal to follow an advance decision.

(17) We recommend that the CQC monitor compliance with advance decisions. This will help the Government and other relevant bodies to understand how the new provisions work in practice, including how frequently advance decisions are overridden in practice.

Right to refuse treatment

(18) The change to section 62 of the Mental Health Act brought in by Clause 15 of the Bill removes the power to administer urgent treatment to alleviate serious suffering for people who have capacity and are refusing. This should also include people who now lack capacity but have made a valid and applicable advance decision against such treatment.

Addressing disproportionality

Community Treatment Orders (CTOs)

(19) The Government should annually monitor the impact of its overall package of reforms to CTOs, and consider abolishing CTOs if the problems identified by the Independent Review are not ameliorated within five years.

(20) There should be a new duty in the Bill to require local mental health trusts 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 to take action to address any disparities for groups sharing protected characteristics, with a particular focus on people from Black ethnic groups. This duty could be introduced through an amendment to Clause 20.

Advocacy

(21) If the current Government pilots of culturally-appropriate advocacy[25] indicate their effectiveness in supporting ethnic minority groups and reducing disproportionality under the Mental Health Act, the Government should consider how to ensure such advocacy is available and accessible in all local authority areas, so that everyone who needs this support is able to access it.

Improving care and treatment

(22) 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 for disabled people), addressing inequalities and preventing discrimination in decision-making and treatment, with a view to reducing the disproportionate detention of people from Black ethnic groups.

Increasing transparency and accountability

(23) Mental health trusts should be required to report on trends in their use of the Mental Health Act, disaggregated by protected characteristic, and to provide a narrative explanation of those trends. Mental health trusts should also be required to provide a comprehensive action plan if they cannot demonstrate a year-on-year reduction in disproportionate detention rates experienced by ethnic minority groups, particularly Black people.

(24) The Government currently publishes annual national data on the use of the Mental Health Act, disaggregated by the protected characteristics race, age and sex. We recommend that the Government should consider whether it is proportionate to disaggregate the data by all protected characteristics, and, with respect to disability, to include analysis by impairment type.[26]

(25) The CQC should monitor local detention rates as part of their inspections, with an expectation of a reduction in disproportionate rates for ethnic minority groups, particularly Black people, and should assess how effectively health and care systems are enabling disabled people to enjoy their right to live independently.

(26) The Mental Health Bill should include a requirement for the Government to report to Parliament within five years and on a periodic basis thereafter on the impact of the reforms in reducing inappropriate 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, the detention of people with learning

[25] Referred to in DHSC (June 2022), Better mental health support for people in crisis.

[26] Government Statistical Serivce (2020), Impairment Harmonised Standard.

disabilities and autism and the disproportionate treatment of groups sharing protected characteristics, particularly people from Black ethnic groups.

Guiding Principles

(27) All those who exercise powers under the Mental Health Act should have due regard to the Guiding Principles in all decisions related to detention, treatment and the commissioning of mental health services. We recommend that the Government consider how best this can be achieved.

(28) The revised Code of Practice for the proposed new Mental Health Act should include clear guidance on applying the Guiding Principles in practice. The Government 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.

Role of CQC

(29) The CQC's new single assessment framework, due to be implemented in April 2023, should include:

- an increased focus on monitoring and inspecting for coercion as part of an extension of the CQC's current role and process. This should include the use of compulsory treatment, restraint, seclusion and other restrictive interventions, and CTOs.[27]
- monitoring of whether and how patients are notified of relevant rights under the Mental Health Act and equality and human rights law, as well as the training that staff receive on these rights.

[27] We define restraint 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', p. 4.

Response to the call for evidence

Ending inappropriate detention

This section includes responses to the following Committee questions:

- How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act? Might there be unintended consequences and, if so, how should those risks be mitigated?
- What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?
- To what extent will the draft Bill achieve its aims of reducing detention, avoiding detention in inappropriate settings […]?

Criteria for detention and risk assessment

1. Following the recommendations of the Independent Review and the responses received to the White Paper consultation, the Bill makes changes to the grounds for detention under the Act. It raises the risk threshold to require a risk of 'serious harm' and consideration of the 'nature, degree, likelihood and imminence of the harm' (Clause 3 of the Bill) as well as for there to be a reasonable prospect of therapeutic benefit to the treatment to be given whilst detained (Clause 6 of the Bill).
2. Whilst these changes do not meet the UNCRPD Committee's recommendation to the UK to repeal legislation providing for non-consensual involuntary, compulsory treatment and detention,[28] we consider that these changes will help in striking the balance between different rights (including Articles 5, 2 and 3 ECHR) and should reduce involuntary detentions, and we therefore welcome them.
3. It is vital however that there is a focus on avoiding involuntary detention wherever possible through early provision of appropriate community-based services, as

[28] 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', paragraphs 34 & 35. In this context we note Article 14 UNCRPD which states that 'the existence of a disability shall in no case justify a deprivation of liberty.' The interpretation of this provision by the UN Committee states that mental health law that permits detention on the basis of impairment discriminates against disabled people. (See UN Committee on the Rights of Persons with Disabilities (2015), Guidelines on Article 14). We also note the consideration by the Independent Review (at p.110) of whether detention should be ruled out where someone has capacity to consent to admission but does not consent. The Review considered that "much greater debate is needed, involving service users, to see whether society is willing to accept the consequences of someone's refusal to be admitted." We would welcome further debate and consideration in this area, including consideration of the interpretation of UNCRPD adopted by the UN Committee.

recommended by the CQC.[29]

4. **We recommend that the Government should – in line with the aims of the UNCRPD and recommendation of the Independent Review[30] – ensure that there are sufficient high-quality, appropriate community-based mental health services and pathways to meet the needs of all adults, children and young people (including those with protected characteristics). These should include therapeutic alternatives to detention, preventative support to minimise the risk of crisis, and wider community services that enable good mental health and recovery.**
5. With respect to the new risk thresholds in the Bill, 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 be at risk from others, than to pose a risk to others.[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 other factors that lead to inappropriate risk assessments.[32]
6. **We recommend that the Code of Practice for the revised Mental Health Act should set out clear standards and requirements for assessing risk of harm to ensure a consistent, evidence-based, unbiased approach. This should be informed by research on what constitutes best practice in the assessment of risk[33] and include standardised processes for making and documenting risk assessments, which should be scrutinised by the CQC as part of their inspections.**
7. **The Government should develop training and other resources for professionals as needed to support a balanced approach to risk.**

People with learning disabilities and autism

8. The Commission is concerned about the inappropriate detention of people with learning disabilities and autism. Too many remain detained in institutions under the Mental

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[29] CQC (2022), Monitoring the Mental Health Act in 2020/21.

[30] DHSC (2018), Modernising the Mental Health Act, p.13.

[31] See e.g. Royal College of Psychiatrists (May 2017), 'Rethinking risk to others in mental health services'.

[32] See e.g. Mind (2019), 'Discrimination in mental health services'. 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', p. 20. See also p. 158.

[33] See e.g. National Confidential Inquiry into Suicide and Safety in Mental Health (October 2018), The assessment of clinical risk in mental health services.

Health Act for long periods with little or no therapeutic benefit, often due to a lack of services to meet people's needs in the community.[34] This is borne out by the latest Government figures which show that 38% of people with learning disabilities and autism in detention have an overdue planned discharge date (with 9% over a year delayed).[35] The most common reasons given for delay relate to a lack of appropriate support.[36]

9. Insufficient progress has been achieved since the issue first received significant attention in 2011, when criminal abuses were revealed at Winterbourne View private hospital. A subsequent national review revealed widespread failures to provide sufficient community-based services, with too many people receiving inappropriate care in closed institutions.[37] The Government set a target to end all inappropriate detention by 2014.[38] Yet this was not achieved and a new national action plan published in 2015, with a focus on building the right services so that all but essential inpatient services could be closed, also failed to address these underlying issues.[39]

10. The latest national Action Plan, Building the Right Support, published in July 2022, continues to show insufficient progress. There has been only a 30.7% reduction of people with learning disabilities or autism who are inpatients in mental health hospitals, from 2,900 in 2015 to 2,010 in 2022.[40] We recognise the progress that has been made, but it does not go far enough to reduce inappropriate detentions (for example, detentions for long periods with little or no therapeutic benefit, and/or detention simply due to the inability to meet people's needs in the community because of a lack of services.) 92% of people with learning disabilities or autism who are inpatients in mental health hospitals are detained under the Mental Health Act.[41] Further, a CQC review in

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[34] CQC (2020) Out of sight – who cares report. 60% of people interviewed as part of the report said that a lack of local service provision meant that their discharge back into the community was delayed.

[35] NHS Digital (June 2022), Learning disability services monthly statistics from MHSDS: Data tables. The figures are contained in the following spreadsheet: LDA monthly statistics from MHSDS - data tables - April 2022, Table 3.

[36] Ibid. The most common reasons given for delay are: 'awaiting supported accommodation' (29%); 'awaiting care home' (24%), 'awaiting care package in own home' (11%)' and 'awaiting further non-acute (including community and mental health) NHS care (11%)'.

[37] Department of Health (2011), Transforming care, a national response to Winterbourne View Hospital, p. 8

[38] Ibid. p.9.

[39] NHS England (2015), Building the right support, a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism, p. 2.

[40] DHSC (July 2022), Building the Right Support for People with a Learning Disability and Autistic People, p. 16.

[41] DHSC (July 2022), Building the Right Support for People with a Learning Disability

2020 found that almost 71% of people with autism or a learning disability whose care they reviewed had been segregated or secluded for three months or longer, with a few who had been in hospital for more than 25 years.[42] They also found many examples of care that was "undignified, inhumane and that potentially breached people's basic human rights'.[43] A follow up CQC review in 2022 found that not enough progress had been made.[44] It is clear that change is urgently needed.

11. In this context we welcome the intention of the Bill to "make it easier for people with learning disabilities and autism to be discharged from hospital."[45] We support the changes which mean that neither a learning disability nor autism will be conditions for which a person can be subject to compulsory treatment under section 3 of the Act. However we consider that further changes are needed to fully achieve the Government's intention.

12. We also note that, whilst changes to legislation and policy are welcome, the situation is urgent for those people currently inappropriately detained. DHSC data at the end of June 2022 showed that the average length of detention under the Mental Health Act for patients with learning disability or autism was 5.5 years, and that 355 people have been in hospital for over 10 years.[46] We consider that the changes to legislation will not come fast enough, particularly for those who are currently inappropriately detained (indeed, the explanatory notes to the Bill anticipate a period of around ten years for full implementation of its provisions),[47] and we are considering the use of our legal powers to help patients and their families.[48]

13. With respect to the Bill, we recommend changes in key areas to ensure the legislation achieves its intention of reducing the numbers of people with learning disability and autism who are detained, and providing them with the support they need to live in the community, in accordance with Article 19 UNCRPD (the right to independent living).[49]

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and Autistic People, p. 70.

[42] CQC (October 2020), Out of sight: who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition.

[43] Ibid. p.46.

[44] CQC (March 2022) Restraint, segregation and seclusion review: Progress report.

[45] Prime Minister's Office (May 2022), The Queen's Speech 2022: Lobby pack.

[46] NHS Digital (July 2022), Learning Disability Services Monthly Statistics, AT: June 2022, MHSDS: April 2022 Final, Table 2.7

[47] DHSC, MoJ (June 2022), Draft Mental Health Bill: Explanatory Notes, p.52.

[48] EHRC (July 2022), Health Department's plan for detained patients falls well short of what's needed.

Co-occurring mental health conditions

14. As set out above, we support the change that learning disability and autism will no longer be grounds for section 3 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.

15. 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'.[50] The Code of Practice has made clear for a number of years that people with autism should only be detained as a last resort.[51] 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.

16. Despite the changes to the detention criteria in relation to section 3, the detention of people with learning disabilities and autism will remain possible for assessment under section 2 and where a co-occurring mental health condition is diagnosed.

17. We are concerned that behaviour associated with learning disability or autism, including behaviour related to detention for assessment and coping strategies, could be interpreted as a mental health condition and used to justify detention under section 3. To avoid this, it would be helpful for all relevant staff to receive specific training on learning disability and autism in this context, including appropriate training on trauma and how to provide trauma-informed care and support.

18. **We recommend that Responsible Clinicians and other relevant staff are given appropriate training and support to ensure that behaviour associated with a learning disability or autism, including coping strategies, is not interpreted as a mental health condition and used to justify detention. We note and welcome the new duty in section 181 Health and Care Act 2022 for mandatory training on learning disability and autism for staff employed in CQC-regulated providers, but recommend that Government consider whether further specific training on this issue is required.**

Risk register and commissioning duties

19. We support the intention behind the new duties proposed in Clause 2 (new sections 125D "Registers of people at risk of detention" and 125E "Registers: duties relating to commissioning of services etc"). Together, the Government intends these provisions to "help ensure the right community provisions are in place for people with a learning

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[49] See EHRC (May 2021), Strengthening the right to independent living for more details on how the right to independent living can be strengthened in England.

[50] Mental Health Act 1983, part 1, section 1 (2A), as amended by the Mental Health Act 2007.

[51] DHSC (January 2015), 'Mental Health Act 1983: Code of Practice'.

disability and/or autistic people to avoid unnecessary admissions to inpatient settings."[52]

20. However, we consider that 125D needs clarifying and 125E needs strengthening to achieve this intention. It is crucial that these duties are clear and strong enough to ensure sufficient community-based services in practice in order to end inappropriate detentions. This was highlighted in the most recent annual review of the Mental Health Act by the CQC, which stated: "While we support the government's objective to reduce hospital admissions for people with a learning disability and autistic people under the MHA, this can only be achieved by an increase in community support, including trained staff, and high-quality alternatives to admission."[53]

Clause 2, new section 125D: Registers of people at risk of detention

21. It is currently unclear what risk factors will lead to inclusion in the register. Clause 2 states that these are to be specified in regulations. We consider that transparency is needed as to what these risk factors will be, and **recommend that the Government should conduct a public consultation on any risk factors to be listed in regulations, and in particular ensure that they consult with affected patients and their families**.

22. We assume the reference to 'people' in section 125D includes children. If so, **the process of giving consent for children ought to be set out in legislation for clarity**.

Clause 2, new section 125E: Registers: duties relating to commissioning of services etc

23. The provisions in Clause 2, new section 125 E, require Integrated Commissioning Boards (ICBs) to have regard to the risk register and, in exercising their commissioning functions, to 'seek to ensure that the needs of people with autism or a learning disability can be met without detaining them under Part 2 of this Act'.

24. We consider that the duty to 'seek to ensure' the specified outcome is too weak, and risks not having the desired effect of ensuring sufficient community based services to avoid inappropriate detention.

25. **We recommend that the commissioning duty in Clause 2, new section 125E, is strengthened as follows: integrated care boards should be required to ensure, so far as reasonably practicable, that sufficient services are available so that the needs of people with autism or a learning disability can be met without detaining them under the Mental Health Act.**

26. This approach would align with that taken in the sufficiency duty imposed on local authorities in relation to the provision of in-area accommodation for looked after

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[52] DHSC and MoJ (June 2022), Draft mental health bill: explanatory notes.

[53] CQC, Monitoring the Mental Health Act in 2020/21, p.51.

children, as found in section 22G of the Children Act 1989.

27. We consider that statutory guidance could give further details on what would and would not be considered 'reasonably practicable'.

Clause 38: Tribunal power to recommend aftercare

28. Clause 38 of the Bill extends the powers of the Mental Health Tribunal (MHTs) to make recommendations. As currently drafted, it will enable MHTs to recommend that 'the responsible after-care bodies make plans for the provision of after-care services for the patient.' It is not clear that this would allow Tribunals to make recommendations as to the contents of the package of after-care that the patient would receive, merely that the responsible bodies should 'make plans' (as they see fit). The Government's intention as set out in the White Paper response was for the MHT to have the power to 'direct services in the community.'[54]

29. Strengthening this provision could assist in ensuring the right community-based services exist for all patients, including those with learning disability or autism.

30. **We recommend that the tribunal power to recommend after-care be strengthened (through amendments to Clause 38(2)(iii)) so that Mental Health Tribunals are able to specify particular services.**

31. **The Mental Health Tribunal should be given the power to require (as opposed to merely recommend) that a section 117 needs assessment be carried out within a specified period and, where appropriate, an assessment for eligibility for NHS continuing healthcare and/or any further Care Act assessment for needs that fall outside the scope of section 117.**

32. **The MHT should then have the power to make equivalent recommendations as to how the needs identified by any further assessments will be met.**

Avoiding unintended consequences: Mental Capacity Act and new Liberty Protection Safeguards (LPS)

33. As set out above, we are concerned about the lack of sufficient high quality community support for people with learning disabilities and autism. The Government's recent Building the Right Support Action plan makes clear that one of the most common reasons for a delayed discharge from inpatient care is a lack of social care support.[55]

34. Whilst we support the removal of learning disabilities and autism as sole reasons for detention under section 3, we are concerned that, rather than being discharged from hospital to live in the community, people may simply be detained under the Mental

[54] DHSC (August 2021), Consultation outcome: Reforming the Mental Health Act.

[55] DHSC (July 2022) Building the Right Support for People with a Learning Disability and Autistic People: Action Plan, p. 45

Capacity Act and new Liberty Protection Safeguards instead. This would undermine the Government's policy intention of reducing the numbers of people with learning disability and autism who are detained, as well as leading to those people benefitting from fewer procedural safeguards.[56] Key to avoiding this will be to ensure sufficient community-based services (as we suggest at paragraphs 37-45 above) but also necessary is consideration of whether specific legislative or other safeguards are necessary to prevent people simply being moved from Mental Health Act detention to Mental Capacity Act detention.

35. **We recommend that the Government consider what safeguards are necessary to prevent people with learning disability and/or autism currently detained under section 3 (or who, in the future, would have been able to be detained under section 3 but for the changes brought in by the Bill), being instead detained under the Mental Capacity Act and the Liberty Protection Safeguards.**

Protecting people's rights

This section includes responses to the following Committee questions:

- How far will the draft Bill allow patients to have a greater say in their care, with access to appropriate support and avenues for appeal?
- What do you think of the proposed replacement of "nearest relative" with "nominated persons"? Do the proposals provide appropriate support for patients, families and nominated people?
- To what extent is the Government right in the way it has approached people taking advance decisions about their care?
- What impact will the draft Bill have on children, young people and their families? Does it take sufficient account of the existing legal framework covering children and young people?

Challenging detention

Statutory notification of rights

36. We welcome Clauses 35 to 37 of the Bill, which would require hospital managers to supply complaints information to different categories of patients (detained, community and conditionally discharged patients respectively) and their nominated persons. However, we consider that these clauses should be strengthened to ensure that patients fully understand all their rights under the Mental Health Act, the Human Rights Act 1998

[56] The Mental Capacity Act 2005 and the Depriviation of Liberty Safeguards scheme, as well as the new Liberty Protection Safeguards scheme, contain fewer procedural safeguards against detention than the Mental Health Act.

and the Equality Act 2010. The Tribunal cannot function effectively as a safeguard against unlawful deprivation of liberty unless patients understand all their rights and the system in which they are detained.

37. 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,[57] despite the existing requirement in the Code of Practice for hospital managers to provide information to patients both orally and in writing.[58] 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).[59] Early testing carried out during the development of our notification of rights document suggested that a resource like this can help patients, families and advocates, as well as staff, better understand and realise people's rights.

38. **We recommend that:**

- **Clause 35 is amended to place a duty on hospital managers to take reasonable steps to ensure that patients are informed about their relevant rights under the Mental Health Act, the Equality Act 2010 and the Human Rights Act 1998.**
- **The Government produce a standardised resource for this purpose in consultation with stakeholders and using our notification of rights documents as a model. This resource should be made available in a range of accessible formats, including Easy Read, to meet individual needs.**

Support during detention

Nominated persons and parental rights

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[57] CQC (May 2022), 'Monitoring the Mental Health Act in 2020/21', p. 19. The report found that half of patients taking part in interviews did not fully understand their rights, and although information about their rights was given on admission, it was not repeated in time to make an appeal about their detention to the Mental Health Tribunal.

[58] DHSC (January 2015), 'Mental Health Act 1983: Code of Practice', paragraphs 4.9 and 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.

[59] Equality and Human Rights Commission (November 2020), 'Your rights when detained under the Mental Health Act in England'. 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)'.

39. We strongly support the new statutory role of nominated persons to replace nearest relatives, introduced in Clauses 21-23 of the draft Bill. 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.[60]

40. In our view there should be an explicit emphasis on ensuring that nominated persons are always acting in line with a patient's wishes, and that every effort is made to identify a patient's preferences about their treatment and care. **We recommend that the Government 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 to ensure that all efforts are made to determine those views, including through supported decision-making, advance choice documents, and access to advocacy provisions.**

41. We consider additional clarification is needed with respect to 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.[61] Currently, we are 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.[62] Clinicians may not be clear 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.

42. Without clarity on these points on the face of the proposed Mental Health Bill there is likely to be uncertainty and inconsistency in practice. In particular, we anticipate that

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[60] 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).

[61] 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* competency), and a right to apply to access the child's health records.

[62] 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* competency for treatment.

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 ECHR. **We recommend that Government specify on the face of the 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.**

Choosing and refusing treatment

Advance decisions

43. We welcome the provisions in the Bill for consideration of advance decisions to refuse treatments. We are however disappointed that the commitment in the White Paper for advance choice documents to be proactively offered to people who have been previously detained has not been taken forward.

44. We note that the principle of an advance decision is incorporated into Clause 11 which introduces new section 57A. This new section refers to "valid and applicable advance decisions," which are defined by reference to section 25 Mental Capacity Act 2005 (see Clause 17(6)(IBD) of the draft Bill). However, whilst the Bill relies on the definition in the Mental Capacity Act, the way such decisions are treated in the Bill differs from the approach taken to them in the Mental Capacity Act: the Bill proposes that advance decisions can be overridden in certain circumstances, which is not possible in the Mental Capacity Act.

45. We welcome the effect of these provisions to make it more difficult to override the stated wishes of the patient. However, we are concerned that, with respect to non-urgent scenarios, the definition of a 'compelling reason' to override an advance decision (new section 57A(4)) sets the bar too low. New section 57A(4) requires only that there be no alternative forms of medical treatment available. We are concerned that this may not meet the requirements of Article 3 and 8 ECHR and that a test of therapeutic necessity[63] would be required for compliance with Articles 3 and 8. In applying a test of necessity, the government's positive obligations to protect people under Article 2, 3 and 8 ECHR would need to be taken into account.

[63] 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.

46. **We recommend that guidance should be included in the Code of Practice to ensure that people who have been previously detained are proactively offered the opportunity to make a valid and applicable advance decision.**

47. **We recommend that new section 57A(4) be revised such that advance decisions may only be overridden where there is both no alternative medical treatment and a test of therapeutic necessity (which takes into account the State's positive obligations to protect people under Articles 2, 3 and 8 ECHR) is met.**

48. **We also recommend that the Bill provide clarity on:**

- **which court or Tribunal will adjudicate on disputes relating to compliance with advance decisions**
- **how cases will be brought (by the detained patient or on their behalf, and if so, by whom); and**
- **whether people will have a right to non-means tested legal aid to challenge a refusal to follow an advance decision.**

49. **We recommend that the CQC monitor compliance with advance decisions. This will help the Government and other relevant bodies to understand how the new provisions work in practice, including how frequently advance decisions are overridden in practice.**

Right to refuse treatment

50. Clause 15 (Urgent treatment to alleviate suffering) amends section 62 Mental Health Act to remove the power to administer urgent treatment to alleviate serious suffering to patients who have the relevant capacity and are refusing. We welcome this change. It is a general principle in law that people have a right to consent to or refuse treatment, even if that results in their suffering. 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.[64] In addition, the UNCRPD states in article 19 that disabled people have a right to exercise choice and control over decisions affecting their lives with the maximum level of self-determination and autonomy.

51. We are concerned that the relevant changes to section 62 explicitly exclude those who lack such capacity but have made a valid and applicable advance decision to refuse treatment.

52. We consider that there is a real risk of unlawful discrimination, contrary to Article 14 ECHR, in distinguishing between the two cohorts of patients in this way (ie. on the one hand patients who have capacity and are refusing treatment and, on the other, patients

[64] See above note 64.

who now lack capacity but have made an advance decision to refuse treatment). We consider it unlikely that the exclusion of those who now lack capacity but have made an advance decision can be objectively justified. These circumstances would be likely to fall within the ambit of Article 8 ECHR (in terms of respect for choices regarding medical treatment) and Article 3 ECHR (not to be subject to inhuman or degrading treatment). There would be a clear difference in treatment between the two cohorts, and this difference is likely to be based on an 'other status' for the purposes of Article 14, given the breadth of this concept in the case law.

53. As such it would be necessary for the state to provide objective justification for this difference in treatment. It is not clear to us presently what this justification would be. It seems to us that both cohorts are in the same position, being that their capacitous choices should be respected.

54. **We recommend that the change to section 62 (to remove the power to administer urgent treatment to alleviate serious suffering) include both people who have capacity and are refusing, and those who now lack capacity but have made a valid and applicable advance decision against such treatment.**

Addressing disproportionality

This section includes responses to the following Committee question:

- To what extent will the draft Bill reduce inequalities in people's experiences of the Mental Health Act, especially those experienced by ethnic minority communities and in particular of black African and Caribbean heritage? What more could it do?

55. People from Black ethnic groups continue to be detained and subject to community treatment orders (CTOs) at disproportionate rates. The latest figures show that in 2020-2021, amongst the five broad ethnic groups, those in the Black or Black British group were over four times more likely to be detained than those in the White group.[65] Rates of detention amongst the Mixed, Asian and Asian British and other ethnic groups were also higher that the White group.[66] As well as being more likely to be detained, Black or Black British people are more likely to spend longer in hospital and have more subsequent readmissions than White people.[67] Rates of CTO use in 2020-21 for the Black

[65] See: NHS Digital (2021), Mental Health Act Statistics, Annual Figures - 2020-21; DHSC (January 2021), 'Reforming the Mental Health Act'.

[66] Ibid.

[67] CQC (February 2021), 'Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic'.

or Black British group were over ten times the rate for the White group.[68] Evidence also suggests people from ethnic minorities may be at increased risk of restraint.[69]

56. We note and welcome the commitments by the Government to reduce this disproportionality, including the new research projects commissioned by the National Institute for Health Research Policy Research Programme, on behalf of DHSC, on how to tackle the rising rates of detention and on understanding the experiences of people from minority ethnic backgrounds and family and friends of people who have been detained, as well as the development of the Patient and Carer Race Equality Framework, with the aim of achieving culture change.[70] We also welcome in this context the commitment in Inclusive Britain: the Government's response to the Commission on Race and Ethnic Disparities, for a new strategy for reducing health disparities.[71]

57. We recognise that, as explained by a recent Parliamentary Office of Science and Technology report, "The reasons for disparities are complex and are driven by wider inequalities both within and beyond the mental health system." [72] However, we consider that there are, in addition to the existing Government commitments, a number of amendments to the draft Bill that could further assist the Government's aim of addressing the "disparities in the use of the Act for people from ethnic minority backgrounds."[73] We set these out at paragraphs 76 et seq below.

Community Treatment Orders

58. As the White Paper acknowledged, there are longstanding issues with CTOs. Evidence indicates that CTOs have not reduced hospital readmissions,[74] and that they have been used significantly more often than originally intended.[75] We share the concerns about CTOs reflected in the Independent Review.

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[68] NHS Digital (2021), Mental Health Act Statistics, Annual Figures - 2020-21.
78.9 uses per 100,000 population compared to 7.8.

[69] See Independent Review of the Mental Health Act (December 2018), 'Modernising the Mental Health Act: final report of the Independent Review', p. 56; UN Committee on the Rights of Persons with Disabilities (2017), 'Concluding observations', para 36.

[70] Further details are set out in: DHSC (June 2022), Draft Mental Health Bill: Impact assessment, paragraph 17.

[71] HM Government (March 2022), Inclusive Britain: the government's response to the Commission on Race and Ethnic Disparities.

[72] UK Parliament POST (May 2022), Mental Health Act Reform - Race and Ethnic Inequalities.

[73] Prime Minister's Office (May 2022), Queen's speech 2022: background briefing notes.

[74] 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', BMJ.

[75] DHSC (January 2021), 'Reforming the Mental Health Act'; Independent Review of the Mental Health Act

59. We welcome the changes to CTOs brought about by Clauses 19 (requiring a community responsible clinician to be involved in decisions regarding the use and operation of CTOs) and 20 (providing that conditions are only made when actually necessary), as well as the alignment of CTOs with the new risk criteria for detention (Clause 4), and the ability of the nominated person to object to a CTO (Clause 24).

60. We also welcome the commitment made by the Government in the White Paper to monitor the effects of the reforms to CTOs over the next five years. The Government should provide further details of how this will be carried out and what will be covered by the monitoring. We consider that 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, the Government must ensure that there is not a corresponding increase in the use of CTOs.

61. **We recommend that:**

- **The Government should annually monitor the impact of its overall package of reforms to CTOs, and consider abolishing CTOs if the problems identified by the Independent Review are not ameliorated within five years.**
- **There should be a new duty in the Bill to require local mental health trusts 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 to take action to address any disparities for groups sharing protected characteristics, with a particular focus on people from Black ethnic groups. This duty could be introduced through an amendment to Clause 20.**

Independent Mental Health Advocates (IMHA)

62. We strongly welcome the changes to the IMHA service in Clause 34, where the IMHA duty is expanded to provide support to both detained and informal patients and for this to be an opt-out model (which we recommended in our response to the White Paper).[76]

63. We note the Government's policy commitment in their response to the White Paper[77] for culturally appropriate advocacy for different groups, including for ethnic minority groups, and note that such services are already being piloted in four areas.[78] We look forward to the findings from these pilots. Given the disproportionality faced by Black

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(December 2018), 'Modernising the Mental Health Act: final report of the Independent Review', p. 132.

[76] Equality and Human Rights Commission (April 2021), Response to the white paper on reforming the Mental Health Act, paragraph 50.

[77] DHSC (January 2021) Reforming the mental health act: Government response.

[78] DHSC (June 2022), Better mental health support for people in crisis.

people with respect to detention and CTO use under the Mental Health Act, **we recommend that, should the current pilots of culturally appropriate advocacy indicate their effectiveness in supporting ethnic minority groups and reducing disproportionality under the Mental Health Act, the Government should consider how to ensure such advocacy is available and accessible in all local authority areas, so that everyone who needs this support is able to access it.**

64. We consider that this could be achieved through regulations, mirroring the approach in the Care Act 2014).[79]

Improving care and treatment

65. With respect to addressing disproportionality under the Act, we note that 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.[80] In line with the Review's recommendations and the requirements of the Equality Act 2010, we emphasise the requirement for public authorities, including mental health trusts, to have due regard to (*inter alia*) the need to eliminate discrimination and to promote equality of opportunity for people with protected characteristics.

66. **We recommend that 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 for disabled people), addressing inequalities and preventing discrimination in decision-making and treatment, with a view to reducing the disproportionate detention of people from Black ethnic groups.**

67. We set out further recommendations on increasing transparency and accountability, which are also relevant to reducing racial disproportionality under the Act, at paragraphs 86-88 below.

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[79] In the Care Act 2014, section 67 imposes the duty to appoint an independent advocate, and the requirements for a person to be an independent advocate are set out in the Care and Support (Independent Advocacy Support) (No. 2) Regulations 2014/2889, see Reg 2.

[80] Independent Review of the Mental Health Act (December 2018), 'Modernising the Mental Health Act: final report of the Independent Review', p. 158.

Increasing transparency and accountability

This section includes responses to the following Committee question:

- What changes and additional support do you think will be needed to help professionals and the third sector implement the proposals effectively? Will additional staffing and resources be required?

68. The use of compulsory detention and treatment powers under the Mental Health Act impacts some of our most fundamental rights – the right to liberty and security (Article 5 ECHR), and the right to be free from cruel, inhuman and degrading treatment (Article 3 ECHR). The changes this Bill makes to the Act seek to better protect these – and other – rights.

69. To ensure the Bill has the positive impacts the Government intends, the changes it proposes must be accompanied by better data, transparency and accountability. This could be achieved through new statutory requirements for reporting by mental health trusts, monitoring by CQC and specific reporting requirements for Government as part of post-legislative scrutiny.

70. We recommend that:

- **Mental health trusts should be required to report on trends in their use of the Mental Health Act, disaggregated by protected characteristic, and to provide a narrative explanation of those trends. Mental health trusts should also be required to provide a comprehensive action plan if they cannot demonstrate a year-on-year reduction in disproportionate detention rates experienced by ethnic minority groups, particularly Black people.**

- **The Government currently publishes annual national data on the use of the Mental Health Act, disaggregated by the protected characteristics race, age and sex. We recommend that the Government should consider whether it is proportionate to disaggregate the data by all protected characteristics, and, with respect to disability, to include analysis by impairment type.[81]**

- **The CQC should monitor local detention rates as part of their inspections, with an expectation of a reduction in disproportionate rates for ethnic minority groups, particularly Black people, and should assess how effectively health and care systems are enabling disabled people to enjoy their right to live independently.**

[81] Government Statistical Service (2020), Impairment Harmonised Standard.

- **The Mental Health Bill should include a requirement for the Government to report to Parliament within five years and on a periodic basis thereafter on the impact of the reforms in reducing inappropriate 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, the detention of people with learning disabilities and autism and the disproportionate treatment of groups sharing protected characteristics, particularly people from Black ethnic groups.**

Guiding Principles

How far does the draft Bill deliver on the principles set out in the 2018 Independent Review? Does it reflect developments since? Is the Government right not to include the principles in the draft Bill?

71. We welcome the Government's acceptance of the four Guiding Principles set out in the Independent Review[82] and the fact that the principles have guided all reforms to the Mental Health Act. However, we are disappointed that the Government has not taken forward its White Paper commitment to "include these four principles up front in the act."[83] We agree with the Independent Review that these principles should provide the statutory basis for all actions taken under the Mental Health Act. We consider that including the principles in the Act would better enable services to be held to account and ensure that the reforms set out in the Bill deliver the desired improvements in patients' experiences.
72. This is particularly important given that 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.[84] As the Government said in its White Paper, "by putting these principles on the face of the act itself, we are hoping to support better understanding and awareness."[85]
73. In this context, we recommend that:

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[82] DHSC (2018) Modernising the Mental Health Act: final report from the independent review. The review proposed the inclusion of four new principles: choice and autonomy, least restriction, therapeutic benefit and the person as an individual.

[83] DHSC (2021), Reforming the Mental Health Act, Part 1.

[84] CQC (2019), 'Mental Health Act Code of Practice 2015: an evaluation of how the code is being used', and Independent Review of the Mental Health Act (December 2018), 'Modernising the Mental Health Act: final report of the Independent Review'.

[85] DHSC (2021), Reforming the Mental Health Act, Part 1.

- **All those who exercise powers under the Mental Health Act should have due regard to the Guiding Principles in all decisions related to detention, treatment and the commissioning of mental health services. We recommend that the Government consider how best this can be achieved.**

- **The revised Code of Practice for the proposed new Mental Health Act should include clear guidance on applying the Guiding Principles in practice. The Government 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.**

Role of CQC

74. As the statutory regulator of the Mental Health Act, the CQC performs a vital role in monitoring the use of compulsory powers under the Act. We have set out above, at paragraphs 24, 67 and 88, a number of ways that CQC can support improvements to care under the Mental Health Act. In addition, we understand that CQC is currently developing a new single assessment framework, due to be implemented in April 2023. We consider that the CQC can continue to play a significant role in reducing the use of coercion and restraint at local levels[86] and **recommend that the framework includes an increased focus on monitoring and inspecting for coercion as part of an extension of the CQC's current role and process. This should include the use of compulsory treatment, restraint, seclusion and other restrictive interventions, and CTOs**.[87]

75. We would also like to see the new single assessment framework reflect a rights-based approach to inspections and Mental Health Act reviews. **We therefore additionally recommend that the CQC's new single assessment framework includes monitoring of whether and how patients are notified of relevant rights under the Mental Health Act and equality and human rights law, as well as the training that staff receive on these rights.**

14 September 2022

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[86] In 2020, the CQC published their 'Out of sight – who cares?' report, which recommended that CQC 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. In March 2022, CQC published a progress report which found that whilst this recommendation had been partly achieved, further action is needed to ensure it is fully realised. (p. 51).

[87] We define restraint 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', p. 4.

Appendix 1- Legal framework

Domestic human rights and equality law

1. Through its incorporation of the European Convention on Human Rights, the Human Rights Act 1998 requires that the following rights must be complied with in the operation of the MHA:

    a. the right to life (Article 2), which requires the State and public bodies to protect life; act on positive obligations to protect life, for example where a public authority is aware of a real or imminent threat to someone's life or where the person is detained by or under the care of a public authority; and in particular circumstances carry out official investigations into deaths, especially deaths in State institutions or police custody.

    b. the prohibition of torture, inhuman or degrading treatment (Article 3), which requires the State and public bodies to refrain from the most intrusive and risky forms of control and treatment used in care and treatment settings, such as use of physical restraint and medication without informed consent or unless medically necessary; refrain from subjecting anyone to torture, or treatment or punishment that is inhuman or degrading; act on obligations to prevent, and protect those at risk against this type of treatment; and investigate allegations of torture and inhuman or degrading treatment.

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

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

    e. the right not to be discriminated against in the enjoyment of ECHR rights (Article 14).

2. The Equality Act 2010 prohibits discrimination against someone because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Under the Act, people are protected against direct and indirect discrimination, failure to make reasonable adjustments for disabled people, discrimination arising as a consequence of disability, harassment and victimisation.[88] The Public Sector Equality Duty at section 149 of the Act requires government, public bodies (including NHS commissioners in England and service planners in Wales), and any organisation exercising public functions, to have due regard to the need to eliminate discrimination, to promote equality of opportunity for people with protected characteristics and to foster good relations between people who share a protected characteristic and those who do not.[89] Where adverse impact for people sharing a particular protected characteristic(s) is detected, having considered these three aims, public bodies need to consider whether there are ways they could reasonably mitigate that impact.

International human rights framework

3. The UK is also a signatory to a number of international human rights treaties which are relevant to the work of the Independent Review. With the exception of the UN Convention on the Rights of the Child in Wales,[90] the treaties have not been incorporated into domestic law, so they are not directly enforceable in UK courts, but they represent legally binding obligations in international law.

4. Under the **International Covenant on Economic, Social and Cultural Rights** (ICESCR),[91] the UK State is expected to recognise everyone's right to the enjoyment of the highest attainable standard of physical and mental health and create conditions to ensure medical services provide for this (ICESCR Article 12). Paragraph 8 of General Comment 14 on ICESCR[92] states that the right to health includes "the right to control one's health and body (…) and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation".

5. Under the **United Nations Convention on the Rights of Persons with Disabilities** (UNCRPD),[93] the UK State is expected to: involve service user organisations in the

[88] Further information on the Equality Act can be found here.

[89] Further information on the Public Sector Equality Duty can be found here.

[90] Rights of Children and Young Persons (Wales) Measure 2011

[91] Further information on the ICESCR can be found here.

[92] UN Committee on Economic, Social and Cultural Rights (2000), General Comment 14 – Right to the highest attainable standard of health

development and running of law and policies (Article 4(3)) and provide for peer support (Article 26); ensure disabled people are equally entitled as non-disabled people to all legal protections (Article 5); provide support to people who are disabled to ensure they can exercise their legal capacity (Article 12); ensure that the existence of a disability shall in no case justify a deprivation of liberty (Article 14); secure the right for disabled people to live independently (Article 19); and secure the highest attainable standard of health (Article 25).

6. Under **the United Nations Convention on the Rights of the Child** (UNCRC),[94] the UK State is expected to: respect and ensure every child can enjoy all UNCRC rights without discrimination (Article 2); ensure that the best interests of a child must be a primary consideration of all actions concerning children (Article 3); ensure that a 'mentally disabled child' should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community (Article 23); and recognise the right of a child who has been placed by the competent authorities for the purposes of care or health treatment to a periodic review (Article 25 CRC).

7. Under the **United Nations Convention for the Elimination of All Forms of Racial Discrimination** (UNCERD),[95] the UK State is expected to eliminate racial discrimination and, when necessary, take steps to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full enjoyment of their human rights (Art 2).

8. Under the **United Nations Convention Against Torture** (CAT),[96] the UK State is expected to ensure that any person who alleges they have been subjected to cruel, inhuman or degrading treatment has the right to complain to, and to have their case promptly and impartially examined by, its competent authorities (Article 13); and ensure victims of cruel, inhuman or degrading treatment are fairly compensated, including the means for as full rehabilitation as possible (Article 14).

9. Under the **United Nations Convention on the Elimination of All Forms of Discrimination Against Women** (CEDAW),[97] the UK State is expected to take all appropriate measures

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[93] Further information on the UN CRPD can be found here.

[94] Further information on the UN CRC can be found here.

[95] Further information on the UN CERD can be found here.

[96] Further information on the UN CAT can be found here.

[97] Further information on the UN CEDAW can be found here.

to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services (Article 12).