WRITTEN EVIDENCE SUBMITTED BY MIND
(MHB0025)

Data on the number of people detained without access to Article 5 safeguards

It is possible to deprive people of their liberty in mental health hospitals using the Deprivation of Liberty Safeguards (DoLS). This can only be done in specific circumstances and the oral evidence of Ms Burnham and Dr Series explores the interface in detail, Mind endorses their evidence.

There are long standing concerns about delays in DoLS applications and authorisations and this was one of the main reasons that the Government sought to replace them with the Liberty Protection Safeguards (LPS). The LPS have not come into force and NHS digital data shows that for 2023/24:

- Of an estimated 332, 455 DoLS application received In England, 123, 790 were not completed by year end
- Despite a statutory time limit of 21 days for completion of DoLS authorisation, the average processing time was 144 days

This means that thousands of people are being left for months without any lawful authorisation of their deprivation of liberty and without any oversight or clear route to challenging that deprivation. Whilst many of these people will be in care homes or physical health hospitals, a significant proportion will be in mental health hospitals.

It's also worth highlighting people who experience delayed discharge from mental health hospitals, despite being clinically ready for discharge. In November 2024, there were 41,767 days of delayed discharge for patients clinically ready for discharge from mental health hospitals in England (MHS26 - Mental Health Services Monthly Statistics, Performance November 2024 - NHS England Digital). The reasons for delayed discharge are varied but a lack of appropriate housing and/or community care and support are common reasons why people cannot be discharged at the point they are clinically ready. As a result, they will continue to be subject to significant restrictions on their liberty, not because it is clinically necessary but because of a lack of resourcing for community housing and services.

A right to assessment and treatment

People currently struggle to get help for their mental health. The overwhelming message we heard during the Mental Health Act review was that people could not get the help they needed when they asked for it. Either they weren't taken seriously, or the options weren't there. We heard from people who were refused help in the community and then

ended up being detained in hospital against their will when their mental health deteriorated further. We also heard from people who were discharged without the necessary support in place, putting their recovery and safety at risk. We know that people from racialised communities are particularly affected and people have repeatedly told us how they struggle to access culturally appropriate support in the community.

Coupled with proper resourcing and a greater range of service provision, Mind believes that an individual right to assessment and treatment could help prevent people reaching crisis point and avoid unnecessary detentions. In this sense, it is relevant both to Articles 5 and 8 ECHR. The Mental Health Bill should introduce a right to assessment and treatment for mental health (similar to Care Act rights) that respects equality and cultural appropriateness. There would be a duty on local authorities, NHS hospitals and community mental health services (according to where the request was made) to carry out an assessment of a person's mental health needs for care, support and treatment and the person would have a right to receive the treatment assessed to be needed. Accepting both the assessment and any treatment offered would be voluntary. Mind has drafted an amendment of what this right could like that (attached to this email).

In the oral evidence session, Mr Bell drew attention to the Mental Health (Wales) Measure 2010, which is a piece of primary legislation introducing various mental health duties in Wales including a duty to assess and meet needs for primary mental health services and a duty to provide care and treatment plans and care co-ordinators for people receiving secondary mental health services.

The Measure has had a positive impact on access to mental health services in Wales, particularly primary care services. However, its impact has been uneven. For example, children and young people generally struggle to access therapeutic primary care services within statutory timeframes and there are concerns about quality of care and treatment plans for people receiving secondary services. I've attached Mind Cymru's report on the Measure, whilst some of the data is now out of date, the themes and conclusions are still accurate.

Ultimately, a right to assessment and treatment will only be effective in providing community services and reducing detentions if properly resourced. In addition, as Wales and England increasingly diverge in rights to health and social care, it is important that both nations have equivalent rights, which is something for both the Welsh and UK Government to consider.

Racial injustices in the use of the Act

Racial bias and discrimination was a strong theme in our engagement work during the Independent Review of the Mental Health Act. People talked about fear and prejudice, stereotyping and lack of cultural awareness. There was anger around the disproportionality in the use of CTOs and they were described as a form of surveillance, a tool to disempower the black community. People also told us about experiences of racism, both from staff and patients, and services being aimed at white patients, black people being overmedicated, or white patients getting better care. For several people, the most positive experiences came from interactions with Black members of staff that they would relate and open up to.

Black people are over 3.5 times more likely to be detained under the Mental Health Act than White people, and over 7 times more likely to be placed on a Community Treatment Order. Experiences and outcomes are also on average worse for people from racialised communities. Black or Black British people are more likely to be detained for longer and to experience repeated admission. They are also more likely to be subject to police powers under the Act and experience higher levels of restraint compared to White people.

These shocking racial injustices were a primary driver of the review into the Mental Health Act and whilst there are some measures in the Bill that should have a positive impact for people from racialised communities, for example the introduction of advance choice documents, the Bill in its current form does not go far enough.

The Bill fails to take on many of the recommendations from both the independent review of the Act and the pre-legislative scrutiny committee that were aimed at addressing racial inequalities. For example, cconsistent provision of culturally appropriate advocacy, race equality principles in guiding principles and a mental health commissioner. The Bill also retains Community Treatment Orders (CTOs) even though they are coercive, intrusive, discriminatory and ineffective.

Mind believes the Bill could go much further in addressing those racial injustices. In addition to the right to assessment and treatment highlighted above, we believe the following are essential:

- CTOs should be abolished. If this isn't possible, the Bill should introduce a statutory review of CTOs and contain a provision that abolishes CTOs unless the review finds convincing evidence that CTOs have value and are being used in a non-discriminatory way. The Bill should also be amended to introduce a maximum duration of two years for CTOs while the statutory review is underway.
- Guiding principles on the face of the Act. This would make it clear that the principles apply for the purposes of all decision made under the Act rather than as something the Secretary of State has regard to when drafting the Code. There should also be a fifth principle of "equity"

- A responsible person at local level to oversee race equity in the operation of the Act. This could be modelled on the responsible person role in Mental Health Units (Use of Force) Act 2018
- A duty on the Secretary of State to report on progress on race equity
- A requirement on the Mental Health Tribunal to include ethnicity in its reporting statistics
- A duty to have regard to culture and protected characteristics at various points in the bill especially in connection with care and treatment planning.

Decision making test for under 16s.

For 16 and above, the test for assessing decision making capacity is set out in the Mental Capacity Act 2005. For under 16s, there is no statutory test for assessing decision making ability although there is a general understanding that if a child has Gillick competence, they can consent to interventions. The Independent Review of the Mental Health Act 1983 recognised the lack of clarity consistency in establishing competence for under 16s and for this reason, made the recommendation that there should be a statutory test for competence in respect of decisions made under Mental Health Act. This recommendation was not accepted by DHSC and in a test for assessing competence was not included in the Mental Health Bill 2025.

This gap in the law for under 16s presents a particular challenge in respect of the reforms in the Mental Health Bill as the question of whether a person has capacity or competence to make the relevant decision is fundamental to operation of key rights and safeguards. The Bill itself contains 13 references to competence.

In the absence of a statutory test of framework for determining decision making ability (competence) for under 16s, they will be unable to access the reforms safeguards effectively. For example:

- Choosing a nominated person (NP)

NPs must be appointed in writing and signed by the patient in the presence of a witness (a health or care professional, or an Independent Mental Health Advocate (IMHA) and the witness must make a statement that the witness has no reason to consider that the patient lacks the capacity or competence to make the appointment.

The absence of a clear way to assess competence could present a significant barrier to under 16s being found competent to appoint an NP and could present practical issues for health and social care professionals/IMHAs who may be asked to confirm that under 16s are competent. IMHAs have expressed concerns to Mind about being asked to assess decision making ability in the absence of a statutory test for under 16s.

- Enhanced safeguards around refusal of treatment (primarily medication)

Where someone is detained and makes a capacitous or competent decision to refuse treatment (primarily medication), that treatment can only be given if enhanced safeguards are followed. Treatment cannot be given unless there is compelling reasons to provide it and a Second Opinion Appointed Doctor (SOAD) has certified various things including that the Approved Clinician in charge of treatment complied with the new section 56A

Where someone has provide capacitous or competent consent or, lacks capacity or competence to consent, a SOAD must certify within two months that the person is consenting or lacks capacity/competence to consent and that the treatment is appropriate.

There is a dichotomy in how safeguards around treatment apply depending on whether the person has or lacks decision making ability. As the safeguards associated with a capacitous/competent refusal of treatment carry greater safeguards, under 16s will be at a significant disadvantage in the absence of a clear way to assess their competence.

It is also worth pointing out advance decisions to refuse treatment made under Mental Capacity Act (which have been given legal weight under Mental Health Act) can only be made by under 18s and therefore a child or young people cannot make an advance decision that will hold any legal weight including within context of Mental Health Act and this means that children and young people will not be able to access those stronger enhanced safeguards around treatment if they lose capacity or competence.

When Mind asked young people about this, the majority said they felt it would be unfair if not having a statutory decision making test in Bill made new safeguards less effective for them.

In Mind's view, the failure to include a statutory decision-making test means that children's voices will not be effectively heard in decisions about them and for this reason, will not comply with Article 12 UNCRC. Arguably, the decision not to include a statutory decision-making test in the Bill puts under 16s at such a disadvantage in

accessing the reforms effectively that it could be discriminatory, either under Article 14 ECHR when read with Article 8 and/or Article 2.

An amendment to include a decision-making test for under 16s has been tabled by Lord Meston at Committee stage in the House of Lords. Mind supports this amendment and I have attached Mind's briefing on that amendment should it be helpful for the Committee members.

Informal patients

I also mentioned the position of children and young people who are admitted informally, who often have very similar experiences to children and young people who are undersection, but because they are there on the basis of consent (their consent or their parents), they do not access from Article 5 safeguards that detained patients receive. Under the current Act this includes IMHAs, nearest relatives, access to Tribunals. Under the Bill, this would include opt out advocacy and statutory care and treatment plans.

NHS England doesn't publish data on children young people admitted informally. However, data obtained by the Children's Commissioner from 2020 suggests many young people are being admitted informally (31%). Without publicly available data on these young people, it's impossible to track trends or even find out why they were admitted.

Mind spoke to children and young people about their experiences of being admitted informally and they reported feeling coerced into consenting and that if they didn't consent, they would be sectioned. This theme of the threat of being sectioned and its coercive power on informal patients has also been picked up in research by Article 39. Children and young people also told Mind that they weren't given enough information and the differences between informal admission and being detained under the Mental Health Act 1983 was not made clear.

Within the cohort of children and young people admitted informally, there is a sub category of children (under 16) who are there on the basis parental consent. Children whose parents had consented to their admission told Mind they felt removed from the decision making process. For some children and young people it wasn't clear whether it

was them, or their parental or guardian who was making the decision to be admitted informally. Leaving them feeling 'bypassed' and 'disempowered' in their own care and treatment

We know that in some cases, parental consent is being relied on for both confinement but also invasive treatment which raises serious questions about Article 8 ECHR compliance. Last year there was a case in which a 12 year old was confined in a hospital for treatment for anorexia and was subject to naso-gastric feeding and high levels of restraint (4 to 5 people) and high levels of restriction. Slightly confusingly, she was confined in a mental health ward that wasn't registered to use the Mental Health Act but what the court found was that where a child lacked Gillick competence and their parents and clinical team were in agreement about their best interest, they could be confined and treated on the basis of parental consent. An NHS Trust v Mother & Ors [2024] EWHC 2207 (Fam).

Because of the higher proportion of children and young people who are admitted informally and because of the experiences they have whilst admitted, Mind believes it is is crucial that safeguards for informal children and young people are strengthened and support the following:

- Opt out advocacy extension to informal patients under 18
- Extension of statutory care and treatment plans to informal patients and putting them on the face of the Bill

We also believe there is a need for greater clarity on the circumstances in which parents can consent to under 16s' admission and treatment.

Alongside all of this, there is a need for publicly available data on the number of children being admitted informally.

Children placed on adult wards

Article 37(c) UNCRC requires children deprived of their liberty to be separated from adults unless considered not to be in their best interests.

Despite this, significant numbers of children continue to be placed on adult wards. The CQC reports that in 2022/23, they received 196 notifications of under 18s being placed on adult wards. The main reason provided for admitting the child to an adult ward was because there was “no alternative mental health inpatient or outreach service available for young people”.

When young people are placed on adult wards they are denied the opportunity for peer support, to socialise with peers their own age, have limited access to educational opportunities and are around staff who are used to treating and tailoring care for adults not younger patients.

Mind believes the Bill should be amended so children and young people are only placed oi adult wards where there are exceptional circumstances to do so, and it is demonstrably in their best interests.

Racial injustices in use of Act for children and young people from Black communities.

Black and mixed-race young people make up over a third (36%) of young people in acute inpatient services, despite representing 11% of that population. Black young people are less likely to be admitted informally, when compared to White young people. Around 1 in 10 are admitted informally versus 1 in 3 White patients but official data on the number of young people admitted informally isn’t published, which is a problem in and of itself.

A young person who identified as having Black heritage told us they immediately noticed a disproportionate number of Black patients on the ward. They sometimes faced discriminatory and racist treatment on the ward but didn’t feel confident calling it out and young people told us was how important it was for staff to have an understanding the impact of racism (including structural racism) on mental health.

December 2024

Rationale: The law needs to give people access to support and services at the point they are needed. As it stands, people can be detained in hospital against their will having earlier been refused the support that they've asked for. This amendment would create a duty on local authorities, NHS hospitals and community mental health services (according to where the request was made) to carry out an assessment of a person's mental health needs for care, support and treatment. This would be accompanied by a right to receive the treatment assessed to be needed.

It would be voluntary – the person who was referred by someone else could refuse the assessment, unless they lacked capacity to consent to the assessment and it was considered to be in their best interests.

This right is especially important for those with the worst experiences and outcomes, such as Black people and other minoritised communities. Only then can we reduce the number of people reaching a crisis point in the first place.

Explanatory statement – creates a new right to assessment for care, support and treatment of mental health needs for people in England. Where an assessment concludes there are needs, these must be met.

To move the following Clause –

Clause 4A Right to assessment and treatment

(1) In the Mental Health Act 1983, after Part 8A, insert –

"**Part 8B**

Rights to assessment for care, support and treatment (England)

Section 125G Assessment of an adult's mental needs for care, support and treatment

(1)Where an adult presents to, or is referred to, a local authority or NHS hospital or Community Mental Health Service requesting assessment of their mental health needs, the local authority, or integrated care board must assess –

(a) Whether the adult does have needs for care, support or treatment

(b) whether those needs should be met in a hospital, the adult's residence or community setting.

2)An assessment under subsection (1) is referred to in this Part as an "adult mental health needs assessment".

3)The duty to carry out an adult mental health needs assessment applies regardless of the authority's view of—

(a)the level of the adult's needs for care and support, or

(b)the level of the adult's financial resources.

(4) Any care, support or treatment that is identified as a result of the adult mental health assessment under subsection (1) shall be offered to the adult following the assessment.

Section 125H Refusal of an adult mental health needs assessment

(1)Where an adult refuses an adult mental health needs assessment, the duty to carry out the adult mental health needs assessment does not apply

(2) But a refusal under subsection (1) does not discharge a local authority or integrated care board from its duty under section 125G if —

CASE 1 - the local authority is satisfied, in the case of a refusal given by the adult, that—

(a) the adult lacks capacity to decide whether to refuse to have the assessment, but
(b) there is an authorised person to make the decision on the adult's behalf;

CASE 2 - the local authority is satisfied, in the case of a refusal given by the adult, that—

(a) the adult lacks capacity to decide whether to refuse to have the assessment,

(b) there is no authorised person to make the decision on the adult's behalf, and

(c) having the assessment would be in the adult's best interests;

CASE 3 - the local authority suspects that the adult is experiencing or at risk of abuse or neglect.

(3)Where a local authority has been discharged from its duty under section 125G by a refusal under this section, the duty is re-engaged if—

(a)the adult (or, where applicable, an authorised person) subsequently asks for an assessment, or

(b)the local authority considers that the adult's needs or circumstances have changed,

(subject to any further refusal under this section)

(4)In this section “authorised person” means a person authorised under the Mental Capacity Act 2005 (whether in general or specific terms) to decide whether to refuse, or ask for, a needs assessment on the adult's behalf.

Section 125I Assessment of mental needs of children and young people for care, support and treatment

(1) Where a child or young person presents to, or is referred to, a local authority or NHS hospital or Community Mental Health Service requesting an assessment of their mental health needs, the local authority, or integrated care board must assess –

(a) Whether the child or young person does have needs for care, support or treatment
(b) whether those needs should be met in a hospital, the child or young person’s residence or community setting.

(2) Where the parent or carer of a child or young person presents to a local authority or NHS hospital or Community Mental Health Service requesting an assessment of the child or young person’s mental health needs, the local authority, or integrated care board must assess –

(a) Whether the child or young person does have needs for care, support or treatment
(b) whether those needs should be met in a hospital, the child or young person’s residence or community setting.

(3) An assessment under subsection (1) or (2) is referred to in this Part as a “a child or young person’s mental health needs assessment”.

(4) The duty to carry out a child or young person’s mental health needs assessment applies regardless of the authority’s view of—

(a)the level of the child or young person’s need for care and support, or

(b)the level of financial resources of the child or young person or any person with parental responsibility for the child or young person

(5) Any care, support or treatment that is identified as a result of the child or young person’s mental health needs assessment under subsection (1) shall be offered to the child following the assessment.

(6)“Parent”, in relation to a child, includes—

(a) a parent of the child who has parental responsibility for the child,

(b)a parent of the child who does not have parental responsibility for the child, and

(c)a person who is not a parent of the child but who has parental responsibility for the child.

(7)“Carer”, in relation to a child, means a person, other than a parent, who is providing care for the child, whether or not under or by virtue of a contract or as voluntary work.

(8)The reference to providing care includes a reference to providing practical or emotional support.

Section 125J Refusal of the child or young person’s mental health needs assessment by a 16 or 17 year old

(1)If a young person aged 16 or 17 (or, where applicable, an authorised person) refuses a child or young person’s mental health needs assessment under section 125I, the duty under that section to assess the young person's needs does not apply.

(2)If a person with parental responsibility for a young person aged 16 or 17 refuses a child or young person’s mental health needs assessment for that young person under section 125I in circumstances in which the local authority is satisfied that—

(a)the young person lacks capacity to decide whether to refuse to have the assessment, and

(b)there is no authorised person to make the decision on the child's behalf,

the duty under that section to assess the child's needs does not apply.

(3)But a refusal under subsection (1) or (2) does not discharge a local authority from its duty under section 125I in the following cases—

- CASE 1 - the local authority is satisfied, in the case of a refusal given by a young person, that the young person lacks capacity to decide whether to refuse to have the assessment;
- CASE 2 - the local authority is satisfied, in the case of a refusal given by a person with parental responsibility for the young person, that the person lacks capacity to decide whether to refuse the assessment;
- CASE 3 - the local authority is satisfied, in the case of a refusal given by a person with parental responsibility for the young person, that not having the assessment would not be in the young person's best interests;
- CASE 4 – the local authority suspects that the young person is experiencing or at risk of abuse, neglect or other kinds of harm.

(4)Where a local authority has been discharged from its duty under section 125I by a refusal under this section, the duty is re-engaged if—

(a)the young person (or, where applicable, an authorised person) subsequently asks for an assessment,

(b)a person with parental responsibility for the young person subsequently asks for an assessment in the circumstances described in subsection (2), or

(c)the local authority considers that the young person's needs or circumstances, or the needs or circumstances of a person with parental responsibility for the young person, have changed,

(subject to any further refusal under this section).

(5)In this section "authorised person" means a person authorised under the Mental Capacity Act 2005 (whether in general or specific terms) to decide whether to refuse, or ask for, a child or young person's mental health needs assessment on the child's behalf.

Section 125K Refusal of a child or young person's mental health needs assessment for a child aged under 16

(1)If—

(a)a child aged under 16 refuses a child or young person's mental health needs assessment under section 21, and

(b)the local authority is satisfied that the child has competence to make the decision about the refusal of the assessment,

the duty under that section to assess the child's needs does not apply.

(2)If a person with parental responsibility for a child aged under 16 refuses a child or young person's mental health child or young person's mental health needs assessment for that child under section 125I, the duty under that section to assess the child's needs does not apply.

(3)But a refusal under subsection (1) or (2) does not discharge a local authority from its duty under section 21 in the following cases—

- CASE 1 - the local authority is satisfied, in the case of a refusal given by a person with parental responsibility for the child, that the person lacks capacity to decide whether to refuse the assessment;
- CASE 2 - the local authority is satisfied, in the case of a refusal given by a person with parental responsibility for the child, that the child—

  (a)has competence to make a decision about the refusal of the assessment, and

(b) does not agree with the refusal given by the person with parental responsibility for the child;

- CASE 3 - the local authority is satisfied, in the case of a refusal given by a person with parental responsibility for the child, that not having the assessment would be inconsistent with the child's best interest;
- CASE 4 – the local authority suspects that the child is experiencing or at risk of abuse, neglect or other kinds of harm.

(4)Where a local authority has been discharged from its duty under section 125I by a refusal under this section, the duty is re-engaged if—

(a)the child subsequently asks for an assessment and the local authority is satisfied that the child has sufficient understanding to make an informed decision about having an assessment,

(b)a person with parental responsibility for the child subsequently asks for an assessment, or

(c)the local authority considers that the child's needs or circumstances, or the needs or circumstances of a person with parental responsibility for the child, have changed,

(subject to any further refusal under this section).

(Feb 2025)