

Mind's submission to the Mental Health Act Review

Mind welcomed the independent review of the Mental Health Act as both necessary and timely. Being sectioned is one of the most serious things that can happen to somebody experiencing a mental health problem.

Whilst significant progress is being made to improve services and care for people with mental health problems, the current legislation is outdated and does not reflect the principles we expect to see in twenty-first century healthcare. And the way legislation is implemented and the care that people receive under it, too often fails to meet basic expectations of treating people with dignity and respect. The Act currently focuses on what people are unable to do, rather than utilising their strengths and empowering people to have choice and control over their own care and recovery.

This submission to the Mental Health Act Review sets out the areas we think are particular priorities; these are areas where we expect the Review to make significant recommendations to Government to improve the current legislation and the mental health services in which it operates. The document draws upon the views and experiences of people we have heard from who have been sectioned under the Act which has built upon Mind's existing knowledge and understanding of how the legislation operates in practice and how it needs to improve. All bolded quotes within the submission are from people with lived experience of the Act who we have engaged with through focus groups, workshops and our Lived Experience Steering Group in 2018.

Since its inception last autumn, Mind has played an active role in the Review. As the Review progresses for the remainder of this year, we will continue to work with colleagues in the Review to ensure that its recommendations reflect the views and experiences of people with mental health problems.

The Review's Interim Report, published in May 2018, set out what it had heard through its own engagement with people with lived experience, as well as its approach to the remainder of the review. This submission follows that structure, splitting the issues covered by the Act broadly into three areas:

- Before detention
- During detention
- Leaving hospital

Additionally, as the Interim Report recognised, some communities are disproportionately impacted by the Mental Health Act, with Black African and Caribbean people much more likely to be sectioned than white people. In order to ensure our input to the Review appropriately reflects the experiences of people from these communities, our work has been guided by a steering group made up of people with a range of relevant lived experience and including Black African and Caribbean perspectives. Throughout this document we have sought to highlight where there are particular issues and challenges affecting people from these communities.

Many of the concerns related to the Mental Health Act are not directly due to the legislation but to the treatment people receive from mental health services before, during and after a period of detention. Throughout our engagement with people who have experienced being

sectioned, it is repeatedly clear that had they received appropriate treatment sooner, sectioning might well have been avoided altogether. Many more people have told us of the poor experience they had while in hospital – an experience not confined solely to those under section. And others have told us of how the system has failed them when they have been discharged. Any discussion of the Mental Health Act cannot be seen in isolation from the need to improve the availability of high quality – and culturally appropriate – mental health services.

Summary of Mind's recommendations to the Review

Being sectioned is one of the most serious things that can happen to somebody experiencing a mental health problem. Whatever the therapeutic intent or clinical need, it can be completely disempowering. And this loss of liberty can be traumatising, when, for example, the police are involved in the initial sectioning or people's wishes and preferences are unheard and overruled when detained. This should not have to be the way that people access mental health care.

Key themes

We believe that a more fundamental review of the legislative framework around mental health and capacity is required, and that the current review should recommend steps to set this in motion. In the context of reform to the current legislation we believe that:

- The need for involuntary interventions and compulsion must be reduced through vastly improved service provision and increased rights of access to support
- The ability to detain and impose treatment must be reduced by tightening criteria and placing a greater responsibility on services to engage with people about their treatment needs and preferences
- The dignity, safety and meaningful involvement of people in their care, and their ability to challenge care when it falls short of reasonable expectations, must be maximised.

Summary of recommendations to the Review

Principles and Rights included in the Act

On **Principles and rights** which should be included in the Act we want the Review to recommend:

1. The incorporation of principles and rights into the Act.
2. The introductions of new additional principles covering anti-discriminatory practice and hospitality.

Before detention under the Mental Health Act

On **Reducing detentions** we want the Review to recommend:

3. The introduction of an individual, enforceable right to a mental health assessment and to treatment and care that people are assessed to need.
4. Increased emphasis on the importance of cultural relevancy and competence in services.
5. The introduction of an individual right to culturally appropriate advocacy.
6. National level commitment to a significant reduction in the number of detentions over the course of the forthcoming long term plan for the NHS.
7. Improvements to availability and timeliness of data on detentions under the Act.

On **Decisions to detain under the Mental Health Act** we want the Review to recommend:

8. A concrete commitment for work to develop options for capacity-based legislation.
9. The inclusion of some elements of a capacity-based approach in the recommendations for the current Act, such as regard to advance decisions and shared decision-making and autonomy.
10. That all decisions about mental health care and treatment should be based on the best understanding possible of the person and their wishes, and be made with, and as far as possible, by the person
11. Explicit reference within the Act to ensure that a diagnosis for a 'mental disorder' must take account of the patient's social and cultural background.
12. The involvement of trusted family or friends and/or advocacy should occur before key decisions are taken.
13. To amend the definition of treatment to include a full range of appropriate treatments. Treatments should lead to an improvement of a person's condition, or prevent its worsening. This should take into account cultural identity and other relevant factors, with the objective of discharge from detention and ongoing recovery.
14. A single gateway with a short initial detention period, while ensuring reviews of treatment and detention can be accessed within seven days and that all patients are eligible for aftercare

On the **Interface between the Mental Capacity and Mental Health Act** we want the Review to:

15. Provide clarity of where each Act applies.
16. Set out how the safeguards in each Act can be harmonised and strengthened.
17. Promote maximum regard for the patient's wishes.
18. Establish a starting assumption that a person has capacity to make and be involved in decisions about their care and treatment.

On **The role of the Police** we want the Review to recommend:

19. Support for the delivery of others' work in this area including joint working embedded through the Crisis Care Concordat, implementation of the Angiolini report recommendations, and the Mental Health Units (Use of Force) Bill.
20. An end to the use of police cells as places of safety for people of any age.
21. An end to the use of police vehicles for conveyancing except in the most exceptional of circumstances.
22. Sustained provision of training and education for police officers in mental health and cultural competence.
23. A statutory duty to provide an appropriate adult for vulnerable adults.

During detention

On the **Dignity and respect of the service user** we want the Review to recommend:

24. Rights and principles on the face of the Act including an anti-discrimination principle referencing racism, and a hospitality principle.

25. Concerted action across all NHS arm's length bodies to require and support quality improvement to put hospitality into practice, create positive cultures on wards and improve environments.
26. Meaningful expectations on trust boards to prioritise dignity and respect.
27. Support for the Mental Health Units (Use of Force) Bill.
28. The Care Quality Commission to include hospitality as a criteria within its inspections as part of the 'Are they caring?' question.
29. The elimination of mixed sex accommodation.

On the **Autonomy of the service user** we want the Review to recommend:

30. The introduction of a system which provides patients with far more transparency, greater involvement and effective means to challenge decisions which can be incredibly important to them.
31. A statutory responsibility to offer advance plans which are binding to various degrees but which must always be given due regard.
32. A requirement to give particular regard to a person's wishes and feelings in making decisions about treatment and care including by involving them directly in those decisions.
33. Culturally competent practice and advocacy.

On **Procedural safeguards** we want the Review to:

34. Significantly increased safeguards to enable patients to challenge detention and to protect them from arbitrary treatment.
35. Automatic triggers for second opinion with initial treatment plans and when significant changes are made to a treatment plan.
36. Broadening of the range of issues that a second opinion clinician can consider to include treatment choices, treatment plans and the quality of care being provided.

On **Tribunals and hospital managers' hearings** we want the Review to recommend:

37. Broadening the range of issues that Tribunals can consider to include treatment choices, treatment plans and the quality of care being provided.
38. That changes in diagnosis should trigger a review of treatment.
39. That it be obligatory where appropriate for membership of the Mental Health Review Tribunal to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.
40. Automatic reviews should be reduced from every three years to annually.
41. Further work to understand the role and benefit to people of Managers' hearings.
42. That the proposals of the Tribunals Procedure Committee are rejected.

On **Advocacy** we want the Review to recommend:

43. Extension of eligibility to all patients in secondary care and automatically available to all inpatients (including voluntary patients) as decisions to section are taken and during treatment planning.
44. Referral to an advocate should be automatic.
45. Advocates should be appropriately trained including to enable them to operate in culturally diverse settings.
46. The introduction of national standards and oversight to ensure that advocates are appropriately resourced.

On **Family and carer involvement** we want the Review to recommend:

47. The introduction of a choice of person to fulfil the 'nearest relative' role and involve those the patient chooses from their family and friends, and to the extent that they choose, in statutory care planning.

On the **Use of restraint and seclusion** we want the Review to recommend

48. The full implementation of provisions in the Mental Health Units (Use of Force) Bill

Leaving hospital

On **Community Treatment Orders** we want the Review to recommend:

49. The repeal of Community Treatment Orders
50. Improvements to aftercare and other existing powers that support people in the community

On **Discharge and aftercare** we want the Review to recommend:

51. The introduction of a statutory framework for care planning.
52. Aftercare should be available to all inpatients regardless of whether they were detained under the Act or by what section they were detained.
53. Aftercare planning should be co-produced with the person concerned, and whoever they wish to have involved, and conducted in a culturally competent way.

Immigration and detention

What we want the Review to recommend:

54. Immigration detainees to be a specific category within the Mental Health Act.
55. Statutory provision setting out the timescales for transfer from IRCs to hospital.
56. Entitlement to IMHAs for detainees with a Section 48 report.
57. Culturally relevant and competent services to support detainees and relevant training for IRC staff.
58. Ensure provision of CPA and Section 117 aftercare services to detainees on release from detention.

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1. BAME communities and the Mental Health Act

“Racism is steeped deeply within British society and its institutional structures, including the health service. A long history of slavery and colonialism shapes how Black people and other minorities are perceived and treated as variously dangerous, child-like, and intellectually inferior, which evokes at the very least a paternalism of ‘we know best’.”

Throughout this document we refer to the need for culturally relevant and competent services. Our engagement with people from Black, Asian and Minority Ethnic (BAME) communities, including the steering group for our work on the Mental Health Act, has highlighted the importance of recognising the role racism plays in not only service delivery but also as a significant factor in why so many people from these communities become unwell in the first place. Cultural advocacy, staff training, community services and the role of detention could change significantly if seen from this perspective and delivered accordingly.

There is substantial evidence that people from some BAME communities are disproportionately and negatively impacted by the Mental Health Act. In particular, Black African and Caribbean people are disproportionately detained under the Act and more likely to be victims of the most coercive powers under the Act, such as forcible restraint. There are multiple reasons for this, including: lack of access to appropriate preventative and early intervention services; stigma and other cultural barriers meaning people present late, if at all, to services; and discrimination which associates particularly BAME communities with dangerousness in need of management through legislation such as the Mental Health Act. As a result, the solution lies in action across a range of fronts.

First, people must be able to access culturally competent and relevant community services at an earlier point. This will require investment in initiatives to address the cultural barriers to certain groups seeking support. There also needs to be a commitment to wider reforms to promote social justice, equality and inclusion to help reduce the social determinants of mental health problems for these communities.

Additional measures, which have direct benefits as well as reducing the need for compulsory treatment under the Act, should include rights-based advocacy, action to counter bias in assessment and clinical decision-making, better quality data and more transparent monitoring, co-produced care planning and more support for the BAME voluntary and community sector.

The Review should consider what actions are necessary to ensure equal access to, and benefit from, rights and safeguards available under the Mental Health Act, and to guard against changes impacting negatively on people from BAME communities.

2. Principles and rights included in the Act

Mind believes that principles and rights should be specified in the Act. These include those rights enshrined in the Equality Act and the Human Rights Act¹ such as the right not to be treated in an inhuman or degrading way or the right to liberty. These are laws with which the Mental Health Act must already comply. The Act should also draw from the Convention on Rights of People with Disabilities (CRPD)² to ensure that people are treated equally for example in accessing health care.

The legislation should seek to protect and operationalise these rights. We think this requires a right to assessment, joint crisis plans and advanced statements (see below), which are culturally appropriate and co-produced, in order to promote the right to health and help avoid unnecessary restrictions on the right to liberty and other human rights.

Within the context of the Mental Health Act, we would want to see the principles within the Code of Practice included in the primary legislation. These should be strengthened around co-production and the effectiveness of treatment for the individual. We would also like to see the following principles added:

- Anti-discriminatory practice and cultural competence: this should specifically address institutional racism and promote cultural competence in decision-making and care.
- Hospitality: the principle of hospitality is a key factor in promoting respect and dignity.³ Hospitality is a characteristic of some highly valued voluntary sector services⁴ which could be carried over into the NHS setting. It involves attention to the quality of the environment and the welcome; being considerate as regards everyday, cultural needs; showing ordinary courtesies and kindnesses; and the nature of relationships with staff.

Incorporating principles and specifying rights is not enough, of course, but putting these principles on a statutory basis will drive and legitimate other actions, such as guidance on governance priorities or regulatory inspections, as well as shape practice.

What we want the Review to recommend:

1. The incorporation of principles and rights into the Act.
2. The introductions of new additional principles covering anti-discriminatory practice and hospitality.

¹ Human Rights Act: Right to life (art. 2); Right not to be tortured or treated in an inhuman or degrading way (art. 3); Right to liberty (art. 5); Right to respect for private and family life, home and correspondence (art. 8); Right not to be discriminated against in relation to any of the rights contained in the Human Rights Act (art. 14)

² CRPD: Equality and non-discrimination (art. 5); Equal recognition before the law (art. 12); Liberty and security of the person (art. 14); Freedom from torture or cruel, inhuman or degrading treatment or punishment (art. 15); Protecting the integrity of the person (art. 17); Respect for privacy (art. 22); Respect for home and the family (art. 23); Health (art. 25).

³ Mind (2011) 'Listening to experience': www.mind.org.uk/media/211306/listening_to_experience_web.pdf

⁴ For example Leeds Survivor-led Crisis Service, Maytree Sanctuary (see *Listening to experience*)

3. Before Detention

3.1 Reducing detentions

Addressing the continued increase in the number of detentions under the Mental Health Act is one of the primary drivers of the Review. Mind is clear that improving the availability and early provision of good quality mental health services in the community will have the biggest impact on reducing the need to detain people under the Act.

A recurring theme of Mind's engagement with people with mental health problems, is that it is not until someone reaches crisis point that they are able to access the services they need, and not always then.

“You need earlier interventions. You have to get to the point when you snap, or they see you snap, and then they have to make a major decision whether to section you.”

The combination of an inability to access timely support voluntarily and the subsequent use of compulsory treatment through the Mental Health Act inevitably breeds a level of mistrust in services. This can often be accentuated for people from some BAME communities, who are both more likely to have experienced additional barriers to the right care and support at an earlier point and to have accessed compulsory treatment through the intervention of the police or the courts.

We therefore welcome the attention given to the development of joint crisis plans and to the work of crisis resolution and home treatment teams in the Interim Report. Well-resourced and well-functioning acute and crisis care services are vital to reducing the number of detentions. These must be sensitive to the needs of, and equally accessible to, people from all communities and people with multiple needs. They should include a range of community options, such as crisis houses and cafes, respite care, and host families, and should include social support as well as health care.

However, it is also important to reduce the incidence of crises in the first place. This will involve resourcing community mental health services and social care, as well as increasing the range of initiatives and services aimed at promoting good mental health and preventing the development of mental health problems, and improving primary care and early intervention services. Child and Adolescent Mental Health Services (CAMHS) are rightly a national priority, and too many young people struggle to access much needed support which could potentially prevent later detentions as an adult under the Mental Health Act.

As with acute and crisis services, particular attention is needed to ensure each of these are effectively supporting people from BAME communities. Reducing racial disparities in detentions will require much more than changes to the Act; initiatives such as Mind's *'Up My Street'* programme⁵ have shown the importance of promoting resilience and wellbeing among young African Caribbean men and how this can be approached. NICE's recently published quality standard 'Promoting health and preventing premature mortality in black,

⁵ Centre for Mental Health (2017) 'Against the odds: Evaluation of the Mind Birmingham Up My Street programme': www.centreformentalhealth.org.uk/against-the-odds

Asian and other minority ethnic groups⁶ includes BAME involvement in design of health and wellbeing programmes, inclusion in peer and lay roles, and access to mental health services in a range of community settings.

Attention is needed to thresholds for secondary mental health care and the gap between primary and secondary services. High quality social care, including that provided through the third sector, can support people to stay well in their communities, to manage life situations that can trigger a mental health crisis, and to access more specialist care when needed. This is a highly cost-effective way of keeping people well, but a thriving voluntary sector cannot be provided without adequate funding.

One of the concerns raised with us most often by people with lived experience is their inability to persuade clinicians of their need for mental health care, whether that be in the community or in hospital, to avert a serious deterioration in their condition. We propose the introduction of an individual, enforceable right to a mental health assessment and to the treatment and care that people are then assessed to need. We are aware that the NHS is not yet at a point that it could respond to all mental health needs, so propose that this right could be introduced over a period of time, starting with those with most urgent needs: people who are in crisis or know they need support to prevent reaching crisis point. Access to advocacy that is culturally relevant should also become an individual right to enable people to access these and other rights within mental health services and under the Mental Health Act.

Clearly, a key indicator of the success of the Review will be a reduction in the number of detentions under the Mental Health Act. In order to be able to monitor and evaluate the impact of the Review's recommendations, high quality, timely data on detention rates is required. Currently data on the use of the Act is only available on an annual basis, with a significant delay to this availability (at the time of writing the most recent data is 2016/17). Earlier, more frequent reporting of detention rates can play an important role in focusing attention within NHS providers and commissioners on the need to reduce detentions under the Act.

What we want the Review to recommend:

3. The introduction of an individual, enforceable right to a mental health assessment and to treatment and care that people are assessed to need. This should be accompanied by:
 - Significant investment in acute and crisis services to ensure high quality care and treatments are available to people to reduce the need for involuntary admissions. This should include community options like crisis houses.
 - Significant investment in prevention and primary care mental health services to reduce the number of people reaching crisis.
 - Reductions to thresholds for voluntary admission to secondary care services.
4. Increased emphasis on the importance of cultural relevancy and competence in services, supported by national guidance, support and funding for commissioners and providers to meet the needs of all their communities, including BAME communities.
5. The introduction of an individual right to culturally appropriate advocacy.

⁶ NICE (2018) 'Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups': www.nice.org.uk/guidance/qs167

6. National level commitment to a significant reduction in the number of detentions over the course of the forthcoming long term plan for the NHS.
7. Improvements to availability and timeliness of data on detentions under the Act.

3.2 Decisions to detain under the Mental Health Act

We heard an overwhelming view that early, accessible, good quality and culturally appropriate mental health services would often remove the need for sectioning. If there is to be compulsory detention, the restriction of a person's right to liberty, something which is often experienced as both highly stigmatising and traumatising, should be very much used as a last resort. We do not believe this is the current situation.

All decisions about mental health care and treatment should be based on the best understanding possible of the person and their wishes, and be made with, and as far as possible, by, the person.

This requires use of joint crisis plans and advance statements, advocacy and the involvement of people that the person knows and trusts. This involvement and/or advocacy is critical before key decisions are taken, otherwise people may be set on trajectory of unnecessary compulsion, characterised as 'escalators' in Colin King's blog for Mind.⁷

In the context of higher rates of detention among some BAME communities, the cultural competence of practitioners is important when decisions to detain are being taken. As Race on the Agenda (ROTA) and the Racial Equality Forum (REF) have noted, the imprecision of the term 'mental disorder' and the room this allows for racial stereotypes or cultural misunderstandings can influence diagnostic decisions made by practitioners. Mind supports ROTA and REF's call for the Act to include that a diagnosis for a 'mental disorder' must take account of the patient's social and cultural background.

“...the psychiatrist who might be racially inclined to think, oh because they studied this in mental health and this is what black people are supposed to be like...and the next minute you're schizophrenic”.

Capacity to make decisions

There is a strong case for exploring basing the system for involuntary treatment on capacity to make decisions, and the Review should have regard to lessons from the Mental Capacity Act (MCA). The potential benefits of having involuntary treatment only for people who lack the capacity to make the decision are:

- Parity between physical and mental health
- Autonomy
- Compliance with international human rights standards
- Addressing stigma towards people with mental health problems.

⁷ Colin King (2018) 'My experiences on both sides of the Mental Health Act': www.mind.org.uk/information-support/your-stories/my-experiences-on-both-sides-of-the-mental-health-act/#.W2wRAU20WM-

Northern Ireland has a unified Mental Capacity Act, but this is not yet in force and we are aware of the number of issues that need to be explored around what mental capacity means in a psychiatric context. Capacity is not well embedded in mental health services at present, and we have heard from those with lived experience how their capacity has been conflated with the concept of 'insight', i.e. whether the person accepts the clinical view of their psychological state. Assessing a person's capacity – and certainly assessing their best interests – requires an understanding of their values and world view, which in turn requires a culturally competent approach and involvement of relevant others.

Reaching conclusions on these questions and how mental capacity and mental health legislation can be integrated will take time. While we understand that the Review will not be recommending an immediate fusion of the MHA and MCA, we would like to see a serious exploration of the implications and options for capacity-based mental health legislation in England starting without further delay.

In the meantime there are ways to engrain questions of capacity within the Act. The introduction of advance statements and a statutory requirement to consider a person's wishes and preferences during care planning would both enhance patient autonomy, and develop a greater understanding of the needs of people detained under the Act.

Appropriate treatment requirement

We welcome the Review's concern that people who are detained should receive clinically effective help. We do not think that the appropriate treatment requirement is sufficient to achieve this. We do not believe that being accommodated in a hospital setting is, on its own, sufficient to be designated appropriate treatment. We have also heard from many people with mental health problems concerned about the over-reliance on medication while detained, about over-medication and about the lack of availability of other therapeutic interventions such as psychological therapies.

While a person is detained, everything possible should be done to speed that person's discharge from detention and ongoing recovery. It follows, therefore that the fullest possible range of NICE recommended treatments should be available for someone at the point the State restricts their right to liberty.

As treatment progresses, its actual effects must clearly influence further treatment decisions and reviews, and clearly, the patient's view of these effects must feature strongly in these decisions.

Combining Sections 2 and 3 of the Mental Health Act

Assuming the current legal framework, we agree with the Interim Report that there should be a unified process and entry point with a short initial period of detention. There should be an early review of both detention and treatment regardless of the entry route and aftercare should be a right to all who would benefit.

What we want the Review to recommend:

8. A concrete commitment for work to develop options for capacity-based legislation.
9. The inclusion of some elements of a capacity-based approach in the recommendations for the current Act, such as regard to advance decisions and shared decision-making and autonomy.

10. All decisions about mental health care and treatment should be based on the best understanding possible of the person and their wishes, and be made with, and as far as possible, by the person.
11. Explicit reference within the Act to ensure that a diagnosis for a 'mental disorder' must take account of the patient's social and cultural background.
12. The involvement of trusted family or friends and/or advocacy should occur before key decisions are taken.
13. To amend the definition of treatment to include a full range of appropriate treatments. Treatments should lead to an improvement of a person's condition, or prevent its worsening. This should take into account cultural identity and other relevant factors, with the objective of discharge from detention and ongoing recovery.
14. A single gateway with a short initial detention period, while ensuring reviews of treatment and detention can be accessed within seven days and that all patients are eligible for aftercare.

3.3 Interface between the Mental Health & Mental Capacity Acts

Currently, a person receiving treatment for their mental health in hospital who lacks the capacity to consent to their admission will be under the Mental Health Act if they object; if they do not object they may be detained under either the Mental Health Act or the Mental Capacity Act.

Pending any future fusing of these two Acts, it is important to address their overlap. The Review should aim for:

- Clarity about where each Act applies, with no grey area where either could be used.
- Harmonisation (at least roughly) in the safeguards of each Act so that people are not in a worse position by being under one Act or the other.

The Liberty Protection Safeguards (replacement for Deprivation of Liberty Safeguards), which are being introduced through the Mental Capacity (Amendment) Bill 2018, maintain objection as the basis for being under the Mental Health Act. However, the fact that a person is not seen or heard to object should not be deemed to imply consent; it might instead reflect the severity or nature of their disability, lack of awareness of the possibility of things being different, lack of agency or hope in changing their situation. This arrangement also leaves ambiguity as to which Act is used where the person does not object.

As both regimes are being reformed it is very difficult to say at this stage which Act better serves patients, although the Liberty Protection Safeguards as currently proposed do not in our view ensure that people without capacity, regardless of whether they object, have their wishes respected or their rights protected. People's wishes and preferences should be taken into account at all points when care and treatment is being considered or reviewed. The starting assumption in decision-making about care and treatment should be that a person has capacity to be involved in this process and make decisions about their own life, care and treatment.

What we want the Review to do:

15. Provide clarity of where each Act applies.

16. Set out how the safeguards in each Act can be harmonised and strengthened.
17. Promote maximum regard for the patient's wishes.
18. Establish a starting assumption that a person has capacity to make and be involved in decisions about their care and treatment.

3.4 The role of the police

Initial police involvement is sometimes unavoidable during crises, but is often an indication of shortcomings in mental health services. Having the police involved makes people feel as though they are criminals and it is intimidating. For black people there is the added dimension of racism and fears associated with policing especially when force is used. It should be a fundamental starting point of any mental health legislation, or indeed any mental health provision, that people with mental health problems should be treated by health professionals rather than managed by police wherever possible.

'When they come to take me to hospital, they bring the police. Why?'

The police have made an extremely positive contribution to mental health through the Crisis Care Concordat and this joint working needs to be sustained. There needs to be continued development of crisis responses where mental health professionals work with the police in control centres and street triage initiatives. We welcomed the banning of the use of police cells as s136 places of safety for young people and consider that they should not be used as places of safety at all – not least because any disturbed behaviour that might lead to use of a cell constitutes a medical emergency. We would also like to see an end to the use of police vehicles in conveying people with mental health problems, for example to a place of safety, except in the most exceptional of circumstances. People with a mental health problem needing emergency care should be transported in a health vehicle, like anyone else needing NHS support.

The recent publication⁸ of the Office for Police Conduct's figures on deaths during or following police contact shows an increase in the number of deaths in or following police custody, and 12 of these 23 people had mental health concerns. A disproportionate number of those who died following restraint were black. This underlines the urgency of work to improve both access to mental health care and the police response, including the implementation of Dame Angiolini's recommendations concerning deaths in custody.

We welcome the introduction of Steve Reed MP's Mental Health Units (Use of Force) Bill which, if enacted will strengthen accountability around the use of force in mental health units, by both police and health care professionals.

A further issue the Review must consider is the provision of appropriate adults for vulnerable adults. Such provision is important to help ensure that vulnerable people are treated fairly. We believe there should be a statutory duty to make this provision for vulnerable adults.

⁸ Independent Office for Police Conduct (2018) 'Deaths during or following police contact for 2017/18': www.policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-201718

What we want the Review to recommend:

19. Support for the delivery of others' work in this area including joint working embedded through the Crisis Care Concordat, implementation of the Angiolini report recommendations, and the Mental Health Units (Use of Force) Bill.
20. An end to the use of police cells as places of safety for people of any age.
21. An end to the use of police vehicles for conveyancing except in the most exceptional of circumstances.
22. Sustained provision of training and education for police officers in mental health and cultural competence.
23. A statutory duty to provide an appropriate adult for vulnerable adults.

4. During detention

4.1 Dignity and respect of the service user

There are many ways in which people's dignity and safety are compromised while detained under the Mental Health Act, or indeed as informal inpatients. These can range from a poor physical environment through unnecessary restrictions to allegations of provocation, intimidation and racism on the part of staff. Closed environments, blanket restrictions, poor communication and misunderstanding can culminate in physical restraint, seclusion or forced medication which continue to be in common use.

Our 2010-11 independent inquiry set out a vision for acute and crisis care 'built on humanity, embodying a culture of service and hospitality, where people are treated with kindness, respect and courtesy, have someone to talk to and feel safe'.⁹ The Promise initiative based in Cambridge¹⁰, which aims to end reliance on the use of force in mental health care, includes staff-led projects to improve the quality of life on wards. We think that a hospitality ethos could really shift the dynamic in inpatient care.

“I found somebody, a black lady...I had this beautiful black nurse and she was absolutely amazing, she just brought it out of me. Because she could identify with me... I just cried, it all just came out.”

All relevant parts of the wider health care system need to be engaged to remove unnecessary restrictions on patients and promote respect and dignity. Our engagement work clearly shows the need for anti-discriminatory and specifically anti-racist foundations to this. Programmes to ensure dignity and safety need also to be gender-sensitive and trauma-informed and to ensure pleasant and homely physical environments that allow people to feel safe and supported. And as a matter of urgency existing promises such as eliminating mixed sex accommodation need to be fully implemented.

What we want the Review to recommend:

24. Rights and principles on the face of the Act including an anti-discrimination principle referencing racism, and a hospitality principle.
25. Concerted action across all NHS arm's length bodies to require and support quality improvement to put hospitality into practice, create positive cultures on wards and improve environments.
26. Meaningful expectations on trust boards to prioritise dignity and respect.
27. Support for the Mental Health Units (Use of Force) Bill.
28. The Care Quality Commission to include hospitality as a criteria within its inspections as part of the 'Are they caring?' question.
29. The elimination of mixed sex accommodation.

⁹ Mind (2011) 'Listening to experience': www.mind.org.uk/media/211306/listening_to_experience_web.pdf

¹⁰ www.promise.global

4.2 Autonomy of the service user

Mind is strongly in favour of increasing the regard paid to patients' wishes, both in advance and at the time. The current requirements in the Code of Practice are insufficient.

“If something was to change in the Mental Health Act, I would like it so that psychiatrist doesn't have the final say”

We believe the Act should provide for a statutory requirement for meaningful involvement and shared decision-making in care and treatment planning. Measures to achieve this need to provide for cultural competence and advocacy that is culturally relevant.

Advance planning and decision-making should also be strengthened through the following:

- People who have capacity to do so should be able to refuse certain treatments by way of advance decision-making. These could include treatments defined by their invasiveness, their potential for serious harm or where they have previously caused harm to the patient.
- People should be able to record, by way of advance decision-making, types of treatment, not just medication, that either they do or do not want. These may not be binding but reasons for not complying with people's wishes should be made explicit and subject to independent review.
- People should be able specify a wide range of things in advance that decision-makers should have regard to. These could include who is or is not involved, where they're detained, and what happens to their children.
- Advance planning and crisis planning need to be put on a statutory footing and to be encouraged far more in practice. There should be a duty to offer these at certain trigger points.
- People's wishes and preferences should be taken into account at all points when care and treatment is being considered or reviewed and the starting assumption in decision-making about care and treatment should be that a person has capacity to be involved in this process.

What we want the Review to recommend:

30. The introduction of a system which provides patients with far more transparency, greater involvement and effective means to challenge decisions which can be incredibly important to them.
31. A statutory responsibility to offer advance plans which are binding to various degrees but which must always be given due regard.
32. A requirement to give particular regard to a person's wishes and feelings in making decisions about treatment and care including by involving them directly in those decisions.
33. Culturally competent practice and advocacy.

4.3 Procedural safeguards

The current safeguards in place for people detained under the Act differ widely depending on the section and the stage of a detention and on a person's capacity. We believe that

safeguards need to be increased significantly to enable patients to challenge detention, protect them from arbitrary treatment and to ensure they have maximum opportunity to voice their concerns.

We believe that there should be automatic triggers for a second opinion, the first of which should be within at least the first few days to review the initial treatment plan. There should also be provision for automatic second opinion, unless declined by the patient, whenever the treatment plan is significantly altered, on application from the patient within reasonable timeframes, and automatically at fixed points during a detention.

The range of issues which a second opinion can consider should be broadened to include treatment choices, the provision of treatment specified in treatment plans and the quality of the care provided. Second opinion clinicians should be required to meet with the patient and the patient should have an advocate or nominated person with them unless they decline.

What we want the Review to recommend:

34. Significantly increased safeguards to enable patients to challenge detention and to protect them from arbitrary treatment.
35. Automatic triggers for second opinion with initial treatment plans and when significant changes are made to a treatment plan.
36. Broadening of the range of issues that a second opinion clinician can consider to include treatment choices, treatment plans and the quality of care being provided.

4.4 Tribunals and hospital managers' hearings

"I didn't understand as a user why it was rejected. It feels like judgement from people after a 20-30 minute hearing".

As with second opinions, there should be automatic triggers for a Tribunal at an early stage within the first detention period, at regular intervals during a detention and on application from the patient.

Similarly, the range of issues which a Tribunal can consider should be broadened to include treatment choices, the provision of treatment specified in treatment plans and the quality of the care provided. Staff preparing Tribunals should be required to meet with the patient and the patient should have an advocate or nominated person with them unless they decline.

We are pleased that the Review is considering whether people should be able to appeal to the Tribunal against compulsory treatment decisions. We urge the Review to consider whether, as in Scotland, the Tribunal should consider issues besides detention such as aspects of the treatment plan, including, importantly, whether it is being delivered.

Tribunals should also consider a person's diagnosis. This is particularly important for people from BAME communities, where (as noted at 3.2 above) there is a risk that cultural misunderstandings and racial stereotypes may have influenced an original diagnosis.

As with all decisions relating to the Act, cultural competence is essential if the person's perspective is to be understood and, in this context, if they are to have a fair hearing. We

agree with ROTA and the Racial Equality Foundation that when appropriate, it should be obligatory for membership of the Mental Health Review Tribunal to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.

People who do not request a review are currently referred automatically only every three years. This is far too long and it should be every year.

The Review notes the overlap in the discharge functions of the tribunal and the hospital managers and asks whether the latter is necessary. Anecdotally we are told that Hospital Managers hearings can provide a useful forum to challenge a patient's care and increase momentum towards discharge. Without more understanding of the role that the hospital managers play it would seem premature to remove these appeals as an avenue for discharge. The priority for the Review is to ensure that there are increased safeguards available to people which are independent, easily accessed and which do not feel intimidating.

Tribunals Procedure Committee proposals

Mind is very strongly opposed to the proposals from the Tribunals Procedure Committee to abolish pre-hearing examinations and to have paper hearings for automatic referrals. We have submitted our detailed response to their consultation. We object to abolishing pre-hearing examinations as these examinations enable the medical member of the panel to be informed, which is necessary for an effective challenge to the detaining authority. The Committee did not consider patient experience and we know that patients value this opportunity to be heard and that tribunals can make recommendations that are important to the patient.

We object to having paper reviews as the default for automatic referrals because oral hearings provide better scrutiny and an 'opt-in' system disadvantages patients who lack capacity to decide whether to have an oral hearing, or who lack the ability or initiative to apply (e.g. because of depression). Detentions require the highest levels of scrutiny as a person's liberty is restricted.

We urge the Review to resist these proposed changes and make the case in the strongest possible terms that no changes should be made that cut across its remit until after the Review has reported and the Government has had an opportunity to consider its recommendations.

What we want the Review to recommend:

37. Broadening the range of issues that Tribunals can consider to include treatment choices, treatment plans and the quality of care being provided.
38. That changes in diagnosis should trigger a review of treatment.
39. That it be obligatory where appropriate for membership of the Mental Health Review Tribunal to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.
40. Automatic reviews should be reduced from every three years to annually.
41. Further work to understand the role and benefit to people of Managers' hearings.
42. That the proposals of the Tribunals Procedure Committee are rejected.

4.5 Advocacy

We welcome the Review's recognition of the importance of advocacy and its attention to the availability, cultural appropriateness and standards of advocacy services. We know that advocates, and their independence, are valued by people with mental health problems, but also that they can be difficult to access. Advocates support people to challenge or question decisions about their treatment and care, and ensure people are fully informed of and able to exercise their rights.

“I didn't know that existed, that's amazing, that's good. But they should make that more accessible.”

Currently, a person becomes eligible for independent mental health advocacy under the Act once they have been detained. A number of people told us they wanted advocacy to be available during the sectioning process to help them express their views.

We also know, from advocacy providers, that commissioning arrangements do not always allow for a full and tailored service to be provided. All patients in secondary care should have an individual right to advocacy. Being an inpatient creates particular vulnerability whether your stay is formal or informal, and inpatients should not be expected to request advocacy to gain access; referral should be automatic. There should be a duty to ensure patients know their right to an advocate and advocates should be available, including from the first point of detention, to support people to express their views and wishes so that these can be reflected in treatment plans and their care from the start. This should be additional to the involvement of any chosen family or friends.

“You need people who know you, who can talk for you even. Understand you, where you're coming from.”

It is vital that advocacy is relevant and tailored to the person needing support. In the context of the Mental Health Act specific skills and knowledge are required. Advocates need to be appropriately trained, including to be able to work in culturally diverse settings. The support people need is often in connection with aspects of life beyond their rights, care and treatment under the Act.

This is a vital role and national oversight of advocacy services is required, with quality assurance and sufficient funding to ensure that services are adequately resourced.

What we want the Review to recommend:

43. Extension of eligibility of advocacy to all patients in secondary care, and advocacy to be automatically available to all inpatients (including voluntary patients) as decisions to section are taken and during treatment planning.
44. Referral to an advocate should be automatic.
45. Advocates should be appropriately trained including to enable them to operate in culturally diverse settings.
46. The introduction of national standards and oversight to ensure that advocates are appropriately resourced.

4.5 Family and carer involvement

We welcome the Review's approach to changing the 'nearest relative' provisions. We know that people who have been sectioned would welcome earlier and greater involvement of chosen family members, but not necessarily of the person assigned as their 'nearest relative'. We also know some people would not want any involvement of their family or friends due to unknown abuse or other complex factors that can impact on safety.

Patients should be supported to choose whether their family or other relations should be involved in their care, and if so, who this should be during an appeals process. This could be written into any advance plan or other statutory care planning framework that requires co-production with the patient.

We have also heard from carers who felt excluded and/or taken for granted in the current system, with little regard being given for their understanding of the person or their ability to provide support following discharge.

“Clients should have the choice to have friends and family present before sectioning, through to diagnosing and beyond.”

Beyond the statutory role, we believe patients should be supported to maintain their family relationships and any unnecessary restrictions on contact should be removed.

What we want the Review to recommend:

47. To introduce choice of person to fulfil the 'nearest relative' role and involve those the patient chooses from their family and friends, and to the extent that they choose, in statutory care planning.

4.6 Use of restraint and seclusion

Mind has long campaigned for a reduction in the use of force in healthcare settings. Being restrained can be frightening and hugely disempowering for anyone, let alone someone in a highly-distressed state.

We believe the main way to reduce the use of restraint and other restrictive practices is to make wards calmer and safer places, where staff and patients know each other better, and where there is a determination within the leadership and across the team not to rely on force. Conversely, the culture and environment of wards can create the situations where restraint is used more readily. If people are not listened to or given the opportunity to have a say in their care, have nothing to do or no-one to talk to, tensions can rise and people may become frustrated and distressed. Over-crowding, being cooped up in poor and institutional physical environments, blanket or arbitrary rules and restrictions, and not being able to go out, all add to a negative environment. Reducing the use of restraint starts with getting the quality of care right.

Mind supports the Mental Health Units (Use of Force) Bill currently being discussed in Parliament, and we want to see it passed into Law. The Bill aims to reduce the use of restraint by improving data and transparency around the use of restraint, ensuring frontline staff receive better training to manage difficult situations, and requiring local providers to commit to reducing the use of force in mental health settings. The Review should support the passing and implementation of the Bill and seek to complement its provisions.

There have been a number of initiatives in recent years aimed at reducing the reliance on force in services. The Review should learn from and seek to build up these initiatives to further reduce the use of restraint and other restrictive practices in services.

What we want the review to recommend:

48. The full implementation of provisions in the Mental Health Units (Use of Force) Bill.

5. Leaving hospital

5.1 Community treatment orders

We are pleased that the Review is persuaded that 'CTOs should not remain in their current form'. Research has shown that they do not achieve their aim of reducing the risk of readmission and they are perceived as coercive and intrusive to those subject to them.

'A tag that nobody can see but you know it's around your mind'

We do not believe that CTOs should be retained in any form. As the Review is aware, Black or Black British people are nine times more likely than white people to be made the subject of CTOs. Our engagement with black African and Caribbean people with experience of the Act, shows that there is a strong sense that CTOs are discriminatory, and some people characterised the powers as 'race surveillance'. Black people felt as though they were not trusted with their medication and the CTO regime was experienced as coercive and intrusive while, at the same time, hugely unsupportive.

The focus of any discharge plan should be to support ongoing recovery and avert the person returning to hospital. In our view these aims would be better achieved by mandating the provision of community support through statutory, co-produced aftercare and crisis plans, with the resources of staff and time to enable professionals to do the work it takes to build trust, know the person they are working with, and avoid compulsion. It is unacceptable that people should be subject to the powers of a CTO simply because we have not been able to resource services sufficiently to deliver this level of care.

In those cases where additional oversight or community testing is necessary, Section 17 can be used for short term testing in the community, subject to regular reviews. The Mental Capacity Act exists to authorise longer term arrangements for those who lack capacity to make decisions about their care and treatment.

We would urge the Review to be bold on this. It would be possible to review the criteria for the use of CTOs, the power of recall, or to set a maximum duration. If the tool for compulsion in the community exists however, given the increasing risk aversion that the Review has noted, we are likely to see a reversion to the 'better safe than sorry' approach which has led to the current levels of CTO usage.

What we want the Review to recommend:

49. The repeal of Community Treatment Orders.
50. Improvements to aftercare and other existing powers that support people in the community.

5.2 Discharge and aftercare

Good care planning is integral to improving people's experience of detention and aftercare. Detention should not just be about ensuring that people take medication but should be a part of meeting their needs holistically when all else has failed.

Under the Care Act you are entitled to an assessment of your needs and the local authority will agree with you, insofar as is possible, how each of those needs will be met. In contrast, what we hear too often with the Mental Health Act is that you will get what you're given.

'I need something that talks with me not about me. It needs to be produced with me.'

People often feel unsupported on discharge from a section. The experience of going into hospital, experienced by many as an all-or-nothing experience of either no support or compulsion, is often mirrored at discharge. Care plans are rarely joined up across different local services and the plans are too often drawn up with no or only token involvement with the patient. One of the most common issues raised from callers to our legal helpline about aftercare is confusion about their entitlement to aftercare.

The CQC's annual report on the Mental Health Act regularly highlights poor care planning, and in their latest report¹¹ stress that things are not improving: evidence suggests that consideration of patient's views, patient involvement and consideration of a patient's particular needs have all deteriorated.

We believe a statutory framework for care planning would help, both during and after detention, and perhaps beforehand. This could unite the various care planning tools and frameworks that those in receipt of mental health services often fall under. It could provide a framework into which more regard for the patient's wishes and feeling could be embedded. It could tie into an extension of tribunal powers so that the tribunal can make decisions on important matters other than discharge.

We are pleased that the Review agrees that 'a general right to aftercare must continue'. The right support on discharge is vital to keeping people well and reducing the need for readmission to hospital. But we know that section 117 doesn't work in practice for too many, including those that have told us that they left hospital with no support at all.

"You need more intensive support when you come out of hospital. To go from all that, then you fall off a cliff and you're all on your own."

We also believe that aftercare should be available to all inpatients regardless of whether they were detained under the Act or by what section they were detained. This would ensure that people are, as far as possible, supported to stay well.

What we want the Review to recommend:

51. The introduction of a statutory framework for care planning.
52. Aftercare should be available to all inpatients regardless of whether they were detained under the Act or by what section they were detained.

¹¹ Care Quality Commission (2018) 'Monitoring the Mental Health Act in 2016/17', p.11:
www.cqc.org.uk/sites/default/files/20180227_mhareport_web.pdf.

53. Aftercare planning should be co-produced with the person concerned, and whoever they wish to have involved, and conducted in a culturally competent way.

6. Immigration Removal Centres

Mind believes that people with mental health problems should not be in immigration detention, or at the very least that this will only be appropriate in very exceptional circumstances. Immigration detainees are some of the most vulnerable people in society. They will have been subject to indefinite detention and may have no friends or relatives to support them. They may have been subject to torture or abuse and may have experienced multiple forms of discrimination.¹²

There is a large amount of evidence on the damaging impact of Immigration Removal Centres (IRCs) on mental health.¹³ Healthcare provided for people with mental health problems in immigration detention is woefully inadequate.¹⁴ Given these inadequacies, we are very concerned about whether people are being properly assessed for transfer to treatment under the Mental Health Act.¹⁵

Immigration detainees should be in a specific category of their own in the Mental Health Act. They need to be distinguished carefully from prisoners. By being identified with prisoners a mistaken impression is created that they are currently detained because of criminal behaviour whereas their detention is often civil and not criminal.

Despite specialist guidance about how transfers are to be effected from IRCs to hospital there are still delays in the process. Statutory provision is required covering transfers from IRCs, setting out a timescale for transfer.

Detainees for whom there is a Section 48 report in place recommending transfer to hospital should have an entitlement to an Independent Mental Health Advocate (IMHA) to ensure that they aren't left without assistance at a time when they are at their most vulnerable. We recommend that these individuals should be qualifying patients.

Detainees are likely to have specific needs for IMHAs and interpreters. Some of the detainees may be victims of torture and careful consideration is needed in the use of any form of seclusion or restrictive practice. Detainees are also more likely to need information in different formats and languages, and there may be specific cultural issues to consider in assessing mental health or mental capacity. Culturally relevant and competent services and appropriate training for staff are therefore essential.

Following discharge from hospital it is particularly important that full Care Programme Approach (CPA) care is provided for them and Section 117 aftercare services are provided both in detention and if they are released into the community.

¹² Individuals who have been victims of torture should not be detained in the UK without exceptional circumstances (under Rule 35 of the statutory Detention Centre Rules 2001 (SI 238/2001)), however evidence suggests this is routinely contravened. See Medical Justice (2012) 'The Second Torture: The immigration detention of torture survivors': www.medicaljustice.org.uk/wp-content/uploads/2016/03/the-second-torture-full-version.pdf

¹³ See Bosworth, M. (2016) 'The Impact of Immigration Detention on Mental Health: A Literature Review': www.papers.ssrn.com/sol3/papers.cfm?abstract_id=2732892

¹⁴ In the last three years, there have been six cases in which judges have found that conditions suffered by mentally ill immigration detainees amounted to inhuman or degrading treatment contrary to Article 3 European Convention on Human Rights.

¹⁵ See R (on the application of MDA) v Secretary of State for the Home Department [2017] EWHC (Admin).

What we want the Review to recommend:

54. Immigration detainees to be a specific category within the Mental Health Act.
55. Statutory provision setting out the timescales for transfer from IRCs to hospital.
56. Entitlement to IMHAs for detainees with a Section 48 report.
57. Culturally relevant and competent services to support detainees and relevant training for IRC staff.
58. Ensure provision of CPA and Section 117 aftercare services to detainees on release from detention.