

Written evidence submitted by Mind and Race on the Agenda (ROTA) (MHB0070)

Introduction

We're Mind, the mental health charity for England and Wales. We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding.

Race on the Agenda (ROTA) is one of Britain's leading anti-racist change drivers. Working with communities impacted by systemic racism, ROTA helps create the policies and practices to tackle inequality.

Summary

We welcome the draft bill. It introduces significant improvements that are urgently needed, especially by increasing people's say over care and treatment and clinical accountability. There are ways to improve it further, to make the reforms more effective, drive change to promote race equity and support children and young people's rights:

- put guiding principles on the face of the bill with the addition of an equality principle
- abolish community treatment orders, which are intrusive, ineffective, and disproportionately used on Black people
- introduce a statutory decision-making test for under 16s and make advance decision-making available to under 18s, so their voices can be heard
- provide advocacy for making advance decisions, make advocacy for informal patients opt-out, create a right to culturally appropriate advocacy, and make advocacy available for Mental Health Act assessments
- introduce a responsible person role at hospital level, to oversee race equity in the operation of the Act
- increase tribunal powers and allow treatment appeals
- introduce a right to assessment and treatment so that people can get earlier help when they ask for it.

We are aware that the bill has been drafted in most part to apply in Wales as well as England. The provisions on care and treatment plans are excluded because of existing provisions in the Mental Health Measure. However, these are fundamentally different and the new rights for people detained under the Mental Health Act should be incorporated into Welsh legislation.

Question 1. 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?

1. The draft bill introduces new duties, rights and safeguards aimed at increasing patients' say over treatment and care. This is an important improvement in rights and could make a significant difference to very many people, and potentially reduce racial disparities. The risk is that there may not be the necessary change in the level and nature of service provision, or

in culture and practice, alongside the legislative change to bring about the intended benefits. Advocacy and tribunal review are key parts of the reforms and critical to fulfilling their ambitions.

2. The risk of insufficient change in racial inequality can be addressed through additional measures to address structural and institutional racism in the bill (see Q5) and through a concerted drive that prioritises race equity and encompasses legislative and non-legislative change.

3. The overriding issue people raised with us in engagement for independent review was for easier and earlier access to services before crisis which would then reduce the need for detention. To make the reforms as effective as possible and to see a sustained reduction in detentions, we need more, and more culturally appropriate, services, rights to assessment and treatment, explicit race equity measures, support for clinicians to change practice, and meaningful treatment appeal that will cement the changes made by the bill.

4. There is already rights-based legislation in Wales in the form of the Mental Health Measure, which has made a significant contribution to improving the way mental health support is delivered for many over the past decade¹. The Mental Health Act reform process is an opportunity to review mental health legislation and practice in Wales, to consolidate and provide greater clarity to existing legislation whilst taking forward much-needed reforms.

5. If the mental health bill is to be legislated in Wales, it is very important to adapt existing arrangements for care and treatment planning to incorporate new rights. The care and treatment planning reforms in the draft bill have not been made applicable in Wales because of existing provisions in the Measure. However, whilst there is some overlap between care and treatment planning provisions in the draft bill and the Measure, both their form and purpose are fundamentally different. The draft bill introduces improved rights for people detained under the Mental Health Act, which go far beyond those included within the Measure. The Welsh Government should therefore ensure that these improved rights are introduced in a way that means the legislation works together seamlessly.

6. Equally, the experience of the Measure, including its holistic approach to care and treatment planning and the right to self-refer back to services within three years of discharge, should inform developments in law and policy for England.

7. We have some concerns arising from the MCA draft code of practice:

- Definition of deprivation of liberty – examples given in the draft code appear to describe scenarios that, according to caselaw, are definite deprivations of liberty.

¹ See 'The Mental Health Measure: ten years on', Mind Cymru, 2022 for our research on its impact and recommendations for improvement

However, in the draft code they have been described as not being deprivations of liberty. This lack of clarity could potentially lead to many people being effectively deprived of their liberty without safeguards. It could also make it harder for people on community treatment orders (CTOs) to challenge unlawful deprivations of liberty arising from conditions imposed by the CTO. Therefore, the examples in the code should be re-written to align with caselaw and so provide clarity.

- Advance consent to informal admission – we are concerned that the draft code includes informal admission to hospital for mental health treatment as an example of advance consent that can be given under the MCA. We strongly disagree with advance consent for informal mental health admissions. We think this would reduce, not enhance, people’s say in care and treatment. The person would not know what they were agreeing to (the admission may not be like their previous experience) and so could not give valid consent. At the point of admission the person may not be able to articulate their objection or it may not be recognised or respected in practice. In effect they would be agreeing to be detained without legal safeguards.
- A+E holding powers – section 4B of the MCA allows people to be deprived of their liberty for life sustaining and vital acts. This power could be used to prevent people leaving A&E while awaiting an application for admission under the Mental Health Act. Mind opposed the introduction of A&E holding powers through the MHA, believing that service improvements were the main way to address waits in A&E. We acknowledged a stronger case for holding powers where people lack capacity to decide about being in A&E and agreed the MCA was the appropriate legislation. However, MCA 4B as it stands is too broad a power; there are no time limits on the authorisation and very weak oversight and monitoring. We recommend that a statutory time limit of up to six hours be introduced for its use in this context. This aligns with nurses’ holding powers in the MHA and should provide enough time. Use of the power for this purpose should be closely monitored through reporting and inspections.

Question 2. 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?

8. Ideally, we’d re-work the whole law, potentially creating one that was focused on rights to health, giving effect to people’s will and preference, based around people’s capacity to make their own decisions, required support for people to enable them to reach their own decisions, and that created positive rights to care.

9. Some of these features are adopted to a greater or lesser extent in other parts of the UK, with fusion law in Northern Ireland and a criterion of significantly impaired decision-making in Scotland. The current review of the law in Scotland is looking at ways to make their legislation more respecting of human rights and autonomy.

10. We think that the law should be based on people's wishes and capacity as far as possible and that work should be done to develop new law fit for the 21st Century. However, we are concerned about potential issues for people's safety in mental health crisis and unintended consequences that may flow from poor quality capacity assessments. Furthermore, there's a need to avoid conflation of patient's capacity with disagreement with clinical teams. The UK Government should explore these approaches and test them out with people with lived experience, with a view to more fundamental reform.

11. However, the MHA needs urgent updating now. Most of the proposed changes head in the right direction and, with further improvements, should significantly strengthen people's rights and voice, and improve experiences and outcomes. So, we support amending the current Act as an immediate, urgently needed step towards a new law fit for the 21st century.

Question 3. 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?

12. The draft bill includes harm to self and others as criteria for using the Act; also, clinicians retain extensive powers. We'd like to emphasise the place of patient autonomy in safety. Patient autonomy and the safety of others are often set in opposition to each other but in fact ensuring patients' rights for the most part supports safety – whether that's about getting help when you ask for it or being able to exercise some choice and control over daily life on a ward. Getting treatment that is more tailor-made to the individual and ensuring that patients retain and regain their independence and 'agency' will allow people to recover more quickly and more fully.

13. The draft bill gives people more say and access to advocacy which should enable them to have their voice heard; it requires clinicians to take greater account of patients' wishes, and to be more accountable for their decisions. This should make a very positive difference and improve safety by making care more person-centred and informed by the person's own knowledge of themselves and, where relevant, how they've been affected by previous treatment.

14. However, to make it effective in practice, this shift will require a stronger focus on patient autonomy. We recommend:

- include guiding principles (which include patient autonomy) in the bill, to give them more force (see Q4)
- advocacy support to make advance decisions and set out wishes in advance (see Q13)

- set a clear expectation on the Tribunal to address the quality of care and treatment plans (CTPs) when reviewing detention including how CTPs include patients' wishes and, where these are overridden, how this is justified
- introduce a right of treatment appeal to tribunal judge (as proposed in the review and white paper) (see Q11)
- ensure that rights and safeguards work effectively for children and young people (see Q14)
- support clinicians to shift their practice to being more rights based.

Question 4. 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?

15. The principles are reflected, and good examples are increased say for patients, choice of nominated person and better access to advocacy. However, the reforms need to go further to deliver on the principles.

- Patient autonomy – this should be strengthened further (see Q3 and Q11).
- 'Therapeutic benefit' isn't delivered by changes to the appropriate treatment test. This requires that there is a 'reasonable prospect' for treatment which only equates to an 'arguable case for treatment'. Given that this test is linked to a person's liberty then our view is that the test should be that treatment should be 'likely' to ameliorate a mental disorder (i.e. more likely to help than not). Tribunal review to ensure that care and treatment plans are being followed is also needed to deliver therapeutic benefit
- Least restrictive – the revised harm criterion speaks to this but needs to be reinforced by duties on the approved mental health professional (AMHP): to show the harms identified, alternatives considered, and if an alternative to detention isn't available when it might become so. Further advocacy reforms (see Q11), advance choices (Q13), abolition of CTOs (Q11) and reforms relating to children and young people (Q14) are all relevant here.
- The person as an individual – involvement in care and treatment planning and new requirements around treatment decisions reflect this principle, though further changes are needed to make advance decisions work for children and young people (Q14). However, the provisions of the draft bill don't address the inequities in how the law is experienced, especially by Black people, despite racial disparities being a major reason for reform. We have several recommendations for advancing race equity through the bill (see Q5). This principle could be one place where racism is addressed; it needs to translate into tangible improvements for everyone whose individuality is misinterpreted, ignored or discriminated against, such as people from racialised communities, older people, those whose sexual or gender identity is

pathologised, those with experience of sexual trauma who are retraumatised in hospital, and young people placed on adult acute wards (Q14).

- Equality – although there is some scope for addressing equalities through the ‘person as an individual’ principle, we recommend adding a new equality principle that would drive the elimination of discrimination and promotion of equity on the basis of protected characteristics.

16. The principles should be included in the Bill – it would give them more force and better enable people to challenge poor care. We understand that some doubt has been cast on the lawfulness of adding guiding principles to an Act through an amending bill. Mind has had the benefit of advice from former parliamentary counsel Gordon Nardell KC who has advised that this course of action is entirely possible and has given the following examples: The Financial Services and Markets Act 2000, which in its most recent incarnation (flowing largely from changes made in 2013 post-crash) imposes a number of “general duties” on the FCA. See sections 1B onwards

<https://www.legislation.gov.uk/ukpga/2000/8/part/1A/chapter/1/crossheading/the-fcas-general-duties>. Further, a recent example of a Bill containing a “general objectives” provision see the current Energy Bill <https://bills.parliament.uk/publications/47229/documents/2107>, Clause 1.

Question 5. 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?

17. There are welcome policy measures – in particular the Patient and Carer Race Equality Framework and culturally appropriate advocacy pilots – but nothing in the bill directly addresses race equity and it does not necessarily follow that improved rights generally will reduce disparities between groups. Disparities – rooted in structural and institutional racism and one of the main reasons for reform – will only be turned around with explicit and concerted measures in legislation that impact on practice.

18. The starkest race inequity is in use of CTOs, which clinical research shows aren’t even effective, and which we strongly recommend abolishing (see Q11). We’re also concerned about potential racial bias in the new power of supervised discharge (see Q15).

19. One of the reforms in the bill that could advance race equity is recognition of advance decisions and consideration of wishes (including wishes expressed in advance). This could make a big difference to people especially those least heard. Research into joint crisis plans (an approach to making advance decisions and planning future care with the clinicians) found these were most cost effective for Black patients². See Q13 for more on advance decision-making.)

20. Further reforms to advocacy could advance race equity (see Q11).

² Barrett B, Waheed W, Farrelly S et al. [Randomised controlled trial of joint crisis plans to reduce compulsory treatment for people with psychosis: economic outcomes](https://doi.org/10.1371/journal.pone.0174210). PLoS One. 2013, 8(11), e74210.

21. The Mental Health Units (Use of Force) Act 2018, also known as Seni's Law, includes a role of responsible person to ensure that the requirements of that Act are implemented and to take responsibility for reporting and intervening as appropriate. We recommend that a similar role be introduced in the Mental Health Act, to oversee promotion of race equity. As they would be concerned with similar issues and some common root causes, this could be an extension of the same role.

22. This would help drive action to reduce inequalities and, together with a duty on the Secretary of State to make reports, and a new antidiscrimination principle, give force to the UK Government's policy intention.

23. Measures we want to see in the bill include:

- A right to culturally appropriate advocacy
- Eligibility for culturally appropriate advocacy to support making advance decisions and choices
- Advocacy when being assessed for admission under the Act
- A right to assessment and treatment for mental health (similar to Care Act rights) so that people receive help at an early stage, preventing unnecessary admissions – combined with provision of culturally appropriate services this could improve Black people's access, experiences and outcomes
- A responsible person role within organisations that use the Act, to oversee race equity in its operation, with duties to report and intervene as appropriate.
- A duty on the Secretary of State to report on progress on reducing inequalities
- The mental health tribunal to report on its discharge rate and use of statutory recommendations with breakdowns by minoritised communities
- Abolish community treatment orders (see Q11)
- Drop supervised discharge (conditional discharge to a deprivation of liberty) from the bill (see Q15)
- At relevant points in the Bill, include a duty to have regard to culture and protected characteristics, especially in relation to care and treatment planning
- Include guiding principles in the Act and add a new equality principle (see Q4)

24. It will be important that any requirements in and beyond the legislation that relate to cultural competence and cultural appropriateness are well defined and explained, and that implementation includes oversight and continuing education.

25. To be effective, these measures would need to be accompanied by the provision of services tailored to needs of racialised communities, as set out in the Key Interventions report from the Ethnicity and Mental Health Improvement Project³. Individual feedback we've received on what is important includes safe spaces and affordable, culturally appropriate therapies for Black people, personalised care, and early intervention.

³ Ethnicity & Mental Health Improvement Project (2020) 'Key interventions'. Emhip.co.uk

Question 6. What more could the draft Bill do to reduce the impact of financial inequalities in people's experiences of the Mental Health Act?

26. Access to legal aid is a key way to do this. There should be non-means tested legal aid across issues relating to the Mental Health Act e.g. legal help for individuals and their nominated persons, judicial reviews, claims for damages and applications for habeas corpus.

27. Being admitted to or discharged from hospital can be a confusing and disorientating experience, even before the demands of navigating a complex benefits system that increasingly requires the claimant to engage. Things can easily go wrong leaving people without any money or unable to pay their rent, which in turn may make their condition worse and stop their recovery in its tracks. Similarly, people's housing needs and circumstances may change, even risking homelessness. People should never be discharged to homelessness. Therefore, the bill should require a holistic care and treatment plan that addresses these social and welfare support issues during the admission and in planning for discharge, whereby relevant advice and advocacy is provided.

28. People who are experiencing poverty are more exposed to the social determinants of mental health problems, and at the same time face more barriers in accessing and navigating health systems and establishing collaborative relationships with clinicians. Proactive support to make advance decisions and choices, together with oversight of care and treatment plans, will be particularly important for people in these circumstances to ensure that they are able to state their views and have them taken seriously.

Question 7. What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?

29. We don't have a view on changes to the law that relate to autistic people and those with learning disabilities who do not have mental health problems as this is outside Mind's remit. Where people with autism or learning disabilities are detained because of their mental health problems, reasonable adjustments must be made so that people are in calm and appropriate environments that aid their recovery.

Question 8. 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?

30. **Reducing detention**– better choice, improved access to advocacy, and more transparent care and treatment planning should combine to improve recovery and so reduce the need for ongoing detention. Provision of greater access to tribunal review should ensure discharges at the earliest appropriate time. If tribunals were empowered to direct transfers, leave and community services (as recommended by the independent review and proposed in the white paper) this could further aid people's recovery and routes to discharge.

31. However, the potential in the proposals will only be realised in practice if:

- there is investment in and expansion of mental health services that can –
 - meet people’s needs before crises escalate
 - provide alternatives to detention when in crisis
 - support people well on discharge
- these services meet the needs of under-served/racialised communities
- advance choices and involvement in care and treatment planning are well implemented so that consensual, better-informed care is more likely.

32. Avoiding detention in inappropriate settings – the draft bill provides greater ability to divert people from prison to hospital, introduces time limits on prison transfers, and ends use of prison and police cells as places of safety, which is very welcome. Levels of service provision will affect the success of these measures.

33. The draft bill doesn’t directly address making settings appropriate to specific needs such as those of autistic people or people who have a learning disability (who have mental health problems), people who are disabled, people who don’t speak English, including deaf people, children and young people, older people, and people with specific cultural or religious requirements. However, the requirements to take account of patients’ wishes should help make professionals more responsive to individual needs and preferences.

34. As the independent review set out, the quality of both physical and social environments in inpatient settings needs to be improved in many cases if people are to receive therapeutic benefit, recover and not be further traumatised by their admission. Ward culture and management need to promote respect, dignity and safety, and end reliance on force. This includes safety for young people, who should not be placed on adult wards, and sexual safety. There needs to be access to outdoor space and a range of therapeutic, creative and physical activities to choose from. These measures require sufficient, appropriately deployed skilled staff.

35. Achieving them will require commitment outside the legislation including through commissioning duties and regulation, but stronger protection in law should be considered. We also recommend giving a role to hospital managers to look at day to day life on the ward and drive quality improvement. This would be a reformed scheme, in which the hospital managers were recruited to be representative of the communities served and were supported in the role.

36. Reducing use of CTOs – We’re calling for CTOs to be removed altogether. Research shows they are ineffective in reducing readmissions⁴; people tell us they are intrusive and coercive (people from racialised communities have described them to us as a form of community surveillance); they represent the starkest racial disparity in the use of the Act with Black people more than ten times more likely to be placed on one than their White counterparts. CTOs were supposed to provide a route out of disproportionate sectioning but

⁴ Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, et al. [Community treatment orders for patients with psychosis \(OCTET\): a randomised controlled trial](#). Lancet 2013; 381:1627–33.

have actually perpetuated and exacerbated Black people's subjection to compulsion under the MHA.

37. While this power remains available, the evidence of their past use indicates that they are likely to be used in a risk averse way, restricting people's lives when those people would be better served by the provision of care tailored to their needs and wishes.

38. The changes in the draft bill are an improvement on the current situation but we don't think they are enough to reduce their use significantly or that they do anything to reduce their racist impact.

39. If CTOs are retained, recommendations made by the independent review should go in the bill including:

- a maximum duration in law of the CTO a tribunal power to change the conditions imposed by the CTO
- government reviews of the effect of the CTO reforms with a view to abolishing them if outcomes are not improved.

40. Any reduction in detentions has to be for the right reasons. To achieve its ambitions, we think the bill also needs to include a right to assessment and treatment, to reduce the likelihood of people being turned away from services when they ask for help. This should in turn make it less likely that the Act is used.

Question 9. What do you think the impact of the proposals will be on the workforce within community mental health services and multidisciplinary working practices both in inpatient and community services?

41. Anecdotally, we know that people prefer to work in services that are well run and where they can see people recovering and they know they are making a difference. Working in more collaborative ways should improve therapeutic relationships, reduce tension on wards and thus both improve job satisfaction and staff retention.

Question 10. 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?

42. There needs to be:

- Funding, in particular for advocacy, for the services that will help people get earlier care including culturally appropriate services, and for improving the quality of inpatient services
- Practical arrangements (as well as a legal right/duty) to enable access to earlier care

- Clear pathways for help in crisis that avoid (or minimise) police involvement and utilise the strengths of the voluntary sector including organisations serving racialised communities
- Training that includes those with lived experience talking to professionals.
- Ensuring that understanding of current racial inequalities is embedded into training to underline the scale of change needed.
- Enough doctors to fulfil the SOAD role and NHS contracting arrangements that allow and encourage this work
- Legal aid for appeals.
- More resources for mental health tribunals in light of increased access and potential further powers
- Recruitment processes and priorities that support the reforms.

Question 11. 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?

43. The draft bill makes significant improvements and we particularly welcome the requirement on clinicians to create care and treatment plans in which they must consider patients' wishes; the new requirements for clinicians when making treatment decisions; and provision for capacitous patients to make choices and refuse treatment in advance and at the time (see Q13). We also strongly welcome improved access to advocacy, though we have further recommendations on this.

44. However, clinicians can still override people's wishes and in some circumstances their refusal of treatment, albeit with safeguards. They can provide urgent treatment under s62 (except capacitous refusal of ECT) whilst waiting for SOAD approval. So it is important that decision-making and care and treatment planning are properly scrutinised and that there is a route for appeal.

45. Further changes are needed to give children and young people a greater say in their care, and to make advance decisions and the safeguards that flow from them available to under 18s. (See Q14 below for more on this point and our recommendations)

46. We're also aware that remote assessments for some MHA purposes are under consideration. Video assessments may be acceptable in some circumstances, with very robust guidance, but we would want to see phone assessments ruled out for SOAD assessments. These are clinical assessments, which may well involve assessing adverse effects of medication, and cannot be done satisfactorily by phone.

47. Advocacy support - We recommend that the bill include:

- Advocacy for making advance decisions (see Q13)
- Advocacy on an opt-out basis for informal as well as formal patients. Informal patients are still within a restrictive setting and may face similar barriers to knowing

and exercising their rights. This should be prioritised for children and young people (see Q14).

- Provision for monitoring of implementation of opt-out to make sure that a person's decision not to accept advocacy is genuine and that people aren't excluded for example because they don't want to work with a particular person, or if they change their mind.
- Culturally appropriate advocacy as a right.
- Advocacy at the point of assessment - currently people only become eligible for IMHA once detained and this is not changed by the draft bill. However, the decision to detain is a pivotal moment at which people may benefit from the support of an independent advocate, where this is practical. Culturally appropriate advocacy at this point would also support race equity; cultural difference compounds the powerlessness inherent in sectioning and having someone who is there to support you and understands your cultural context should result in a less traumatising experience and better decisions. In a survey of our campaigners, 95% agreed with having support at this stage.⁵

48. Review and appeal – Several recommendations by the independent review and white paper proposals were not taken forward in the draft bill. We think they are important safeguards and believe they should be introduced:

- A power for the Tribunal, when reviewing detentions, to require clinicians to reconsider a care and treatment plan for example because it doesn't adequately address the patient's wishes
- A power for the Tribunal (when not discharging the patient) to direct leave, transfer, or community services. This may not come from the patient, but it could make a big difference to their experience and progression towards discharge. In any new power and in the current power to recommend transfer, the transfer provision should apply to transfers between types of ward or unit not just between different hospitals.
- A right of appeal to a tribunal judge against treatment. It's an important human rights issue – there's currently no way to appeal against treatment as distinct from detention other than by judicial review. The adverse effects of treatment on people can be very profound and enduring; people may for instance want to refuse a specific medication that has had a bad impact on them previously or choose one they have found helpful. The bill must not fall short of allowing this. It's also important to give force to the safeguards earlier in the process, which if successful would limit the number of appeals being made. If the argument is that a tribunal judge can't or shouldn't make decisions about clinical matters, we disagree. At present these matters go to Judicial Review, where they are heard by a judge. Judges in other courts also make similar decisions.

⁵ Open, online survey, 2021. 725 respondents out of a total of 764 answering the question agreed "Do you think that people should be entitled to have an advocate, or someone else they trust, with them while being assessed for detention (ie before being sectioned)?"

- Any ECT given in the face of capacitous refusal (ie when urgent criteria are met) should be pre-authorised by a court – as proposed in the white paper – not a second opinion appointed doctor (SOAD). ECT remains a controversial treatment; people have talked to us in terms of being threatened with it; some doctors don't use it. Overriding capacitous refusal is a very serious step. It should be possible to obtain a judge's decision urgently, as happens in other circumstances.

Question 12. 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?

49. We strongly agree with replacing nearest relative with a nominated person. However, because health or social care professionals will need to assess if someone is capacitous or competent to appoint their own nominated person, under 16s are at a disadvantage as there's no test for competence. Therefore we recommend a test of competence be introduced (see Q14).

Question 13. To what extent is the Government right in the way it has approached people taking advance decisions about their care?

50. We agree with using existing provisions of the MCA, as far as adults are concerned. However, we're concerned that this excludes under 18s from advance refusal of treatment. It's essential that this is addressed (see Q14)

51. Many people will need support to make advance decisions and set out their wishes in advance. This is especially important if the new right is to reduce inequalities; without information and support it is only those with privilege who are likely to know about and use the provisions. In the bill as it stands, people aren't eligible for advocacy support with advance decisions as they are likely to make them some time after an admission rather than while they are detained.

52. Therefore, the bill should include:

- eligibility for advocacy for this purpose for all inpatients including after they have been discharged
- an IMHA responsibility to support advance decision-making
- advocacy that is culturally appropriate
- a duty to inform patients about advance decisions and statements of wishes and how to get support to make them.

53. It is important that advance choice documents are developed as a practical way to facilitate people setting out advance decisions and wishes and clinicians accessing them. These should be accessible to children and young people as well as adults.

54. We are glad that the draft bill does not introduce advance consent to informal admission but are concerned about how this is included in the MCA draft code of practice (see Q1).

Question 14. 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?

55. Mind is a member of the Children and Young People's Mental Health Coalition and sit on their Mental Health Act Reform working group. We endorse the Coalition's detailed response for further evidence and submissions.

56. However, we also wish to set out a number of key concerns for Mind. The Act is all age but children and young people don't benefit equally from the reforms even if these are intended for people of all ages.

57. How the bill works relies a lot on the patient's decision-making capacity. Although there is a general understanding that a 'Gillick' competent child can consent to interventions there is a lack of clarity on how to assess whether the child is able to make their own decision, and the Independent Review highlighted a lack of consistency in how Gillick competence was assessed. A statutory test in the Bill and applicable to inpatient admission would provide this clarity and is important for children and young people – and their parents and health professionals – in ensuring effective access to rights and safeguards that depend on capacity (nominated person, consent to admission, consent to treatment, advance decisions – if extended to under 18s).

"Sometimes, this professional says I have competence but this one doesn't, it could be within the same hour. Competency and capacity should be decided on a case-by-case basis. There should be a set-in-stone process, where you need to tick this box or that box to assess competence." – young person with experience of going into hospital for their mental health

58. Advance decisions are a key reform aimed at providing greater patient autonomy, but under 18s are excluded from it. This is a serious gap in young people's rights to be heard. Including under 18s could be achieved by 1) finding a different way to give effect to advance choices rather than through the MCA, or 2) by introducing a complementary mechanism that would apply to capacitous/competent young people. This would require a statutory decision-making test for under 16s for it to work properly for them.

59. Young inpatients who are admitted informally have told us they experience similar levels of control and coercion as detained patients.⁶ It's important that they have the same or equivalent rights and safeguards as their detained counterparts. Young people have also told us that they are treated as less unwell if they are informal and they feel that their treatment is deprioritised. The Government have previously committed to placing care and treatment plans for informal patients on a legislative footing but they do not appear in the Mental Health Bill. Young people we spoke to were consistently positive about making sure the care and treatment plans were extended to informal patients⁷. We think care and treatment plans for informal young people should be on the face of the Bill.

⁶ Open, online survey of young people, 2022.

⁷ Ibid

60. Children and young people also continue to be admitted onto adult wards, despite government policy stating that under 16s should not be admitted to adult wards. Placement in adult wards can be traumatising, exclude young people from appropriate treatment, and lead to more restrictive care, for safeguarding rather than clinical reasons. Therefore, we think there should be a presumption in law against placement of under 16s in adult wards and a requirement to notify the responsible local authority when a child is placed in an adult ward and to notify the CQC (within 24 hours of the placement) should be set out in the Bill.

61. Placements out of area can take young people away from support of family, friends and education and there is a growing consensus that in the majority of cases, it is better for a child or young person to receive treatment at home or in their community (Health and Social Care Select Committee, 2021)⁸. A requirement to notify the responsible local authority when a child is placed out of area should be set out in the Bill.

62. Many young people have also told us about problems with discharge from inpatient settings and going from high support inpatient setting to virtually nothing in the community. They've told us about the importance of multi-agency working prior, during and after discharge to ensure they have the right support in the community⁹. We believe there needs to be clearer statutory mechanisms for ensuring that children and young people are supported during and after inpatient care.

63. There is no centrally collected data on education provision, but available information suggests that 80% of inpatient education provision are "schools" registered with the Department for Education¹⁰. Only schools registered with DfE are inspected by Ofsted and we know that education on inpatient settings is often poor¹¹. There is also no published data on the number of children and young people with Education Health and Care plans (EHCP) in CAMHS inpatient units. We think the Department of Health and Social Care and the Department for Education should improve education support and publish guidance for secondary schools on how to ensure young people who have been admitted to a mental health ward have the opportunity to access education and learning¹². We also think that admission to hospital for mental health, should be an automatic trigger for an assessment or review of an EHCP.

64. As set out in the CYPMHC coalition's detailed response, there are numerous issues with data collection on children and young people in mental health hospitals. Notably, no data is

⁸ Health and Social Care Committee (2021) Children and young people's mental health (see para 120). Available at: <https://committees.parliament.uk/publications/8153/documents/170201/default/>

⁹ A full analysis of our engagement with young people about the reforms (survey, focus groups and interviews) will be made available to the Committee.

¹⁰ Department for Education (2018) Education in inpatient children and young people's mental health services Research report. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/678683/Education_in_Inpatient_CHYPMH_Services.pdf

¹¹ Commons Health Committee (2014) Children's and adolescents' mental health and CAMHS. Available at: <https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf>

¹² Mind (2021) Not Making the Grade. Available at: <https://www.mind.org.uk/media/8852/not-making-the-grade.pdf>

published on the total number of children and young people and the basis on which they are admitted. For example, no data is published on informal patients under 16 and whether they have been admitted on the basis of their own consent or parental consent. 50% of young people we spoke to, who had been admitted informally when they were under 16, told us that it was their parents instead of them who had consented to the admission.¹³ The Mental Health Bill should include a duty on the Secretary of State to ensure that national data on the experiences of children and young people as mental health inpatients is regularly collected and published.

“They did not ask me anything when I was first sectioned. They sidestepped me and pressured my parents. This exacerbated the problem. Doctors did not care if I had competence or not. Made me feel bypassed and disempowered” - young person with experience of going into hospital for their mental health

65. Finally, we wish to highlight the lack of provision for a group of young people with complex and varied needs, who have experienced trauma, and who require therapeutic care in a restrictive environment. Whilst they may be admitted as inpatients for brief periods of time, they are various barriers to them receiving long term inpatient care. As a result, these young people fall outside of MHA (although they may have been sectioned and admitted for brief periods of time) and are being placed in social care placement, often unregulated accommodation, due to a lack of suitable alternatives. They often need significant NHS involvement but their care appears to fall primarily to local authorities. There have been numerous judgments from the Family Courts on this group of young people, as well as [media reports](#). It is important to be clear that nothing in the Bill will address the lack of appropriate care and accommodation for this group of young people.

66. We recommend that the bill include:

- A decision-making test for under 16s in respect of decisions relating to inpatient admission and the Mental Health Act
- Inclusion of under 18s in advance decision-making
- Automatic referral to advocacy for all under 18s regardless of status – ideally we’d like to see automatic referral for patients of all ages, but it is particularly important for young people many of whom are informal but will be subject to conditions and restrictions akin to detention. The majority of young people in our survey (92%) thought that every young person on a ward should be offered support from an advocate, regardless of legal status.¹⁴

¹³ Open, online survey of young people, 2022. A full analysis of our engagement with young people about the reforms (survey, focus groups and interviews) will be made available to the Committee.

¹⁴ Open, online survey of young people, 2022. A full analysis of our engagement with young people about the reforms (survey, focus groups and interviews) will be made available to the Committee.

- Stronger protection against out of area and adult ward placement - a presumption in law against placing under 16s in adult wards and a duty to notify the responsible local authorities
- A duty on ICSs to commission better community provision, including multi agency provision for young people with complex needs currently placed in unsuitable and unregulated accommodation.
- Care and treatment plans for informal children and young people to be on the face of the bill
- A clear statutory mechanism in the Bill for multi-agency support for young people's care during their admission and at the point of discharge
- A duty to ensure that admission to hospital triggers assessment or reassessment of the Education, Health and Care Plan
- A duty on the Secretary of State to ensure national data on the experiences of children and young people as mental health inpatients (including informal patients) is regularly collected and published.

Question 15. To what extent are the proposals to allow for conditional discharge that amounts to a deprivation of liberty workable and lawful?

67. We disagree with introducing supervised discharge. It is important to address the needs and rights of people that this proposal is intended to benefit. (We understand that there are about 75 people who cannot be discharged for the sole reason that they cannot access the community safely.) They should have the least restrictive care and the opportunity to live as independently as possible.

68. However, we are concerned that:

- the new power would use the Act for public protection only, not mental health treatment
- it creates an additional step for some patients to go through in getting discharged from compulsory powers, one which could be used in a risk avoidant and/or racially biased way
- there is a potential for the power to be used more widely than the small group referred to - the experience of CTOs suggests that once introduced, such a power would be used more widely than intended
- it is unclear what the annual review would review, and how patients could progress to discharge as they could not be tested out on unescorted leave to progress to traditional conditional discharge.

69. The relatively small specific patient population that would purportedly benefit from this measure could obtain more access to the community via placement, not legislation. Placement in a step-down service that is registered as a hospital would enable the person to

gain therapeutically and potentially move towards greater independence, while remaining on section with the ability to facilitate escorted leave. Some such placements have accommodation within the grounds providing patients with their 'own front doors' a more homely and independent setting.

70. Given the racial bias in risk assessments that leads to greater use of CTOs on patients from racialised communities, we suggest this new power would similarly be disproportionately applied in practice.

71. Annual tribunal review would need to be clear what the criteria were for the order and hence how the person could be discharged from it; also how they could progress, albeit it on a slower track, towards discharge, and on what basis restrictions would be reduced.

Question 16. 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?

72. We welcome the greater ability to divert people from prison to hospital, introduction of time limits on prison transfers, and ending the use of prison (as well as police cells) as a place of safety. We are concerned that people under part 3 of the Act should not be disadvantaged in the extent to which they benefit from the reforms as compared with people on civil sections. However, other organisations are better placed to comment on these issues.

Question 17. Are there any additions you would like to see to the draft Bill?

73. The following summarises the additions we would like to see in the draft Bill; they are all explained elsewhere in our submission:

All age

- New rights that are introduced through care and treatment planning provisions incorporated into Welsh legislation in a way that means the MHA and Mental Health Measure work for people seamlessly
- A right to assessment and treatment
- Guiding principles added to the bill with the addition of a new equality principle
- Amendment of the appropriate treatment test so that treatment is 'likely' to ameliorate a mental disorder
- Duties on the approved mental health professional, when applying for admission, to show the harms identified, alternatives considered, and if an alternative to detention isn't available when it might become so
- A responsible person to oversee race equity in operation of the Act
- A duty on the Secretary of State to report on progress on race equity in the operation of the Act
- Advocacy support for making advance decisions and choices
- A duty to inform patients about advance decisions and statements, and how to get support to make them

- Culturally appropriate advocacy as of right
- Automatic referral to advocacy for informal as well as detained patients, prioritising under 18s
- Advocacy at the point of assessment for admission under the Act
- Safeguards to ensure advocacy opt-out operates correctly and people aren't effectively excluded from the scheme
- Abolish community treatment orders; otherwise introduce a maximum duration and government review of the effect of the reforms
- Drop the proposal for supervised discharge (conditional discharge to a deprivation of liberty)
- Hospital managers – a reformed scheme that is representative of the community it serves and has a role in driving quality of care and treatment and life on wards.
- The mental health tribunal to report on its discharge rate and use of statutory recommendations with breakdowns by minoritised communities
- At relevant points in the Bill, include a duty to have regard to culture and protected characteristics, especially in relation to care and treatment planning
- Care and treatment plans that are sufficiently holistic to include social and welfare issues such as benefits and housing
- Any ECT given in the face of capacitous refusal (ie when urgent criteria are met) should be pre-authorized by a court not a SOAD
- Tribunal review of delivery of care and treatment plans and power to require clinicians to reconsider
- Tribunal power to direct leave, transfer, or community services. Transfer should mean within or between hospitals in any new power and in the current power to recommend transfer
- A right of treatment appeal to a tribunal judge
- Non-means tested legal aid across all MHA issues

Children and young people focus

- A decision-making test for under 16s in respect of decisions relating to inpatient admission and the Mental Health Act
- Inclusion of under 18s in advance decision-making
- Stronger protection against out of area and adult ward placement - a presumption in law against placing under 16s in adult wards and a duty to notify the responsible local authorities
- A duty to on ICSs to commission better community provision, including multi agency provision for young people with complex needs currently placed in unsuitable and unregulated accommodation.
- Care and treatment plans for informal children and young people to be on the face of the bill
- A clear statutory mechanism in the Bill for multi-agency support for young people's care during their admission and at the point of discharge

- A duty to ensure that a young person's admission to hospital triggers assessment or reassessment of the Education, Health and Care Plan
- A duty on the Secretary of State to ensure national data on the experiences of children and young people as mental health inpatients (including informal patients) is regularly collected and published

16 September 2022