Written evidence submitted by Disability Rights UK, Inclusion London, and Liberation (MHB0067)

Introduction

1. Liberation (the lead organisation) is a quite recent, user-led organisation which operates at a grass roots level. Its aim (supported by 27 other, mostly user-led organisations, as well as a range of individuals) is to promote full human rights for people with lived experience of mental distress/trauma (mostly, but not always people given a mental health diagnosis). In particular, we promote the fundamental rights set out in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Liberation's focus is on adults. We operate in England, but have links with other countries both inside and outside the UK.

2. Inclusion London (IL) is a disability equality infrastructure organisation run by and for Deaf and Disabled people. Established in 2008, we promote Deaf and Disabled people's equality and inclusion by strengthening our disability rights and justice movement, by capacity building Deaf and Disabled people's organisations (DDPOs) to deliver empowering and inclusive services and by supporting DDPOs to have a strong and influential collective voice on issues affecting our diverse communities.

3. Disability Rights UK (DR UK) works with Disabled People's Organisations and Government across the UK to influence regional and national change for better rights, benefits, quality of life and economic opportunities for Disabled people and to create a society where Disabled people have equal power, rights and equality of opportunity. We campaign for the rights of all Disabled people to be included in every aspect of life. We bring the lived experiences of Disabled people to everything we do. We challenge policy makers, institutions and individuals to remove the barriers that exist for us. All our work is guided by four values:

- Strength in difference
- Sharing power
- Connecting
- Innovating.

Why we are submitting evidence

4. The draft Mental Health Bill, if enacted, will have a direct effect on people given a mental health diagnosis and people with learning difficulties or autism whom we represent. As

user-led organisations representing a rich diversity of views, we have unique contributions to make. We would very much welcome the chance to follow up our written submission with an opportunity to provide oral evidence.

Summary

5. Liberation, Inclusion London and Disability Rights UK welcome the government's recognition that the Mental Health Act 1983 urgently needs reform. However, we have strong doubts as to whether the draft Mental Health Bill, as it stands, will effectively reduce the numbers of people with a mental health diagnosis detained in psychiatric hospitals, the numbers of community treatment orders and the lengths of time which these last. It is welcome that people with learning difficulties[1] or autism will no longer be subject to mental health legislation purely on the basis of those characteristics. However, we are concerned that increased numbers of people with learning difficulties, or autism may now fall under the Mental Capacity (Amendment) Act 2019 and that, despite the provisions in the Bill, the community resources needed to ensure that they can live independently in the community may well continue to fall short of what is needed. We would also like to see a much stronger intersectional focus within the draft Bill.

6. A more fundamental issue for us is that the draft Bill falls well short of the fundamental human rights set out in the UN Convention on the Rights of Persons with Disabilities, or UN Convention on the Rights of Disabled People (UNCRDP), as Deaf and Disabled people more often call it in this country. It also falls well short of the recommendations in the UNCRPD's 2017 concluding observations[2]. A Mental Health Bill must start from the assumption that people given a mental health diagnosis, people with learning difficulties and people with autism should have the same human rights as anyone else, including the right to live in the community, with whatever support is needed, free from detention on the basis of disability and institutionalisation.

Our detailed response

[1] The term "learning difficulties" is used in this submission because it is a preferred term for many people with "learning disabilities".

[2] 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.* CRPD/C/GBR/CO/1. Available at: https://www.ohchr.org/en/documents/concluding-observations/crpdcgbrco1-committee-rights-persons-disabilities-concluding (Accessed: 1 September 2022)

Areas of interest addressed

How the changes made by the draft Bill will work in practice, particularly alongside other key pieces of legislation, including the Mental Capacity Act? Might there be unintended consequences and, if so, how should these risks be mitigated?

7. The Government's recognition of the need for improvements in mental health law is welcome. However, a major concern is that the draft Bill aims to be compliant with the European Convention on Human Rights (ECHR) and so with the Human Rights Act (HRA) 1998, not with the UN Convention on the Rights of Persons with Disabilities, or UN Convention on the Rights of Disabled People (UNCRDP), as Deaf and Disabled people more often call it in this country. (See further below.) An additional complexity is that plans to replace the HRA with a Bill of Rights have now been shelved. Whilst this is a positive move, given widespread criticisms of the Bill of Rights, it remains unclear with what human rights reformed mental health law will come to be made compliant, given that further work is now due on human rights legislation. It will be very important both that the current rights in the HRA are retained and that these are strengthened further, so that the Act is compliant with the UNCRDP.

8. A number of key issues have arisen in relation to the Mental Capacity (Amendment) Act (2019). One is that reform of mental capacity law has preceded reform of mental health law, despite the overlap between them, whereas it would have been more meaningful to reform both pieces of legislation at the same time. There continues to be an apparent lack of clarity as to which should be used when. There also seems a risk that, where people with learning difficulties and autistic people will no longer be subject to mental health law, they will be still less protected under the Mental Capacity (Amendment) Act, which is itself non-compliant with the UNCRDP.

9. We recommend that:

9.1 Urgent reconsideration of the human rights basis for the draft Mental Health Bill takes place, with mental capacity legislation reformed further in line with this

9.2 There is a clear definition of when mental health law should be employed and when mental capacity law should be.

To what extent is the approach of amending the existing Mental Health Act the right one? What are the advantages and disadvantages of approaches taken elsewhere in the UK?

10. As has been indicated above, a major issue is that reform of the Mental Health Act 1983 does not have the UNCRDP as its foundation. Equally, it has not been designed as a series of steps towards full implementation of the UNCRDP. Despite the important place that the ECHR has in history, it is a much older convention which does not address disability issues and falls short of incorporating the full human rights which Disabled people should have, including people given a mental health diagnosis, people with learning difficulties and autistic people. The UNCRDP does so, not least because, unlike the ECHR, Disabled people were fully involved in its collation. An ongoing concern is that although the UK Government has signed up to the UNCRDP, it has so far failed to incorporate it to any meaningful extent within the legal system as a whole. This shortfall is reflected in the planned reform of mental health law.

11. As a result of the above failure, the draft Mental Health Bill remains rooted within a medical model instead of being rooted within the social model which is fundamental to the UNCRPD. (See, for example, Articles 1-4 and the recommendation in point 7c of the UNCRDP Committee's concluding observations about the UK[3].) In turn, this means that a diagnostic model is dominant within the Bill, despite recent strong challenges to the scientific evidence for mental health diagnoses from professionals such as the psychologist Johnstone (2022)[4]; the psychiatrists Moncrieff (2020)[5] and Timimi (2020)[6]; professionals and people given a mental health diagnosis (Watson, 2019)[7]; groups such as the Hearing Voices Network (HVN) which also provides non-medical perspectives.

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[3] 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.* CRPD/C/GBR/CO/1. Available at: https://www.ohchr.org/en/documents/concluding-observations/crpdcgbrco1-committee-rights-persons-disabilities-concluding (Accessed: 1 September 2022)

[4] Johnstone, L. (2022) *A Straight Talking Introduction to Psychiatric Diagnosis.* 2nd edn. Monmouth: PCCS Books Ltd

[5] Moncrieff, J. (2020) *A Straight Talking Guide to Psychiatric Drugs. The Truth About How They Work and How to Come Off Them. 2nd edn.* Monmouth: PCCS Books Ltd

[6] Timimi, S. (2020) *Insane Medicine. How the Mental Health Industry Creates Damaging Treatment Traps and How You Can Avoid Them.* (N/P)

[7] Watson, J. (ed) (2019) *Drop the Disorder. Challenging the Culture of Psychiatric Diagnosis.* Monmouth: PCCS Books Ltd

12. There is a continuing, deeply rooted assumption, too, that problems experienced by people given a mental health diagnosis stem from a chemical imbalance despite extensive evidence of strong links between trauma and distress and the debilitating conditions in which many of us live because of socio-economic deprivation; the impact of pandemics such as Covid; the negative effects of climate change; sexual and other forms of violence against women; major inequalities stemming from racism, ableism, homophobia, transphobia and ageism. Thus, "mental illness" is thought to be increasing extensively, instead of there being recognition that fundamental causes of acute distress and trauma are so often powerful social factors and that reform should be based on tackling these. As the psychologist Ahsan (2022)[8] powerfully puts it:

> "If a plant were wilting, we wouldn't diagnose it with "wilting-plant-syndrome" - we would change its conditions. Yet when humans are suffering under unliveable conditions, we're told something is wrong with us, and expected to keep pushing through. To keep working and producing without acknowledging our hurt".

13. Reform based on changing the attitudinal, environmental, structural and societal barriers experienced by people in mental distress/trauma, people with leaning difficulties and autistic people also needs to be led by those who have skills in undertaking it, with a key role given to user-led groups. (For points related to people with learning difficulties and autistic people, see also the relevant section below.)

14. Because mental health law and planned reforms of it in other parts of the UK (for example, Scotland) also fall well short of the UNCRDP, the relevant question is not what are the advantages and disadvantages of their approaches, but what can be done to make mental health law in all parts of the UK compliant with the UNCRDP. The draft Bill needs to adopt a non-institutional approach focused on providing a diverse range of resources in the community, one which both enables people to continue living independently in their local community and facilitates deinstitutionalisation of people who are currently detained against their will and forcibly treated in institutions.

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[8] Ahsan, S. (2022) 'I'm a psychologist – and I believe we've been told devastating lies about mental health', *The Guardian,* 6 September. Available at: https://www.theguardian.com/commentisfree/2022/sep/06/psychologist-devastating-lies-mental-health-problems-politics (Accessed: 6 September 2022)

15. In point 45 of its concluding observations in 2017, the UNCRDP Committee made some very clear recommendations about action which the government should take to implement independent living in line with Article 19, including the need to collaborate with user-led organisations in the process of doing so. The Committee (2022) has also just published some important guidelines to support states with achieving deinstitutionalisation[9]. These recommend moving funding right away from institutions and from improving these to community-based resources for adults and children alike, providing redress for harm experienced in institutions and supporting people to resume and maintain life in the community.

16. We recommend that:

16.1 The UK Government makes fundamental changes to the draft Mental Health Bill which bring it into line with the UNCRDP, its recommendations and its guidelines

16.2 The Government ensures that reforms are led by people with a genuine understanding of the UNCRPD and its guidelines, with a key role given to relevant user-led groups.

Does the draft Bill strike the right balance between increasing patient autonomy and ensuring the safety of patients and others? How is that balance likely to be applied in practice?

17. A concerning aspect of this question is that it rests on the assumption that a balance needs to be struck between patient autonomy and the safety of patients and others. The result is a question that is leading in nature. There is a similar problem with the survey, for example, question (d) is worded in a similar way. (See further our response below about additions to the Bill.) The assumption that mental health law needs to be based on risk factors is a deeply rooted one. However, it is not soundly based. As Gooding (2017, pp. 110-111)[10] has said:

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[9] Committee on the Rights of Persons with Disabilities (2022) *Guidelines on Deinstitutionalisation, Including in Emergencies. Advance Unedited Version.* CRPD/C/27/3/. Available at: https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crpdc273-guidelines-deinstitutionalization-including (Accessed: 10 September 2022)

[10] Gooding, P. (2017) *A New Era for Mental Health Law and Policy. Supported Decision-Making and the UN Convention on the Rights of Persons with Disabilities.* Cambridge: Cambridge University Press

> "Is greater protection for citizens achieved by restrictions under mental health law on the movement and decisions of certain individuals who may pose harm to others? The claim that such powers are necessary appears to rest on justifications that have been challenged by a growing body of evidence. Indeed, the literature suggests that the public protection measures contained in mental health law are overblown, ineffective and unreasonable, particularly when tied to a diagnosis of mental disorder. This would suggest that the 'risk of harm to others' justification is informed by disability-based prejudice … As for the protection of people from themselves, can it be said that the present legal system is actually protecting people with psychosocial disability from harming themselves, even in acute crisis? Again, the literature does not support this view".

18. An additional issue is that, quite apart from the research findings above, it will be a continuing breach of human rights to detain people in psychiatric hospitals on the basis of potential risk, whether that is people given a mental health diagnosis, people with learning difficulties, or autistic people who continue to come under mental health law; it is not regarded as legal to detain members of the public in general on the basis of potential risk (For further points related to people with learning difficulties and autistic people, see further the specific section below.)

19. We recommend that:

19.1 The Government recognises both the ineffectiveness of risk-based foundations to mental health law and the serious human rights breach represented by psychiatric detentions based on potential risk

19.2 The Government removes the risk-based elements of the draft Mental Health Bill.

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?

20. The fundamental point here is not whether the draft Mental Health Bill delivers on the principles set out in the Independent Review and subsequent developments, but the fact that the principles are qualified and conditional in nature. An example is the principle of

'choice and autonomy'. Patients with physical health conditions have the right to refuse consent to treatment and withdraw, even if medical practitioners believe that the treatment is in their best interests. However, the draft Bill will allow clinicians to overrule patients in mental distress, people with learning difficulties and autistic people, provided that its criteria are met. The principle of 'least restriction' again means that, contrary to practice with patients in general, it will remain possible to compulsorily admit and treat both patients given a mental health diagnosis and people with learning difficulties or autism who still fall under mental health legislation.

21. Including principles in reformed legislation will strengthen the weight that they carry. What will be crucial, however, is that the draft Bill incorporates the human rights principles in the UNCRDP under its *Preamble,* together with Articles 12 and 14 and the recommendations in points 31 and 35 of the UNCRDP Committee's concluding observations in 2017.

22. We recommend that:

22.1 Human rights principles relating to the draft Bill are drawn from the choice and control principles enshrined in the UNCRDP and that these are then included in mental health act reform.

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?

23. Because the draft Bill contains very limited intersectional content, it seems unlikely that it will have a major impact in reducing inequalities. In addition, although its aim is to reduce detentions, that will not in itself reduce disproportionate representation of people of Black and Caribbean heritage made subject to the Act. A concern, too, is that while the extent of institutional racism remains unacknowledged at government levels, reforms to the Mental Health Act will not have a substantial enough base to reduce a continued, disproportionate impact on people from minority ethnic (racialised) communities.

24. A weakness both of the Independent Review and of the White Paper was that intersectionality as a whole was not given a focus. Thus, despite known issues, there was

little or almost no emphasis on people given a mental health diagnosis, people with a learning disability/difficulty and autistic people who are, for example, older, female and/or identify as lesbian, gay, bisexual or transgender. Issues for women with children were amongst those which were neglected. For example, a mother may be experiencing acute distress/trauma herself and, at the same time be trying to support disabled children. Feedback to Liberation has been that, in contravention of Article 23 of the UNCRPD and the Committee's recommendations in point 49 of its 2017 concluding observations, support for both mothers and children is extremely limited, including for those whose first language is not English and those who have a hidden disability. Mothers have found that they are frequently blamed for 'inadequate' parenting, thought to overstate, or even imagine problems experienced by their children and/or have their children removed. There is also a higher prevalence of autistic people amongst those who identify as non-heterosexual (George and Stokes, 2017)[11]. A key concern is that, in its current form, the draft Bill will do very little to address such factors, given its own intersectional shortfalls.

25. We recommend that:

25.1 The intersectional focus of the draft Bill is increased in line with Article 5 of the UNCRDP and the recommendation in point 15 of the 2017 concluding observations from the UNCRDP Committee

25.2 The government addresses institutional racism and other forms of institutional discrimination in order to ensure that there are adequate foundations for the draft Bill.

What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?

26. Whilst it is a step forward that people with learning difficulties and autistic people will no longer be subject to section 3 of the Act purely on the basis of these characteristics, a disappointment is that, in continuing breach of the UNCRDP, they, too, will remain subject to section 3 if they also receive a mental health diagnosis and that people with learning difficulties in the criminal justice system will remain subject to section 3.

[11] George, R. and Stokes, H.A. (2017) 'Sexual orientation in autism spectrum disorder'. *Autism Research,* 11(1), pp. 133-141. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1002/aur.1892 (Accessed: 14 September 2022)

27. A further factor is that autistic people and people with learning difficulties are more likely than the general population to be given a mental health diagnosis (Rosen *et al*, 2018)[12] and so more at risk of being sectioned. In addition, autistic women are hospitalised for a psychiatric condition five times more often than women in general and almost twice as often as autistic men[13]. There can also be diagnostic overshadowing. Inaccessible and distressing conditions which people with learning difficulties and autistic people experience in psychiatric hospitals often lead to expressions of trauma which are wrongly interpreted as their having a mental health condition.

28. A wide-ranging report from the House of Commons Health and Social Care Committee (2021) on the treatment and care of autistic people and people with learning difficulties has found that a lack of community provision has led to many experiencing unnecessary admissions to inpatient facilities[14]. There again needs to be recognition of the need for fundamental changes in economic, social and political systems, for example changes that draw on the 12 pillars of independent living (Hammersmith and Fulham, 2021)[15] and a focus on high quality community care provision which ensures effective support for people with learning difficulties and autistic people and enables the replacement of institutionalisation with independent living. In line with Article 7 of the UNCRDP and the recommendations in point 21 of the UNCRDP Committee's concluding observations in 2017, this needs to start right from childhood with good family and educational support and a community-based resource system which promotes wellbeing from people's earliest years.

29. People with learning difficulties and autistic people can find themselves in the criminal justice system because of factors such as inaccessible environments, serious shortfalls in resources and support provision, not understanding social norms, misunderstanding of their actions by others and/or because they are drawn into crime without realising it. To redress

[12] Rosen, T.E. *et al. (*2018) 'Co-occurring psychiatric conditions in autistic spectrum disorder', *Int. Rev. Psychiatry* 30(1), pp. 40-61. doi: 10.1080/09540261.2018.1450229

[13] Mccarty, N. (2022) *Psychiatric conditions hospitalise almost one in four women by age 25.* Available at: https://www.spectrumnews.org/news/psychiatric-conditions-hospitalize-almost-one-in-four-autistic-women-by-age-25/ (Accessed: 14 September 2022)

[14] House of Commons Health and Social Care Committee (2021) *The Treatment of Autistic People and People with Learning Disabilities. Fifth Report of Session 2021-22.* HC 21. Available at: https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/21/21.pdf (Accessed: 1 September 2022)

[15] Hammersmith and Fulham (2021) *Independent living vision statement. Making independent living a reality.* Available at: https://livingindependently.lbhf.gov.uk/strategies-and-reports/independent-living-h-f-vision-statement/ (Accessed: 2 September 2022)

this, the focus again needs to be on providing effective community resources, including good quality housing, healthcare, education and support, together with opportunities for meaningful activities and participation in every day community life. (See further the section below on the criminal justice system.)

30. It is a step forward that the draft Mental Health Bill includes reforms aimed at improving resource provision for people with learning difficulties and autistic people through statutory Care (education) and treatment reviews (C(E)TRs) and that decision-makers will be required to pay regard to the latter. However, it is unclear whether there will be sufficient resourcing to make these changes a reality and to what extent they will result in non-institutional provision. The planned requirement for integrated care boards to set up risk registers appears somewhat double-edged. Whilst the registers might result in earlier, or improved provision, there might also be a danger of their leading to further stereotyping of people with learning difficulties and autistic people.

31. We recommend that:

31.1 There is a complete end to compulsory hospital admissions and a statutory requirement for services to resource and implement the full range of independent living services which enable this to happen for people with learning difficulties and autistic people of all ages

31.2 Improved community provision is used to pre-empt people with learning difficulties and autistic people becoming involved in the criminal justice system

31.3 Further thought is given to the advantages and disadvantages of risk registers.

To what extent will the draft Bill achieve its aims of reducing detention, avoiding detention in inappropriate settings and reducing the number of Community Treatment Orders?

32. The draft Bill's aim of reducing detention is something of a step forward However, a major issue is that the revised detention criteria appear to be too weak legally to have much impact on detention rates. It seems highly questionable whether much will be achieved by the two risk tests which will now have to be met (a judgement that the patient concerned, or others may be at risk of "serious harm" and use of a "nature, degree and likelihood"

assessment). Adding a stipulation of “appropriate medical treatment” being available to the prospect of treatment having therapeutic benefit also seems unlikely to make any major difference.

33. Whilst the draft Bill’s aim of eliminating the use of police cells and prisons as ‘places of safety’ appears progressive, this aspect of the Bill is also somewhat undermined by a failure to consider alternatives to healthcare approaches which might be provided, for instance, through transformative community approaches.

34. Because of the lack of evidence for Community Treatment Orders (CTOs) and the further breach of human rights which they represent, a key concern is that CTOs have been retained at all. In addition, the risk and treatment criteria for them are the same as for other forms of detention and so have the same weaknesses. The new powers for mental health tribunals (MHTs) appear to be too limited to have any major impact, given that tribunals would be restricted to recommending reconsideration of a CTO. It also seems unlikely that the involvement of community clinicians in authorising CTOs would make a difference in more than a limited number of cases.

35. A fundamental point of concern is that retaining involuntary hospitalisation and forced treatment on a disability basis is a retention of discrimination, even if the intention is to reduce these. Doing so is a breach of Articles 12 and 14 of the UNCRDP and runs contrary to the recommendations in points 31 and 35 of the UNCRDP Committee’s concluding observations in 2017.

36. We recommend that:

36.1 The draft Mental Health Bill is employed to bring a complete end to all forms of substitute decision-making (including guardianship), involuntary detention in psychiatric hospitals and involuntary treatment

36.2. Non-clinical, community-based options for people in crisis are also explored.

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?

37. Additional resources are undoubtedly needed. Because these will be dependent on successive spending reviews, an overarching concern is that resource provision will not be secure, even for such improvements as are contained in the draft Mental Health Bill.

38. There needs to be a major increase in funding for user-led groups and groups representing a social approach. Currently, the majority of funding is allocated to clinically led services whether these are in hospital, or are community-based. In addition, large, non-user led charities in the third sector receive much more funding than user-led organisations (with the two groups often thought to be one and the same), despite the major contributions which the latter have to bring because they are made up of people with direct experience of being disabled, using services and what genuinely helps.

39. A further factor is that there has been a large expansion of private psychiatric hospitals funded by very costly NHS contracts. Our concern is that this is resulting in a conflict of interest within the system. There is a built-in incentive for private businesses to continue supporting the detention system because this is financing their enterprises, including the cost of staff wages.

40. We recommend that:

40.1 Secure funding is provided for reform of the Mental Health Act 1983

40.2 Funding is employed to bring in a fundamental change from hospital-based and institutional provision to a wide range of community-based resources

40.3 The value of user-led groups is fully recognised and is reflected in a major increase in funding for them.

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?

41. There clearly are intended improvements to the amount of say which patients will have about their treatment. For instance, the checklist which treating clinicians will have a duty to use gives weight to considering patients' wishes and feelings. However:

- Contrary to the basic rights held by patients in general, it will still not be possible for either people given a mental health diagnosis, or people with learning difficulties, or

autism to whom the draft Mental Health Bill applies to refuse compulsory admission to hospital

- The draft Bill remains capacity-based; it focuses on whether people are judged to have mental capacity as opposed to recognising that everyone has legal capacity (the right to be both a holder of rights and a legal actor)
- Even in the case of people judged to have capacity, clinicians will still be able to administer involuntary treatment if there is a "compelling reason" (again defined in a way which could be subject to varying legal interpretations) and if there is certification from a Second Opinion Appointed Doctor (SOAD). It is concerning that these criteria apply even to ECT, given strong concerns about damage which ECT causes and the fact that it is not only prescribed disproportionately to women and older people, but they are particularly at risk of memory loss as a result (Oppenheim, 2022)[16].

These parts of the draft Bill are in continuing breach of Articles 12 and 14 of the UNCRDP and run contrary to the recommendations in points 31 and 35 of the UNCRDP Committee's concluding observations in 2017.

42. The extension of independent mental health advocacy to informal patients in England is welcome. What remains to be seen is whether there will be the necessary increase in resourcing of advocacy services for detained and informal patients alike and whether advocacy services will be genuinely independent of service providers. (At the moment, it seems that this is not always the position.) In the case of people subject to detention, a further issue is that, by definition, advocates are limited to representing someone's wishes; final decisions rests with mental health professionals.

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[16] Oppenhein, M. (2022) *Thousands of women given 'dangerous' electric shocks as mental health treatment in England. Exclusive: Figures fuel calls to ban or suspend use of electroconvulsive therapy on NHS.* Available at: https://www.independent.co.uk/news/health/electroconvulsive-therapy-brain-mental-health-b2095155.html (Accessed: 24 June 2022)

[17] Care Quality Commission (2022) *First-Tier Tribunal (Mental Health).* Available at: https://www.cqc.org.uk/publications/major-reports/first-tier-tribunal-mental-health#:~:text=In%202020%2F21%20and%202019,conditional%20discharge%20of%20restricted%20patients. (Accessed: 8 September 2022)

43. The draft Bill clearly represents an attempt to improve time scales for detained patients who appeal to MHTs. However, it seems unlikely that this measure alone will be enough to improve the MHT appeals route. As data from the Care Quality Commission (2022)[17] demonstrates, the overall percentage of detained patients who were discharged in 2019/20 and 2020/21 amounted only to 10%. Whilst the success rate for patients is as low as this, it would be hard to feel confident that much would change as a result of the draft Bill's provisions. The draft Bill's retention of MHTs also, of course, rests on the assumption that, contrary to the UNCRDP, the detention system should continue.

44. We recommend that:

44.1 In line with the UNCRDP, the legal capacity of all patients is both acknowledged and enshrined within the draft Bill

44.2 Non-consensual ECT is also banned, in line with both Article 12 of the UNCRDP and the recommendation in point 37 of the UNCRPD Committee's 2017 concluding observations.

44.3 The draft Mental Health Bill is employed to bring a complete end to all forms of substitute decision-making (including guardianship), involuntary detention in psychiatric hospitals and involuntary treatment

44.4 Adequate resourcing of a fully independent advocacy system is put in place.

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?

45. This change is welcome in the sense that people will now have considerable control over who represents them when they become subject to mental health legislation. This, in turn, may have some effect in reducing numbers of detentions. However, it is concerning that, in breach of the UNCRDP, people's freedom to choose a nominated person will be capacity-based. (For human rights issues with a capacity-based approach to proposals made, see further above.) The draft Mental Health Bill stipulates that a health, or care professional must confirm that someone had capacity at the time when the nomination is made and that if s/he is assessed as lacking capacity either per se or at the relevant time, an approved mental health professional would have the power to make the nomination instead.

46. An additional issue to address will be the extent to which nominated persons will have an effective voice in decisions made. Feedback to us from nearest relatives suggests that they not infrequently feel marginalised in decision-making processes and/or at risk of being displaced if they express opinions that are unwelcome to clinicians.

47. We recommend that:

47.1 The capacity-based approach to the selection of nominated people is withdrawn

47.2 Nominated persons receive meaningful powers in decision-making processes.

To what extent is the government right in the way it has approached people taking advance decisions about their care?

48. It is valuable that the draft Mental Health Bill includes some emphasis on advance choices. However, flaws in the proposals are similar to those mentioned above, in our response to patients having a greater say about care:

- It will not be possible for people to employ advance decisions to refuse involuntary hospitalisation
- Recognition of advance directives will again be based on judgements about mental capacity as opposed to a recognition that everyone has legal capacity
- Even in the case of people judged to have capacity, clinicians will be able to overrule them if there is a "compelling reason" (again defined in a way which could be subject to varying legal interpretations) and if there is certification from a SOAD.

These flaws are in breach of the UNCRDP, for the reasons given above.

49. We recommend that:

49.1 The draft Bill enshrines a comprehensive right to refuse admission to hospital and involuntary treatment through advance directives.

49.2 In line with the UNCRDP, the draft Bill gives full recognition to legal capacity.

To what extent are the proposals to allow for conditional discharge that amounts to a deprivation of liberty workable and lawful?

50. These proposals are not acceptable. They are both legally dubious and run contrary to the UNCRDP.

51. We recommend that:

51.1 They are dropped from the face of the draft Mental Health Bill.

What are your views on the proposed changes in the draft Bill concerning those who encounter the Mental Health Act through the criminal justice system? Will they see a change in the number of people being treated in those settings?

52. A fundamental problem is that the draft Bill rests on the assumption that some people should continue to be denied the right to put their case in court, on mental capacity grounds, and that it is legally valid to authorise enforced treatment in hospital as an alternative. The limit of the question posed above is that it does not give scope to respondents to raise the fundamental human rights issue which is involved here. Because legal capacity represents a basic human right (see above), the focus should be on providing procedural adjustments and communication support within the criminal justice system, for people given a mental health diagnosis, people with learning difficulties and autistic people alike (Article 13 of the UNCRDP and recommendations in point 33 of the UNCRPD Committee's 2017 concluding observations).

53. We recommend that:

53.1 There is full recognition in the draft Bill that people given a mental health diagnosis, people with learning difficulties and autistic people have the same right to a fair trial as anyone else and that adequate procedural adjustments and communication support should be in place to ensure this

Are there any additions you would like to see to the draft Bill?

54. The draft Mental Health Bill currently falls well short of fundamental human rights which people given mental health diagnoses, people with learning difficulties and autistic people should have. For that reason, the issue is not whether further additions should be made to the draft Bill, but the need for a fundamental rethink of it. The draft Bill must be informed both by the UNCRDP and by the recommendations in the UNCRDP Committee's concluding observations in 2017. We need legislation which guarantees people given mental health

diagnoses, people with learning difficulties and autistic people the same human rights and the same opportunities to live independently in the community as anyone else.

55. It is also concerning that there are questions in the survey for individuals and among those set for organisations which weight answers in a particular direction.

56. We recommend that:

56.1 The draft Mental Health Bill is completely overhauled to make sure that it is compliant with the UNCRDP and with the UNCRDP Committee's concluding observations in 2017

56.2 Where survey and consultation questions weight responses made to them in certain directions, action is taken to redress this.

Questions for the Joint Committee to pose to the government

1. Could the government explain its reasons for not using the UN Convention on the Rights of Disabled people as its basis for the draft Mental Health Bill?
2. What steps will the government now take to address shortcomings in the Draft Bill which arise from this?

16 September 2022