

Mind's response to the Mental Health Act White Paper

April 2021

Introduction

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. To lose control over where you live, who you live with, what you do in your day, what medical treatment you take and other aspects of your life, inevitably has a profound impact on a person's sense of self and, unsurprisingly, can slow down a person's eventual recovery even while the treatment received may contribute to recovery in other ways. And this loss of liberty can be additionally traumatising, when, for example, the police are involved in the initial sectioning or people's wishes and legitimate preferences are unheard and overruled when detained. This should not have to be the way that people access mental health care.

In developing our response to the Government's White Paper, *Reforming the Mental Health Act*, we have worked with a range of organisations and partners including Race on the Agenda (ROTA), the Mental Health Alliance, and the Mental Health Policy Group. We have continued to base our response based upon people's lived experience of mental health problems and of the Act itself, and this response makes use of evidence that shaped our original submission to the Independent Review of the Mental Health Act (2018). We have supplemented it through further conversations with people, and we ran a campaign action that gave people the opportunity to share their views with us on selected areas in the white paper. This gave Mind campaigners and supporters on social media an opportunity to tell us what they thought of the White Paper. It was clear from the comments received that many people who responded had direct or family experience of the Mental Health Act.

This response applies to both England and Wales. A separate response from Mind Cymru addresses specific issues that relate to the application of these reforms in Wales only.

Mind's vision for reform of the Mental Health Act

Mind has long called for reform of the Mental Health Act. A lot has changed in the way we view mental health and we have a higher expectations of the treatment people should receive than when the Act was written. We want legislation and services which are fit for purpose, and which support people when they are in crisis.

We have welcomed both the Independent Review's recommendations and the UK Government's White Paper because we see both as important steps on the

journey to achieving our vision for a legislative framework that supports people to get the help and support they need, when they need it. There are important areas where we disagree with both documents and while we want to see the White Paper progress to legislation, we will continue to fight for further improvements to the proposals so that both legislation and practice better reflects the needs of people with mental health problems.

Since the publication of the Independent Review's recommendations in 2018, the need to address one of its key themes – the need to address the structural and institutional racism pervading the use of the Mental Health Act and wider mental health services – is particularly urgent. Mind is determined to ensure that these reforms better meet this challenge. The continuation of Community Treatment Orders, which are ten times more likely to be used on Black people than White, are an obstacle to this, and as we set out below, should be repealed.

Our vision for reform encompasses understanding and respect for a person's will and preference. Our vision is for rights of access to care and treatment that meets people's needs and that people are willing to engage with. Our vision is one in which people are treated with respect and dignity, and where treatment enhances not jeopardises people's life chances and quality of life.

To achieve this will take more than legislative reform. It will require an urgent and committed drive forward on policy within the White Paper, of which we highlight:

- commissioning services to meet the needs of all ages and communities, with a range of therapeutic approaches
- the right to a statutory care plan, with joint working duties
- safe and therapeutic service environments, including co-produced guidance for both physical and social aspects
- continued development and delivery of the Patient and Carer Race Equality Framework in England
- full implementation of the Mental Health Units (Use of Force) Act 2018 including targets for reduction of restraint
- data and targets to better understand and drive down the use of coercion.

Mind's response mirrors the structure of the *Reforming the Mental Health Act* as far as possible. We have not limited our response to the specific questions where the UK Government is seeking views, and where we don't have the relevant expertise to respond to a question or issue, we have left that out of this document.

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1. New Guiding Principles

The UK Government proposes embedding the principles in the Mental Health Act (MHA) and the MHA Code of Practice. The new principles are:

- choice and autonomy – ensuring service users' views and choices are respected
- least restriction – ensuring the act's powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged as quickly as possible
- the person as an individual – ensuring patients are viewed and treated as individuals

Q: Where else would you like to see the Principles applied to ensure that they have an impact and are embedded in everyday practice?

We welcome the guiding principles and strongly support their inclusion in the Act as well as the Code. We agree with the focus of the principles: following them should enable people's human rights to be better supported, particularly rights to liberty, private and family life, and not to be discriminated against. They will provide a basis for challenging any decisions and practice that fall short of people's reasonable expectations and for raising expectations of what should be provided. However, the European Convention on Human Rights (ECHR) Convention rights should be referenced in the Act to ensure it is clear and explicit that the Act and its implementation must uphold human rights.

The principles should be:

- embedded in guidance, practice directions, training and resources provided to tribunal members, including anti-racism training
- taught in curricula for all professionals with duties under the MHA
- explained in information provided to patients and families
- incorporated into estates guidance, specifically the review of physical requirements of wards recommended by the independent Review
- incorporated into commissioning guidance and service specifications.

It needs to be clear that they apply to everyone who is subject to the Act, inside or outside hospital, and they should inform mental health practice beyond the use of the Mental Health Act.

Additionally, the principles need elaborating to be more effective:

- 'Choice and autonomy' are central to the changes being proposed to the Act and will require significant reorientation of culture and practice, so guidance needs to support this
- 'Least restriction' is already part of MHA decision-making and is well understood as a concept, yet there remain high levels of detentions and uses of restrictive practices so this principle is not currently being used to drive practice in reality. The relevance of 'least

restriction' needs to be drawn out for commissioners, who can then ensure that less restrictive alternatives are made available, and for those on the ground responsible for ward environments, both physical and social.

- 'Therapeutic benefit' must be more tightly defined – at the moment anything that happens in hospital is deemed to be therapeutic when it very clearly isn't. Mental health services must provide a full range of therapies and therapeutic activity that enables people to recover and where the person's own assessment of benefit is central. They must be culturally appropriate and be designed to lead to the person's mental health improving with the ultimate aim of detention being lifted
- 'The person as an individual' should highlight the need to challenge stereotypes of how people with mental health problems are seen, and the fact of being detained influencing how the person is seen. A focus on the individual must not negate the reality of structural inequalities, particularly racism, which affects people as individuals – the person as an individual is the person in their community. This principle needs to translate into tangible improvements for everyone whose individuality is misinterpreted, ignored or discriminated against, such as people from racialised communities, older people, those whose sexual or gender identity is pathologised, those with experience of sexual trauma who are retraumatised in hospital, and young people placed on adult acute wards.

2. Clearer, stronger detention criteria

The UK Government proposes to change the detention criteria so that detention must meet two core principles:

- Therapeutic benefit - greater consideration must be given to whether, and if so how, detention and interventions provided under the Act are or would be beneficial to a person's health and recovery
- Least restriction - ensuring a person is only detained where it is absolutely necessary, where not detaining poses a substantial risk of significant harm being caused to themselves or others

Mind agrees with the need to require stronger justification for detention. This must mean substantive justification with a clear, evidenced rationale for what is therapeutic, what constitutes risk, and for the level of harm it is believed would ensue if the person were not detained.

What must not happen is that detention criteria become, in practice, admission criteria, and that hospitals are only treating people with ever greater levels of acuity or turning away any other people who want admission voluntarily. We are

particularly concerned that barriers to care are not raised for children and young people, whose problems may just be emerging.

We want to see a reduction in the need to use the Act through a greater range and quantity of high quality, responsive services for people of all ages, and rights to access them. These should include responses such as short self-referral stays for people who know that they need support away from home to prevent their mental health needs escalating. Services must engage with and respond to people's preferences. They must be adequately resourced so that they can provide support whenever people ask for help.

The impact of the Patient and Carer Race Equality Framework (PCREF) in England will be particularly important; services need to become much better at meeting the needs and promoting the wellbeing of racialised communities. The need for greater involvement from these communities is key (see also section 10 below) and engagement with the PCREF must be as accessible as possible, in particular engaging those Black communities most disproportionately affected, and co-producing services that are truly accessible and acceptable to, and trusted by, communities.

Therefore, in addition to delivery of the NHS Long Term Plan commitments and the PCREF, there should be rights of access to services beginning with early intervention (to avoid a crisis) and crisis care. We recommend a duty to commission crisis care alternatives to detention, for people of all ages, and an individual right to access crisis care.

We are conscious that rights of access do not automatically translate into improvements in access and experience. A review of community mental health teams in Wales found that, despite rights of access and self-referral back into secondary mental health services, there was lack of clarity about referral, lack of knowledge among GPs of what community mental health teams do, and lack of consistency in how crisis needs are responded to. In most Community Mental Health Teams (CMHTs) people were not being routinely told about their right to re-refer themselves back without going via their GP¹. A combination of policy and commitment to its implementation, alongside updated legislation and the willingness to uphold it in the courts, would strengthen people's rights and improve their outcomes.

The White Paper can be further improved to give people more voice in decision-making and tackle racial bias and discrimination. The decision to detain may be based on allegations against the patient and we are concerned that the patient's word is not given sufficient weight. Furthermore, having clearer detention criteria will not address racial disparity by itself because of existing racial stereotypes relating to risk, which was a strong theme in our earlier engagement with people

¹ Healthcare Inspectorate Wales and Care Inspectorate Wales (2019) Joint thematic review of community mental health teams.

from racialised communities². Having more transparent decision-making should help but by then the person has already been detained. As we argue later in our response, ensuring that advocacy is available to people at the assessment stage is essential to ensuring that the person's word is listened to and racial discrimination is countered.

We are very concerned at the rejection of the Review's recommendation to introduce a common framework for understanding risk. This recommendation was made to make assessment fairer for Part III patients. It was rejected on the basis that different parties – clinicians, courts and Secretary of State – legitimately have different approaches because of their different roles and responsibilities. We agree that they may legitimately come to different conclusions from the assessment of risk, but we strongly believe that a common approach to understanding what constitutes risk, and different types of risk, would bring transparency to the process, improve decisions and the experience of the individual, and respect their article 5 and 6 rights to in relation to knowing the basis for restrictions and being able to challenge them.

In particular, having a more transparent approach would help address racial discrimination in decision-making, which is particularly pertinent when Black patients are more likely to have come into the system through a police or criminal justice route. We recommend adoption of the Review recommendation of a common framework and that racial bias is an explicit part of it.

3. Giving patients more rights to challenge detention

The White Paper sets out a number of proposals to give patients more rights to challenge detention as the UK Government recognises that too often patients are detained for longer than is needed, and beyond the point of therapeutic benefit to the individual. They propose more checks and more frequent reviews of detentions and increased access to Tribunal.

Mind strongly supports increasing patients' access to the Mental Health Tribunal. The current period of three years between automatic referrals for patients on Section 3 is too long for people to be deprived of their liberty without review.

However, people's experience of tribunal hearings can be poor and hearings can feel bewildering and intimidating. This can be exacerbated by holding sessions remotely and we are concerned that the move to remote hearings during the coronavirus pandemic may become permanent as a convenience to the system rather than to give patients the fairest hearing.

² Reported in our submission to the independent Review <https://www.mind.org.uk/media-a/5135/mind-mhar-submission-final.pdf> and engagement work <https://mind.turtl.co/story/5c3f4b11903f285d2e0f30e3/> and described in this video - <https://www.youtube.com/watch?v=mo53v7FJT-U>

To fulfil the ambitions of the reforms, the tribunal will need to have high expectations of care and treatment planning and of how the patient's wishes inform it. Where appropriate, it should be obligatory for membership of the tribunal to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.

Tribunals should also consider a person's diagnosis as treatment decisions flow from this. This is particularly important where there is a risk that cultural misunderstandings and racial stereotypes may have influenced an original diagnosis.

We recommend that tribunal discharge statistics, including ethnicity data, are routinely published.

We strongly disagree with the rejection of the Review recommendation to allow the Tribunal to change CTO conditions (see section 6 below)

Q: We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?

We strongly agree with this change.

Therapeutic benefit should always be central to the purpose and the outcome of detention in hospital for a mental health problem. Given the seriousness of any decision to take away someone's liberty, the focus of services must be on restoring that liberty.

When we asked people, many of whom have lived experience of the Act and/or mental health problems, whether they agreed that detention should provide therapeutic benefit, 87 percent of people answering this question agreed.³ People told us that detention should be the last resort and that decisions to detain should be taken after discussion with people close to the person being detained (e.g. family members).

Some people we heard from did not agree. Reasons given for not agreeing included that it is already too hard to detain people, the terms are too vague

³ 663 respondents agreed out of a total of 759 answering the question 'The changes to the law would tighten up the criteria for sectioning. Stronger criteria for sectioning would say that detention must benefit you and that you, or someone else, would come to serious harm if you were not detained: detention must have a therapeutic benefit for the person; there must be "a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person". Do you agree with including 'therapeutic benefit'?

and subjective, that the only criteria should be actual harm, and that fundamentally detention is not therapeutic.

‘Therapeutic benefit’ needs to be defined and described in a way that is meaningful and allows for the person’s own assessment of what they find beneficial. This includes ensuring people have choice of a range of therapies, ensuring treatment is trauma informed and is itself not traumatising and that treatment is recovery focused. Understanding of ‘therapeutic’ can also differ between people of different backgrounds, ethnicity and culture, and services must be able to respond to these differing needs.

We are concerned that therapeutic benefit is not being included in Part III criteria. It should be explicit that patients in the criminal justice system are to receive therapeutic benefit as well.

While therapeutic benefit is not part of the criteria for s2, it should be made clear that the whole Act (including assessment followed by treatment) should be about therapeutic benefit.

Q: We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?

We strongly agree with this change which would mean that stronger justification would be required in order to remove a person’s liberty and to impose treatment.

When we asked people, many of whom have lived experience of the Act and/or mental health problems, whether they agreed with this change, 83 per cent agreed.⁴ Respondents told us of their own experiences of being sectioned; a number raised the question of who gets to decide whether sectioning will be ‘beneficial’ and that often sectioning is for the benefit of everyone except the person being detained.

⁴ 626 agreed out of 757 respondents to the question ‘The changes to the law would tighten up the criteria for sectioning. Stronger criteria for sectioning would say that detention must benefit you and that you, or someone else, would come to serious harm if you were not detained: detention must have a therapeutic benefit for the person; there must be “a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person”. Do you agree with including ‘therapeutic benefit’? Do you agree with including ‘substantial likelihood of significant harm’?

We are, however, very concerned about the introduction of ‘welfare’ to the criteria. It is dangerously ill- or un-defined and counteracts the main thrust of focusing on therapeutic benefit. Is the aim to safeguard people who may take actions during a manic episode that are damaging to their lives, but who may not meet the health and safety criteria? If so, it must be clear that detention in hospital is the appropriate response and that the need cannot be addressed through for example emergency provisions in the Court of Protection. The circumstances in which this applies must be tightly defined in law, otherwise it will simply have the effect of widening the criteria by which someone can be detained. It would also be necessary to distinguish it from the meaning of welfare in other legislation, such as the Children’s Act, to avoid unintended carry over of those meanings into the Mental Health Act.

Q: Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal?

a) Patients on a Section 3 – we agree for adults but there should be more frequent review for children and young people and recommend that this be at four months. Under 18s do not benefit from the increased frequency of referrals after the first reference, as referral is already annual, and a year is a long time in a child or young person’s development as compared with an adult. Reducing the period to a third of the current period would be in proportion to the reform for adults and match the proposed period for the first reference.

b) Patients on a CTO – we agree, if CTOs are retained. However, there is an expectation in the White Paper that CTOs end after two years. Therefore, at two years there should be a presumption in the tribunal that the person should be discharged from the CTO unless there are very strong grounds for continuing it. In our view, CTOs should be repealed, but if retained, the maximum duration of two years should be in the Act.

c) Patients subject to Part III – we agree.

d) Patients on a Conditional Discharge – we disagree. We welcome the introduction of automatic referrals for the reasons given in the independent Review, but consider that four years is too long. People on conditional discharge can apply for a tribunal hearing between the 12th and 24th month and then in two year windows. Two years is a long time to wait; people can make significant progress in this time. Tribunals are not only about absolute discharge; they can also vary conditions, most commonly enabling a move

from hostel accommodation to the person's own accommodation. This is a very important step in a person's rehabilitation.

We recommend that people be able to apply annually and have an automatic referral every two years.

Q: We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?

We agree that this is not an effective safeguard as the patient's status has generally changed by the time the Tribunal is held and there will be more frequent access to the Tribunal than now.

However, there should be scrutiny of the grounds for revocation decisions, both in fairness to the patient (including informing future care) and for monitoring practice. This could be looked at when the patient's case is next reviewed, as it would have been a critical development in their care and treatment under the MHA. It could also be looked at by associate hospital managers if this role is retained, which may have more impact on local practice.

Q: We want to give the Mental Health Tribunal more power to grant leave, transfers and community services. We propose that health and local authorities should be given five weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?

We strongly agree with giving Mental Health Tribunal's more powers. The changes will support movement towards discharge and improve lives.

We believe that five weeks is an appropriate amount of time in general but there will be occasions where it will unavoidably take longer. Any flexibility needs to be strictly controlled to ensure only legitimate grounds are included. We suggest that extensions of up to a further ten weeks could be allowed subject to a report on progress or further hearing.

There should be sanctions for failure to meet deadlines, such as fines and use of Tribunal powers to summon senior managers of the responsible organisations. It should also be reported to the Care Quality Commission (CQC), who should have a role in monitoring adherence.

Q: Do you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order?

We disagree with this proposal.

We are very concerned about removing any safeguard for patients. This change would remove an option from people as to how and when their detention and care in detention was considered. This goes against the White Paper's emphasis on increasing autonomy and choice.

Managers' panels are less intimidating than tribunals, they are quicker and easier to arrange and patients are more likely to attend. They can look at day to day matters that a tribunal might not. They have a different range of powers and can address shortcomings in how care is being provided due to their position at the heart of the person's detention. If there is a lack of consistency this could be addressed through, for example, a national framework, guidance, and reporting outcomes. Where the panels work well, they are beneficial.

Through targeted recruitment, from among local communities and people with lived experience, there is scope to make these panels stronger drivers of equality and service improvement. We recommend that they are retained and modernised.

While the Independent Review recommended the removal of managers' hearings, this was in the context not only of increased access to Tribunals, but also of its recommendation for a new independent hospital visitor role. This independent visitor would monitor day-to-day life in hospital and ensure patients are treated with dignity and respect.

We are very concerned that the White Paper has accepted the recommendation to remove managers' panels while concluding that this additional scrutiny can be provided by existing organisations with a monitoring role. There must be an independent visitor role, be that through a new scheme or through a modernised associate hospital managers scheme.

4. Strengthening the patient's right to choose and refuse treatment

The right to choose and refuse treatment is central to the reforms. The reforms do not provide this right but they significantly increase the say that the patient has and should reduce the likelihood of forced treatment. We strongly support

them. Clearly, for the right to choose or refuse treatment to be meaningful, people need to be given a real choice in their treatment options.

People should also expect that the full range of NICE-approved therapies will be available to them whether detained or not, as an inpatient or in the community, and culture change within services will also be a key part of this. Shared decision-making needs to become the norm across mental health services and approaches like Open Dialogue which fully involve patients in decision-making about their treatment need to be adopted everywhere. When people wish to try reducing medication, there should be support available for them to do so as safely as possible. Otherwise, people may be tied into a treatment that they disagree with, even after discharge from the MHA, because they don't want to adjust their treatment unsupported, without advice.

The quality of statutory care and treatment plans, including the extent to which they are informed by the patient's wishes, will be influenced by the robustness of tribunal scrutiny and the expectations tribunal panels have of care and treatment.

Safeguards for people who lack capacity to make treatment decisions

The White Paper is not clear about the grounds on which a Nominated Person or Independent Mental Health Advocate can appeal to the Tribunal about treatment – i.e. whether this can be on a best interests basis in any circumstances or only on the basis of the advance choice document.

We share the view of the Independent Review that the Nominated Person or Independent Mental Health Advocate (IMHA) should have the power to apply on the person's behalf where "the patient is unable to do this themselves, and the Nominated Person or IMHA believe that the patient would not agree to that treatment (or the Nominated Person or IMHA themselves has reason to believe the decision is not in the patient's best interests)". This would provide stronger protection to people who lack the relevant capacity and have not expressed their wishes in an advance choice document.

We agree strongly with reducing the three-month period before second opinion authorisation is required but consider that two months is still too long. We recommend reducing it to one month.

Q: Do you have any other suggestions for what should be included in a person's advance choice document?

Inclusion should be entirely voluntary, but people should be prompted to consider including information about:

- things that trigger distress for them and that should be avoided

- things that help calm and soothe or distract
- anything they think it is important for health care professionals to know about them.

Q: Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act?

We agree that the validity of advance choice documents should be the same as under the Mental Capacity Act, in which there is a presumption of capacity.

However, there must be clear guidance on the process for making advance choice documents (ACDs) for children under 16, so that ACDs are an effective safeguard for children who are competent to create one. There is no presumption of competence and no test of capacity for under 16s. Advocates also need to be clear on the process of creating these documents so they can effectively support under 16s.

Q: Do you have any other suggestions for what should be included in a person's care and treatment plans?

The Care and Treatment planning process should be led by the patient's own understanding of their needs. Therefore, the plan should say how the care and treatment is intended to benefit the patient and their recovery, and what needs the plan is seeking to meet.

Care and Treatment Plans (CTPs) should include multi-agency working and meet the needs of people who face multiple disadvantage and who experience a combination of problems including homelessness, substance misuse, and contact with the criminal justice system as well as mental health problems.

There should be a pro forma that captures multi-agency support for children and young people that must be completed.

We welcome that CTPs will be made for children and young people who are informal patients and recommend that these be statutory and on the face of the legislation. Consideration should be given to extending this safeguard to young people aged 18-25.

We assume that the last bullet point ('a plan for readmittance after discharge e.g. informal admission, use of civil sections, or recall by the Justice Secretary') is in reference specifically to Part III patients who have been conditionally discharged.

We can understand that it may be helpful for people who are subject to recall to hospital to know what scenarios would justify recall and what could be managed in other ways. However, the CTP cannot and should not determine how a patient is readmitted. Individual risk indicators may trigger intervention, but formal admissions must have a common reference point of risk and be based on clear legal criteria.

For all patients, the CTP should include how to avoid future crises and the need for involuntary intervention through discharge and aftercare planning and crisis planning. Crisis planning may best be done following discharge.

Planning for discharge and delivery of aftercare are critical. Getting it wrong can lead to a deterioration in someone's mental health and increase suicide risk. Huge improvements are needed to achieve timely, joined up care and support. We strongly support the Independent Review's recommendation for a statutory care plan for everyone receiving secondary mental health services and a joint working duty.

Q: Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?

We agree that patients with capacity who are refusing treatment should have the right to have their wishes respected, even if the treatment is considered immediately necessary to alleviate serious suffering. This is a right afforded to patients in the physical health system and there is no justification for withholding this right within the mental health system.

When we asked people, many of whom have lived experience of the Act and/or mental health problems, 68 percent agreed with the proposed changes.⁵ People told us of their own difficulties in challenging decisions

⁵ 516 respondents agreed out of 759 respondents to the question: 'The changes to the law should make it harder for doctors to override your choices about treatment whilst you are detained under the Mental Health Act. You would have a care and treatment plan that has to say how your views have been taken into account. You could refuse particular treatments, though not

about their treatment. Others highlighted the importance of individuals having agency in decisions about their treatment; taking choice away would only be harmful down the line.

Please see section 9 for a broader discussion of decisions by and about children and young people.

Q: Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?

We agree. This is necessary in order to make the right to appeal against treatment meaningful.

5. Improving the support for people who are detained

Nominated Person

As recommended by the Independent Review, the Government is seeking to replace the ‘Nearest Relative’ with a new statutory role, known as the Nominated Person, who the patient can personally select to represent them. The new Nominated Person will have the same rights and powers to act in the best interests of the patient as nearest relatives have now, with additional rights to be consulted on treatment plans, transfers and other decisions.

Q: Do you agree or disagree with the proposed additional powers of the Nominated Person?

We agree with the proposed additional powers of the Nominated Person.

Q: Do you agree or disagree that someone under the age of 16 should be able to choose a Nominated Person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as ‘Gillick competence’)?

all treatment. You may be able to have your refusal of treatment respected even if your doctor thought you needed it because you were suffering. You would also have a right to appeal against treatment and a judge may be able to stop a specific treatment being given. Do you agree with these changes?’

We agree that competent children should have the same right to choose their Nominated Person as other people detained under the Act. Further work will be required to fully consider its impact and any unintended consequences. For example, it is not clear what will happen if a child chooses a Nominated Person who poses safeguarding risk to them, nor what happens to looked after children where the local authority is corporate parent.

In addition, under the Children Act 1989 parents have ongoing rights and responsibilities for a child until they reach 18. It is unclear how these will interact with those of the Nominated Person, particularly if child or young person chooses someone who is not a parent as their Nominated Person.

We recommend:

- further consideration of how the rights of a parent or carer to receive information interact with the rights of the child or young person when the parent/carer is not the Nominated Person
- further clarification of the role of a Local Authority in relation to the Nominated Person
- processes within the Mental Health Act for where a Nominated Person poses a safeguarding risk.

Advocacy

The Independent Review made a number of recommendations relating to Independent Mental Health Advocates (IMHAs). IMHAs play an important role in ensuring patients are supported and helped to exercise their rights.

Q: Do you agree with the proposed additional powers of IMHAs?

We strongly welcome the proposals in the White Paper on IMHAs. Advocacy is central to the ambitions of the overall reform of the Act; strengthening the powers and role of advocates will enable people to make choices, have a voice, and help make the new rights within the Act effective.

Therefore, it is essential the UK Government ensures the required funding is made available to deliver both high quality advocacy services and their extension to informal patients.

We welcome the prioritisation of the development of culturally appropriate advocacy services. Advocates whose training or lived experience gives them a sharp understanding of racialised issues can ensure that marginalised voices are better heard, and dignity upheld.

There are a number of areas where the proposals need strengthening or to go further:

We strongly support the extension of IMHAs to informal patients and want to see this implemented. Care must be taken to avoid an extension impacting the commissioning of other, non-statutory advocacy services which provide different types of support to people in hospital. When a person is in such a vulnerable position they should not have to take the initiative in requesting an advocate. We know from local Mind IMHA providers who have a presence on the ward that people are more likely to use their service through having seen it and met the people providing it.

We strongly support the Review's recommendation that IMHA referral is on an 'opt-out' basis and want to see this implemented. Care must be taken to ensure it is not offered in a way that undermines the person's autonomy or agency and the person should be able to decline.

Given the seriousness of depriving someone of their liberty, especially at a time when someone might feel least able to make decisions about their treatment and care, or able to make their wishes known, it is unacceptable that such a key support is not automatically provided as of right. There should be an individual, enforceable right to advocacy.

People should have the right to advocacy at the point of assessment. Currently people only become eligible for IMHA once detained. However, that decision itself is a pivotal moment at which people may benefit from the support of an independent advocate. As we detailed in our original submission to the Independent Review, we have heard directly from people from racialised communities of the particular importance of advocacy at the point of detention. Cultural difference compounds the powerlessness inherent in sectioning and having someone who is both there to support you and understands your cultural context should result in a less traumatising experience and better decisions. We see this as an essential part of addressing racial discrimination.

When we asked people, many of whom have lived experience of the Act and/or mental health problems, there was very strong support for being able to have an advocate or someone else you trust with you in the assessment, with 95 per cent of respondents in agreement⁶. People told us it would be reassuring to have an independent, knowledgeable person on your side; someone who would be a witness and make sure things were done correctly. People felt it would have made them feel less alone, as well as making the

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

process fairer and less frightening. Some people thought that if they had had an advocate they would not have been sectioned. For some people it was important to have choice of advocate.

A key issue for the few people who disagreed with this proposal was the possibility of introducing delays, or further delays, into the process and this is an important consideration. However, duties can be made subject to practicability (in the legal sense) and, while face-to-face is to be preferred, recent experience with remote communications makes it more achievable to involve an advocate at this stage.

We recommend:

- piloting advocacy provision at MHA assessments, as recommended by the independent review
- placing a duty on Approved Mental Health Professionals to proactively offer to arrange for someone to be with the person during the assessment, where practicable, in line with the guidance at 14.53 of the Code.

Q: Do you agree or disagree that advocacy services could be improved by: enhanced standards, regulation, enhanced accreditation, or none of the above, but by other means?

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

Resourcing, commissioning, training and support for IMHAs need to match their new legal powers and duties so that IMHAs are able to fulfil them. For example, understanding the consequences of appealing against someone's treatment, should the person regain capacity. It is essential that regulation does not create a barrier to smaller organisations providing services, so that there is diversity among providers and an ability to represent different sections of the community. There needs, therefore, to be a balance between regulatory requirements and valuing what smaller, locally rooted organisations can offer.

6. Community Treatment Orders

Mind is opposed to the retention of Community Treatment Orders (CTOs) within the White Paper. The proposal is to retain them despite research showing that

they do not achieve their aim of reducing readmission⁷. The retention is also despite people telling us that they find CTOs to be coercive and intrusive.

The racial disparity in their use is an example of structural racism in the use of the Act – Black people are ten times more likely to be put on a CTO than White people; people from racialised communities have described them to us as a form of community surveillance. Systemic racism is evident in the fact that such racial disparity emerges not from the intentional actions of individual decision makers. Rather, it is an emergent feature of the ‘normal’ operation of CTOs. This is further evidenced by the fact that CTOs were originally intended as route out of in-patient sectioning disproportionately applied to Black people, as well as to an end to the ‘revolving door’, where people, again disproportionately Black people, were constantly recalled back to hospital following discharge.

Contrary to the anticipated fall in the disproportionate levels of sectioning of Black people, it has perpetuated this disproportionality. Added to this, people are not transitioning from CTOs to full discharge to the extent originally anticipated. Instead, people are left languishing on CTOs for years⁸. This further exacerbates the disproportionate increase in the extent to which Black people are subject to compulsion under the Mental Health Act. Removing CTOs would be a step towards improving trust with communities upon whom they are used disproportionately.

While this power remains available, the evidence of their past use indicates that they are likely to be used in a risk averse way, restricting people’s lives when those people would be better served by the provision of care that actively responds to their needs and wishes.⁹

Therefore, Mind recommends repealing CTOs.

If CTOs are to be retained, there must be practical steps to achieve a significant reduction in their use, which is the stated aim of the UK Government’s proposals. However, the proposed steps need further improvement to achieve this:

- We do not believe the proposals are sufficient to reduce racial disparity; indeed, if, as is generally accepted, biased decisions around risk and lack of tailored care play a part in this disparity, then racial disparity could even increase as a result of the changes proposed.

⁷ Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* 2013;381:1627–33.

⁸ Barkhuizen W, Cullen AE, Shetty H, *et al*
Community treatment orders and associations with readmission rates and duration of psychiatric hospital admission: a controlled electronic case register study *BMJ Open* 2020;10:e035121. doi: 10.1136/bmjopen-2019-035121

⁹ For example the ‘Ethnicity & Mental Health Improvement Project’ in South West London (<http://wcen.co.uk/wp-content/uploads/2020/05/EMHIP-Intervention-Final-1.pdf>)

- We are concerned that the Review recommendations to set a maximum duration for CTOs and allow the Tribunal to change conditions made under the CTO have not been included within the White Paper. We do not believe that putting an expectation of two years' maximum duration in the Code of Practice is enough to change practice.
- The White Paper gives the Tribunal the power to check the justification for CTO conditions and recommend that they reconsider any which they believe are overly restrictive. However, the Tribunal would not even be able to recommend changes that impact on clinical treatment. In our view, the conditions are integral to the CTO and we consider that meaningful appeal must include the conditions imposed by the CTO, both clinical and non-clinical.

7. The interface between the Mental Health Act and the Mental Capacity Act

Mind wants to see people supported to make their own decisions as far as possible, for services to be proactive about engaging with people's wishes and for compulsory powers to be minimised. The legislation needs to be based as far as possible on decision-making capacity consistent with safety (aligned to Article 2 right to life of the Human Rights Act).

One option for addressing the interface issue is fusing mental health and mental capacity law. The Independent Review set out five tests that it said should be met before introducing such law. There should be no delay to the reforms currently proposed, but we would want to see a commitment from the UK Government to take forward exploratory work on fusion law and the five tests which the Review said needed to be met.

Q: How should the legal framework define the dividing line between the Mental Health Act (MHA) and the Mental Capacity Act (MCA) so that patients may be made subject to the powers which most appropriately meet their circumstances?

While there are two distinct legal frameworks it is essential that people in similar circumstances have equivalent safeguards. This equivalence is not obtained between the weaker Liberty Protection Safeguards (LPS), being introduced through amendments to the MCA, and the enhanced safeguards being introduced into a reformed MHA. Specifically, we would want to see:

- Comparable frequency of review mechanism (i.e. the tribunal)
- Comparable ease of accessing the review mechanism
- Comparable levels of independent scrutiny - currently, someone can only access the independent scrutiny of the approved mental capacity professional if they appear to be objecting to the LPS

- Comparable routes to complain – someone does not have a direct channel for raising individual issues with the Care Quality Commission in the same way as those detained under the MHA
- Access to advocacy - there is no automatic right to an independent mental capacity advocate if you are on LPS

We do not agree with using objection as the dividing line. People may be quiet, compliant, resigned, unaware of any options, or lacking the capability to articulate their feelings. People may express their feelings but not have this recognised or acted on as objection. In general, if people are in a mental health hospital for mental health treatment and do not have capacity to agree to their admission, they should be under the MHA which is designed for this purpose.

We recommend that any identified circumstances where the MCA is more appropriate are specifically defined as exceptions to the norm of using the MHA, and that equivalent safeguards are provided. These should include a statutory care and treatment plan.

Q: Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals? Are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

We strongly disagree.

We are very concerned that this would reduce, not enhance, people's say in care and treatment. People would not know what they were agreeing to (the admission may not be like their previous experience), and in the event they may not be able to articulate their objection or it may not be recognised or respected in practice. In effect people would be agreeing to be detained without the safeguards of either the MHA or Mental Capacity Act (MCA).

In *M v Ukraine* [App No 2452/04, 19 April 2012](#), the European Court of Human Rights found that consent to an admission is only valid if:

- there is sufficient and reliable evidence that the person's ability to consent and comprehend the consequences of the admission has been established through a fair and proper procedure; and
- all necessary information concerning placement and intended treatment has been adequately provided to them.

Admissions vary significantly and even if a patient has been detained previously, the circumstances of a subsequent informal admission could be completely different. For example, a patient might be detained in mixed-sex accommodation having previously been in single-sex, or on a ward with frequent use of restraint or seclusion, in a frightening or untherapeutic environment, or far from public transport links, preventing family visits. It is difficult to see how the second point of the *M v Ukraine* test could ever be complied with.

In addition to the loss of safeguards detailed above, we question the efficacy of the 'get out' clause. As explained above, there is often a gap between actively consenting and clearly objecting, where a person may be objecting but find it difficult to express this and/or may be coerced into being compliant (either consciously or unconsciously by staff). Whether or not ward staff consider behaviour to constitute an objection to an admission is likely to be highly subjective.

There is also a potential unintended consequence of preventing people from becoming eligible for s117 aftercare, one of the few enforceable rights to NHS services. Patients who have never previously been subject to s3 and are admitted on the basis of advance consent, cannot become eligible for free aftercare services under s117 thus reducing their opportunity to avoid future crises.

While we recognise the desire of some people to identify in advance the point at which they know, from experience, they will need inpatient treatment, this proposal is not an appropriate way of responding to this need. It is important to find a way better to support this group.

Q: We want to ensure that health professionals are able to temporarily hold individuals in Accident and Emergency (A&E) when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the Mental Health Act (MHA)?

- rely on section 4B of the Mental Capacity Act only
- extend section 5 of the MHA so that it also applies A&E, accepting that section 4B is still available and can be used where appropriate

We are concerned about introducing a new compulsory power, when the main issue is to provide timely assessment. Moreover, the existence of such

a power could impact negatively on people's willingness to seek help from A&E.

We know that for many people, one of the factors that makes a service feel safe and makes them confident to approach it for support, is the absence of any element of compulsion. Therefore, the actual use of the power may further destroy trust and affect the person's willingness to seek help in future.

We appreciate the need and duty to protect life and also that the person may have come to A&E wanting to be kept safe. We would not want to see a person who has self-referred but is not well enough to keep themselves at A&E to receive less help than someone who has been brought to A&E by the police under s136.

There is a stronger case for intervention where the person is thought to lack capacity to decide about being in A&E. We believe the MCA is the appropriate legislation to address this issue and question whether section 4B of the MCA is beyond further amendment. Therefore, there may be a need for a power, but only for a very limited time period and with very robust monitoring.

We recommend:

- Priority is given to ensuring that crisis care and the A&E/liaison psychiatry response in particular are sufficiently resourced, including:
 - a full range of crisis care options including sufficient provision of community options for people who frequently attend A&E as a way of managing high - and high risk - distress
 - sufficient resourcing of A&E and mental health liaison to:
 - meet access standards and not keep people waiting for assessment
 - provide a calm environment in which to wait
 - potentially provide someone to stay with the person to support them.
- Any new power should be time-limited. For these circumstances, 72 hours is far too long. Up to six hours is allowed in the MHA nurses holding power and this should be enough to arrange an assessment.
- The use of any new power should be closely monitored, through both reporting and inspections. It is important to ensure that usage is limited to only those situations where there is strong justification for compulsion.

8. Caring for patients in the criminal justice system

We are concerned that the inclusion of therapeutic benefit in the detention criteria is not extended to patients in the criminal justice system.

Black patients are more likely to be detained through the criminal justice system. This would leave detention, associated forcible medication and access to the courts on a different and detrimental basis for a group of patients where racialised communities are over-represented.

An important clarification is needed on the outlined policy on victims. While we welcome improvements in support for victims, we are concerned that the White Paper refers to allowing victims of unrestricted patients to make personal statements requesting conditions on their leave and discharge. Unrestricted patients are not subject to conditional discharge and responsible clinicians can grant leave without going to the tribunal. Confirmation is needed that there are no plans to change this aspect of the law.

Q: To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28-day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?

We recommend that the time limit is set out in statute. If time is needed for implementation, an implementation date for this provision should be set in statute.

Q: For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty. Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?

We disagree.

It is important to address the needs and rights of people in these circumstances and ensure they have the least restrictive care and the opportunity to live as independently as possible. However, we are concerned that:

- the new power would use the Act for public protection only, not mental health treatment

- it creates an additional step for some patients to go through in getting discharged from compulsory powers, one which could be used in a risk averse and/or racially biased way
- the experience of CTOs suggests that once introduced, such a power would be used more widely than intended
- there is a potential for the power to be used more widely than the small group referred to
- it is unclear what the annual review would actually review, and how patients could progress to discharge.

The specific patient population that would purportedly benefit from this measure could obtain more access to the community via placement, not legislation. Placement in a step-down service that is registered as a hospital would enable the person to gain therapeutically and potentially move towards greater independence, while remaining on section.

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

Q: We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?

It would need to be clear what the criteria were for the order and hence how the person could be discharged from it; also how they could progress towards discharge and on what basis restrictions would be reduced.

9. Children and young people

While the proposed reforms in the White Paper will be available to children and young people, more consideration needs to be given to how they will work. Stronger commitments are needed to ensure the rights of all children in mental health inpatient care are protected. Further consideration also needs to be given to how the proposals align with legislation such as the Children Act 1989 and 2004.

Points about the Nominated Person, advance choice documents and care and treatment plans are in the relevant sections above.

Decision-making

We are disappointed in the UK Government's response about decision-making by and about under 16s. This misses an opportunity to provide clarity for children,

young people and their families on the question of how best to approach Act decisions about them.

It is important to make the new rights and safeguards that are being introduced effective for children under 16 who are detained under the Act. Choosing a Nominated Person, making an Advance Choice Document, or refusing a treatment depend on having the capacity to make that decision. However, the Mental Capacity Act, with its presumption of capacity, does not apply to under 16s, nor is there a presumption of competence or a statutory test for assessing their competence.

There is also a need for greater clarity on the circumstances in which parents can consent to under 16s' admission and treatment. In our view, parental consent should only be relied on in limited circumstances and where the child is not competent to make their own decisions.

We recommend:

- the extension of section 131 of the Mental Health Act to under 16s who are competent to make decisions about their admission. This would enable them to consent or refuse their admission without this being overridden by parental consent, as is the case for 16 and 17 year olds with capacity.
- legislation sets out the situations in which it would be appropriate to rely on parental consent.
- a formal test for assessing Gillick competence is included in the Mental Health Act, with accompanying guidance published.

Out of area placements and admissions to adult wards

NHS data shows that for the past three years over 1,000 children a year have been placed 'out of area', most of whom were detained under the Mental Health Act. In 2017/18, 518 of the 1,255 'out of area' admissions were considered to be 'inappropriate', based on an assessment of the child's clinical need, their individual preference and any special circumstances.¹⁰

It is also of concern that under 18s continue to be admitted onto adult wards and, contrary to government policy, such admissions include under 16s. The most recent information from NHS England (for Q2 of 2020/21) shows that 72 under 18s were admitted to hospital during that period. (It is also of great concern that, despite its importance, this remains an area for which there is not reliable and relevant data.)

¹⁰ Figures provided by NHS England in response to Freedom of Information request, 3 September 2020, Ref: FOI-2003-1157432. Of the 1,040 children placed out of area in 2018/19, 1006 (97%) were detained under the Mental Health Act. 'Out of area' relates to the Children's Commissioning Group hub area in which the child lives. The definition of 'inappropriate' did not just look at distance because 'more specialised in-patient services would normally serve a larger geographical area'. See National Audit Office (2018) Improving children and young people's mental health services, para 2.10

We recommend:

- a statutory presumption against children being placed on adult wards
- introduction of the independent Review's recommendations regarding improved CQC oversight
- primary legislation introducing the duty to notify the local authority when a child or young person is placed in an adult ward or out of area, or if an admission lasts more than 28 days. Statutory guidance should make clear that such a notification is trigger for an assessment of whether the child is in need under section 17 of the Children Act.

Data

While much data is broken down by age group, there are still gaps in the available data on children in mental health hospitals, for example experiences and outcomes, waits, reasons for admission, the basis for admission (including whether on the basis of parental consent) and the numbers receiving advocacy support.

We recommend:

- a duty on the Secretary of State to ensure that national data on the experiences of children and young people as mental health inpatients is regularly collected and published.

Resourcing

Proposals in the White Paper and the commitments in the NHS Long Term Plan need to be fully resourced and delivered so that 100% of children and young people in need of support access it.

Please see the Children and Young People's Mental Health Coalition's response, which Mind supports, for more detail.

10. The experiences of people from Black, Asian and minority ethnic backgrounds

One of the key reasons for the Independent Review was the disproportionate use of the Mental Health Act on some Black groups. These disparities are widely known and not new, however previous efforts to address them have failed to make a difference.

The Review, as well as many working within services, acknowledge this disproportionality as institutional and structural racism that requires a sustained and concerted effort to dismantle. We are therefore very concerned about the recent report by the Commission on Race and Ethnic Disparities, whose recommendations on mental health fall far short of the wholesale changes which most in the sector recognise as essential. We therefore urge the UK Government to recognise institutional racism in the mental health system and use of the Mental Health Act and to address it with urgency and commitment.

Without recognition of institutional racism in the mental health system and use of the Act, we will not be able to make the changes required.

In developing our response to the White Paper, we asked people, many of whom have lived experience of the Act and/or mental health problems, whether they believed the proposals would ‘help stop racial discrimination and improve the experiences of people from racialised communities’. Our campaign action was an opportunity to share views, rather than a piece of research, and to encourage maximum participation we did not ask for information about respondents, such as ethnicity. Compared with other areas of the reforms, there was less consensus on this issue. While the majority of people (56%) answered yes, a sizeable number of people weren’t sure and others said no.

<i>Do you think these will help stop racial discrimination and improve the experiences of people from racialised communities?</i>		
Yes	No	Don’t Know
426	73	253

We asked people to explain their responses. Some people told us that the reforms would reduce but not stop discrimination; others expressed doubt that behaviours and practice would change, and that complaints or whistleblowing systems needed to be strengthened to support implementation. Other people argued that wider societal racism needed to be addressed.

These views underline the urgent need for concerted and sustained action across the whole mental health system, from tailored services to protection of rights.

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. Services need to be developed with racialised communities, as exemplified by the Ethnicity and Mental Health Improvement Project in Wandsworth, London. The Patient and Carer Race Equality Framework is central to the proposals and it must be developed and delivered with urgency and expectation.

Communities disproportionately affected by the Act could also play an important part in overseeing the care and treatment of their peers and holding the system to account. A role of volunteer ‘guardian’ has been suggested to us (like an independent observer), that would tap into the very real desire of communities to offer support and lived experience to those they live alongside - a desire seen in community responses to COVID-19, Grenfell and other tragic individual deaths where a community is desperate to prevent similar events happening again. We recommend this idea is explored further, along with the independent visitor scheme proposed by the independent Review.

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 racialised communities. The Black Lives Matter movement last year reignited a long overdue exploration of racism and the urgent need to make institutions truly reflect and serve all members of our multicultural society.

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 Black, Asian and Minority Ethnic led voluntary and community sector.

We recommend:

- the description of the ‘Person as an individual’ principle be explicit about anti-discrimination and anti-racism: a person as an individual means a person in their community
- an explicit requirement is included within the Act to ensure a diagnosis for a ‘mental disorder’ always takes account of the patient’s social and cultural background
- therapeutic benefit is defined as including a full range of appropriate treatments and takes account of cultural identity and other relevant factors, with the objective of treatment being discharge from detention and ongoing recovery
- the introduction of an individual right to culturally appropriate advocacy
- that it 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 when appropriate (i.e. if the person concerned is from a racialised community)
- Aftercare planning be co-produced with the person concerned, and whoever they wish to have involved, and conducted in a culturally competent way
- CTOs be repealed
- Consideration of the ‘guardian’ role outlined above

11. Quality and monitoring

Q: How could the Care Quality Commission (CQC) support the quality (including safety) of care by extending its monitoring powers?

These should include:

- MHA monitoring powers to require institutional information be provided (for example data on admissions, uses of force, ethnicity data)
- A role in ensuring adherence to timeframes for fulfilling tribunal directions
- Advocacy provision as a key part of CQC inspections.