Mind evidence for the Committee on the Mental Health Bill

Summary

- Mind welcomes the Mental Health Bill but there are areas which need to go further.
- Racial disparities should be tackled through the abolition of community treatment orders (failing that, a statutory review), a new responsible person role at local level to oversee race equity, and a duty on the Secretary of State to report annually on progress.
- People's say in their treatment should be strengthened through introducing a right to assessment and treatment, and a right to appeal treatment decisions. Treatment appeal could be trialled in the first instance.
- The bill should be made to work for children and young people by introducing a statutory decision-making test for under 16s. Other measures are set out in the Children and Young People's Mental Health Coalition, of which Mind is a member.
- Amendment text is included as an appendix.

1. Mind warmly welcomes the introduction of the Mental Health Bill [HL] and the opportunity to share evidence with the committee. 54,000 people are sectioned under the Mental Health Act every year. The Bill provides a powerful opportunity to deliver much needed reforms to the Mental Health Act.

2. However, as many MPs and Peers have noted, there are areas of the Bill which need to go further to deliver the truly transformational change the mental health system desperately needs. The Bill must be stronger and more ambitious to tackle the serious racial disparities enabled by the Act, provide better support for almost a thousand young people detained each year, and give people more say in their treatment.

3. Mind has identified three key areas where the Bill must go further:

- Tackling racial disparities in how the Act is used
- Strengthening people's say in their treatment
- Making the Bill work for young people.

4. Our evidence focuses primarily on these three priority areas. However, we have also detailed changes we support that other organisations or parliamentarians are calling for.

Tackling racial disparities in how the current Mental Health Act is used

5. A primary driver of the review into the Mental Health Act was the shocking racial injustices in the use of the Act. Black people are over 3.5 times more likely to be detained

under the Mental Health Act than White people, and over 7 times more likely to be placed on a Community Treatment Order.

6. Experiences and outcomes are also on average worse for people from racialised communities. Black or Black British people are more likely to be detained for longer and to experience repeated admission. They are also more likely to be subject to police powers under the Act and experience higher levels of restraint compared to White people.

7. There are some measures in the Bill that should have a positive impact for people from racialised communities, for example the introduction of advance choice documents. However, the Bill in its current form only scratches the surface on addressing racial disparities in the current Act. It fails to take on many of the recommendations from both the independent review of the Act and the prelegislative scrutiny committee that were aimed at addressing racial inequalities.

Community Treatment Orders

8. A Community Treatment Order (CTO) allows a responsible clinician to discharge a detained patient from hospital while imposing conditions and retaining the ability to recall the patient to hospital.

9. Black or Black British people are over 7 times more likely to be placed on a Community Treatment Order than white people. Black people have shared with us their anger at the disparities in the use of CTOs, with some characterising the powers as 'race surveillance'. CTOs were supposed to provide a route out of disproportionate sectioning but have perpetuated and exacerbated Black people's subjection to compulsion under Act.

10. Research shows that CTOs don't achieve one of their primary aims, reducing readmission, nor do they reduce the amount of time people spend in hospital. People have told us that CTOs are coercive and intrusive while being hugely unsupportive.

11. People don't know what needs to happen for them to come off the CTO. As one person with lived experience told us, a CTO can feel like "a tag that nobody can see but you know it's around your mind."

12. Mind supported the successful amendment passed in the House of Lords which introduced a maximum duration of 12 months for CTOs. This must be retained in the House of Commons. However, we want the Bill to go further by either abolishing CTOs or establishing periodic statutory reviews of CTOs.

13. The Joint Committee on the draft mental health bill concluded that CTOs should be abolished for people under part II of the Act (civil sections). For people under part III of the Act (criminal justice sections) they recommended the bill include a statutory review of CTOs, with a provision to abolish them unless the government legislated to keep them.

14. The Mental Health Bill should be amended to abolish Community Treatment Orders for all patients. In their place, we want to see the Bill introduce rights to assessment and treatment, and community mental health services to be resourced to provide intensive, tailored care that meets people's needs.

15. If this amendment is not accepted, the Bill should at least introduce a statutory periodic review of CTOs. This would require the government to undertake a review of the continuing use of community treatment orders within two years of the Act being passed. A review would then be required to take place at set intervals for as long as CTOs continue to exist under the Mental Health Act.

16. We are concerned about the Government amendment to remove the House of Lords amendment which introduced a 12-month maximum duration for CTOs. We believe that the House of Lords amendment should be retained.

A responsible person role to oversee race equity

17. The Bill should also introduce a new 'responsible person' role at the hospital level to oversee race equity in the operation of the Mental Health Act. This was recommended by the pre-legislative scrutiny committee and is supported by Mind.

18. Having a responsible person role, who is an identifiable and senior individual within a provider's structure, will create a clear accountability mechanism for the policies, training and action plans that would bring down disparities at a local level.

19. The person in the role would have responsibility for monitoring data and overseeing workforce training and policies to address bias and discrimination in the use of the Mental Health Act. Having an identifiable responsible person would also assist patients and their families in understanding who is responsible at a local level for addressing racial (and other) injustices they may experience.

20. The government has argued that a responsible person role may duplicate existing roles and duties such as those under the Equality Act, PCREF, or those delivered by CQC. However, the responsible person would be an individual working at a local (or Trust) level. They would have responsibility for local policies, training and monitoring of inequalities. There is currently no equivalent local role and introducing one would not duplicate existing functions. The role would assist providers in complying with PCREF and their Equality Act duties.

21. The responsible person would assist in implementing measures in the bill that have the potential to advance race equity, such as advance choice documents and opt-out advocacy. These measures are much more likely to succeed if there is someone tasked with ensuring that the mental health unit / service implements the Act.

22. The responsible person role would provide a practical means to help ensure that the Mental Health Act reforms are put into practice in a way that reduces racial disparities, as the government intends.

Reporting duties on race equity

23. There is insufficient collection and reporting of data on the experiences and outcomes of people from racialised communities under the Mental Health Act. This hinders the government and stakeholders' ability to oversee and scrutinise the progress being made in reducing racial disparities in the use of the Act.

24. The Bill should introduce a duty on the Secretary of State and Welsh Ministers to review and report annually on the use of treatment and detentions broken down by protected characteristics. This will enable us to understand whether reforms are fulfilling their intended purpose of bringing down inequalities, and what further action may be needed.

Patient and Carer Race Equality Framework

25. We also support putting the Patient and Carer Race Equality Framework (PCREF) on a statutory footing. The PCREF is the first national programme to address the longstanding and deeply entrenched racial inequities in mental health services systematically. It supports both local and national work to build a more culturally competent workforce, in more equitable organisations, with transparency and accountability to communities. Giving it statutory backing would help build and maintain momentum and support its consistent implementation across all providers.

Strengthening people's say in their treatment

A right to assessment and treatment

26. The overwhelming message we heard during the independent review of the Mental Health Act was that people could not get the mental health support they needed when they asked – or were crying out - for it. Either they weren't taken seriously, or the options weren't there. People are too often refused help in the community and are then detained in hospital against their will when their mental health deteriorates further.

27. People from racialised communities are especially affected. We hear repeatedly about how they struggle to access culturally appropriate support in the community.

28. There is also a lack of support in the community when people leave hospital, putting their recovery and safety at risk.

29. The Mental Health Bill should give people the right to assessment and treatment for a mental health problem, similar to existing rights in the Care Act 2014. More accessible and responsive services are essential, but an individual right is also needed to empower people.

30. A right to assessment and treatment, coupled with a greater range of service provision, would strengthen people's voices when trying to get help. Help should be from services that are inclusive and tailored to people's needs, especially for those from Black and other minoritised communities. Only then can we reduce the number of people reaching a crisis point in the first place and avoid unnecessary detentions.

31. The Mental Health Bill should introduce a right to assessment and treatment for mental health supported by guidance which shows how the right should be implemented to ensure respect for equality and cultural appropriateness. This would include a duty on local authorities, NHS hospitals and community mental health services (according to where the request was made) to carry out an assessment of a person's mental health needs for care, support and treatment. The person would have a right to receive the treatment assessed to be needed. It would be voluntary – a person who was referred by someone else could refuse the assessment.

A right to appeal treatment decisions

32. Currently, if you are detained under the Mental Health Act, you can't challenge decisions about your treatment, as distinct from your detention, except through judicial review. This route is very difficult and rarely used.

33. Oversight of involuntary treatment is limited, but medication can have very serious adverse effects. Currently, you can be given medication without consent for the first three months of detention. This can be administered by force. Many people experience side effects from medication and these effects can be very serious, for example affecting the heart, vision, weight, muscle movements, or blood. Some people know from experience which medications they find better or worse. Being able to challenge treatment without consent is essential to support people's human rights.

34. A right to appeal against a treatment decision should be added to the Bill. A tribunal judge would be able to hear appeals where both the responsible clinician and second opinion appointed doctor had overridden a patient's refusal of a specific treatment. The judge could ask the clinician to reconsider treatment or prevent a specific treatment from being given.

35. The judge would have to give permission for an appeal to be heard. And if the reforms to the Mental Health Act work as intended, people's wishes are more likely to be respected in the first place. This should mean the number of appeals would be manageable.

36. This recommendation was made by the Independent Review of the Mental Health Act. Valid concerns have been raised about how it would work in practice, so we recommend that the bill include a provision for piloting this in the first instance, as recommended by the Joint Committee on the Draft Mental Health Bill. This approach was successfully used for an extension of powers of the First-tier Tribunal Special Education Needs and Disability (SEND) in a national trial running between 2018-2021.

Advocacy provision

37. People's say in their treatment would also be strengthened by further reforms to advocacy provision: providing independent mental health advocacy to all mental health inpatients on an opt out basis, requiring advocacy to be culturally appropriate, and mandating data collection on the use of advocacy services.

Making the Bill work for children and young people

38. Children and young people who are detained under the Mental Health Act 1983 should be guaranteed the same rights and safeguards as adults. The Mental Health Bill falls short of this in several key areas.

A statutory decision making test for young people under the age of 16

39. A person's ability to decide is integral to the reforms the Mental Health Bill seeks to introduce. One of the four key principles of the Bill is "Choice and autonomy" and the Explanatory Note to the Bill states that the reforms included in the Bill are to "Strengthen the voice of patients – with measures that aim to increase the role of the patient in decision-making regarding their care and treatment".

40. As such the Bill places greater emphasis on the views of individuals with the capacity or competence make the relevant decision, for example choosing who they would like to take on the role of the Nominated Person (clause 24 and Schedule 2) and determining whether someone should benefit from enhanced safeguards before treatment can be given (clause 13).

41. However, children aged under 16 are at risk of not benefitting from these important reforms because there is no statutory decision-making test or framework for assessing whether they are competent. This is in stark contrast to those aged 16 and over, for whom the Bill refers to the Mental Capacity Act (MCA) 2005, which sets out a test to be applied for assessing a person's capacity.

42. Without an amendment to the Bill to introduce a test to determine a child's ability to make decisions, it is unclear how the reforms will operate for children aged under 16. The Children's Commissioner for England noted that whilst many of the provisions of the Mental Health Act hinged on a patient's capacity or capacity, there was no consistent criteria to test a child's decision-making ability. She recommended that the new Mental Health Act should establish a test for assessing children aged under 16's competency to make decisions and give consent[1].

43. Including an amendment that provided a test for assessing children aged under 16's ability to make decisions would also provide much needed assistance to professional who will be asked to implement these reforms but do not currently have a "consistent approach to establishing competence"[2]. This includes:

- Clinicians who are determining which processes and safeguards to implement when a child is refusing treatment.
- Approved Mental Health Professionals (AMHPs) who must determine whether they need to appoint a nominated person on a child's behalf.
- Independent Mental Health Advocates (IMHAs) who can be asked to certify that a child has competence to appoint a nominated person.

44. This need for clarity in how to assess decision making for children aged under 16 was also recognised by the Joint Committee on Human Rights which noted that "children under 16 may be denied the opportunity to benefit from the rights provided by the Bill if their ability to make decisions for themselves is not properly assessed. Clarity in such assessments is therefore important"[3].

45. A clear and consistent approach to assessing a child's competence can only be achieved by including a test in the Bill. The Code is not the right place. This is because the courts have made clear that codes of practice, such as the Mental Health Act Code, should reflect the law (set out in legislation and case law) and cannot create law. The Code can only provide guidance. This means that while any departure from the Code would need to be justified, the Code cannot require professionals to assess competence in the manner suggested by the Code. Accordingly, unless the test is set out in the Bill, there will be no requirement to apply the test set out in the Code, so the current inconsistencies in how a child's competence is assessed are likely to continue.

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[1] Children's Commissioner for England, Children's mental service 2023 – 2024, May 2025, p. 115
[2] Modernising the Mental Health Act (Final report of the Independent Review of the Mental Health Act 1983), December 2018, page 174
[3] Joint Committee on Human Rights, Legislative Scrutiny: Mental Health Bill, Third Report of Session 2024 - 25, May 2025, paragraph 106

46. In Mind's view, the Bill should include a test for whether a child aged under 16 is able to make decisions, namely whether they are able to understand, retain, use and weigh the relevant information, and to communicate the decision. This approach reflects the functional element of the test for lacking capacity under the MCA 2005[4] and is therefore familiar to professionals working in mental health services. The test should be limited to decisions made under the Bill and the Mental Health Act 1983. Crucially, the test would only be concerned with the question of the child's ability to decide, not what happens once that has been determined. What happens once it is known whether the child is competent to make the decision is provided for by other parts of the Bill and/or the Mental Health Act 1983.[5]

47. During the debates in the House of Lords, the Government made statements suggesting that the courts had made clear that the approach of the functional test within was not suitable for children and/or that there was no consensus in the courts as to whether. Mind is not aware of any court decision that supports this position[6], rather we can point to cases where judges have adopted an approach to determining a child's ability to decide that is based on the MCA 2005's functional test[7]. The Government also suggested that the functional test was not compatible with the United Nations Convention on the Rights of the Child (UNCRC). Mind disagrees with this analysis and believe that the inclusion of the functional test in a statutory decision-making test for under 16s would provide a means of assessing the child's ability to make decisions for him or herself and would therefore help to ensure that "the views of the child are given due weight in accordance with the age and maturity of the child" as required by Article 12 of the UNCRC.

48. As such, we consider that a test based on the functional element of the test for lacking capacity under the MCA 2005 is not only the most appropriate test, but is absolutely fundamental to ensuring that children aged under 16 are able to benefit from the reforms and safeguards in the same way as everyone else. Without an amendment to the Bill to introduce a test to determine a child's ability to make decisions, these potentially positive reforms are at risk of being illusory in practice.

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[4] This approach has also been recommended by the Law Commission for decisions related to children's social care in their consultation on Disabled Children's Social Care para 21.27

[5] The Bill makes numerous references to 'competence'. In addition, the current provisions of the Mental Health Act 1983 refer to competence in relation to children aged under 16 who are subject to community treatment orders ("CTOs"). For example, Part 4A refers to "Child community patients lacking competence" (section 64F).

[6] It is possible that the Minister's comments were based on the decisions in *NHS Trust v X (In the matter of X (A Child) (No 2))*[6] and *Bell & Anor v The Tavistock and Portman NHS Foundation Trust*.[6] The judgments in both cases referred to the assessment of a child's competence and the relevance of the MCA 2005. However, it is not clear whether the comments made by the judges in these cases were directed to the use of the functional test for children aged under 16.

[7] *Re S (Child as parent: Adoption: Consent,* Cobb J adapted the functional test to determine the ability of a child aged under 16 to make the relevant decision (the adoption of her child).[7]

Additional safeguards for children and young people

49. The Bill includes very little protection for children and young people placed in inappropriate environments such as adult wards and far from home. We believe this is a significant gap in the Bill's provisions.

50. Guidelines say that under-18s must only be admitted to adult wards in exceptional circumstances, but it is happening too often. In 2022/23 almost 200 children and young people were admitted to adult wards (CQC, 2024). Children and young people on adult wards are not receiving care tailored to young patients, have limited access to educational opportunities, and miss out on peer support.

51. Peers debated this at length during the Bill's progress through the House of Lords. In response, the UK government tabled an amendment requiring the Secretary of State to review whether current safeguards against inappropriate placements remain adequate. Mind believes this is insufficient and that safeguards must be included in the Bill.

52. To make the reforms to the Mental Health Act work for children and young people, and provide additional safeguards against poor care, the Bill should be amended to strengthen safeguards to ensure that admission to an adult ward or out of area only happens in the best interests of the child, and that they receive age appropriate care.

53. Mind is a member of the Children and Young People's Mental Health Coalition and endorses the evidence they have submitted to the Committee as well as their amendment in Appendix A of their evidence to ensure age appropriate treatment on adult wards.

Mind are also supportive of the following changes to the Bill proposed by other organisations or parliamentarians.

54. Human Rights Act – we support the Government amendment to ensure that the remit of the Human Rights Act 1998 covers private care providers when providing certain services arranged or paid for by public authorities.

55. Mental health commissioner – this would be a new national leadership role, helping to drive the ongoing process of reform and ensure accountability for implementation. It would complement existing roles and structures.

56. Resourcing - the reforms' success depends on ensuring that the NHS, Ministry of Justice and local authorities have the workforce and resources they need to implement them. We're supportive of amendments seeking to achieve this.

57. Formal debriefing by IMHA – the House of Lords agreed an amendment to ascertain and learn from patients' experiences of hospital treatment through the offer of a consultation with an independent mental health advocate following discharge from hospital. We're supportive of this amendment, with sufficient resourcing, as it would strengthen patients' voices and enable providers and professionals to improve and/or maintain their standards of care. We're therefore concerned about the Government's amendment to remove this from the bill.

June 2025

Appendix: Amendment text

This appendix contains text for amendments on:

- Decision making for under 16s
- Community treatment orders
- Responsible person / duty on SoS to report
- Right to care, support and treatment
- Pilot of treatment appeals.

Decision making for under 16s

Rationale: Many of the safeguards set out in the Mental Health Bill rely heavily on consent, capacity and competence to make decisions. For those aged 16 and above, the test for assessing capacity is set out in the Mental Capacity Act 2005. However, there is no test for determining whether an under 16 year old can make a decision about their care. This is of huge importance because unless those aged under 16 demonstrate that they are able to make the particular decision, they are assumed to be unable to do so. Accordingly, without a framework in place, children and young people aged under 16 will not benefit fully from the rights and safeguards included in the Bill. For example, a lack of a decision-making framework will impact on determining whether an under 16 year old can exercise their right to choose a Nominated Person (or terminate their nomination) and to access enhanced safeguards around treatment. It will also be a crucial factor in determining whether or not they can consent to informal admission.

Explanatory statement: An amendment to insert a test for determining a child's ability to make decisions (competence) under the Mental Health Act

After Clause 54 insert -

Clause 55 Determination of ability to decide for persons under 16

(1) For the purposes of this Act, a person aged under 16 (referred to in this section as a child) is able to make the relevant decision if they can:

    a. Understand the information relevant to the decision;
    b. Retain that information;

c. Use or weight that information as part of the process of making the decision;
d. Communicate their decisions (whether by talking, using sign language or any other means).

(2) Where a child is able to decide in accordance with paragraph (1) above, that child will be competent for the purpose of this Act
(3) A child is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).
(4) A person determining a child's ability to decide under this section must
  (a) have due regard to Article 12 of the United Nations Convention on the Rights of the Child adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 ("the Convention")
  (b) Must be able to show reasonable grounds for their belief that the child is or is not able to make the relevant decision.
(5) Before the Tribunal, any question whether a child is able to make the relevant decision within the meaning of this Act must be decided on the balance of probabilities.

Community Treatment Orders

Rationale: CTOs are ineffective, coercive and discriminatory. Black or Black British people are over 7 times more likely to be placed on a Community Treatment Order than white people. CTOs were supposed to provide a route out of disproportionate sectioning but have perpetuated and exacerbated Black people's subjection to compulsion under Act. The Joint Committee on the draft mental health bill also concluded that CTOs should be abolished for people under part II of the Act (civil sections).

Option 1 – Abolish CTOs

Explanatory statement: This clause amends the Mental Health Act 1983 and removes the responsible clinicians' s power to discharge a detained patient onto a community treatment order and other associated powers relating to CTOs

After Clause 4, insert -

Clause 4A Abolition of Community Treatment Orders

(1) Part 2 of the Mental Health Act 1983 is amended as follows -
(2) omit section 17A

OR

Option 2 – Introduce a statutory periodic review of CTOs

Explanatory statement: This amendment requires the Secretary of State to initiate a review of the continued use of community treatment orders and their impacts, and to repeat such review every 5 years.

After Clause 4, insert -

Clause 4A Duty to review CTOs

(1) Within two years of the day on which this Act is passed, the Secretary of State must arrange for a review of the continuing use of community treatment orders.

(2) Thereafter the Secretary of State must arrange for a review of the continuing use of community treatment orders every five years.

(3) The review in subsections (1) and (2) must include—

(a) the impact of community treatment orders on people from different ethnic minority backgrounds,

(b) the effectiveness of the continued use of community treatment orders in preventing readmission to hospital and detention under the 1983 Act,

(c) an assessment of whether community treatment orders provide net therapeutic benefits to patients, and

(d) a recommendation on whether the use of community treatment orders should continue.

(4) The review in subsections (1) and (2) must be published in a report.

(5) The Secretary of State must lay any report published under subsection (4) before both Houses of Parliament."

Responsible person/duty on SoS to report

Rationale: A primary driver of the review into the Mental Health Act was the shocking racial injustices in the use of the Act. Black people are over 3.5 times more likely to be detained under the Mental Health Act than White people, and over 7 times more likely to be placed on a Community Treatment Order. Experiences and outcomes are also on average worse for people from racialised communities. Black or Black British people are more likely to be detained for longer and to experience repeated admission. They are also more likely to be subject to police powers under the Act and experience higher levels of restraint compared to White people. The Mental Health Bill should introduce a new 'responsible person' role at the hospital level to oversee race equity in the operation of the Mental Health Act. The person in the role would have responsibility for monitoring data and overseeing workforce training and policies to address bias and discrimination in the use of the Mental Health Act.

Explanatory note – introduces a new responsible person who will be responsible for addressing racial disparities (and other inequalities) for people admitted to inpatient wards or subject to compulsory powers in the community and introduces a new duty on the Secretary of State/Welsh Ministers to publish an annual report on the progress made in reducing inequalities in the use of the Act.

After Clause 54, insert -

Clause 55 – Addressing and reporting on racial disparities and other inequalities in the use of the Act

In the Mental Health Act 1983, after Part 9, section 120D, insert -

Part 9A

Addressing and reporting on racial disparities and other inequalities in the use of the Act

Section 120E Mental health units and services to have a responsible person

(1)A relevant health organisation that operates a mental health unit or community mental health service for qualifying patients must appoint a responsible person for that unit or service for the purposes of addressing racial disparities and other disparities based on protected characteristics

(2)The responsible person must—

(a)be employed by the relevant health organisation, and

(b)be of an appropriate level of seniority.

(3)Where a relevant health organisation operates more than one mental health unit or service, that organisation must appoint a single responsible person in relation to all of the mental health units or services operated by that organisation.

(4) A patient is a qualifying patient if he is–

(a)liable to be detained under this Act (otherwise than by virtue of section 4 or 5(2) or (4) above or section 135 or 136 below);

(b) subject to guardianship under this Act

(c)a community patient

Section 120F Policy on racial disparities and other disparities based on protected characteristics

(1)The responsible person publish a policy on how the unit plans to reduce racial disparities and other disparities in that unit or service

(2) The policy provided under subsection (1) must cover the following topics—

a) the application of the guiding principles to all aspects of operation of the Act
b) staff knowledge and competence in connection with promoting equality and anti-discriminatory practice in relation to the Mental Health Act
c) workforce demographics, recruitment, retention and progression
d) implementation of the PCREF (England only) and any other requirements of relevant national policies
e) care planning and decision-making in the use of the Act including section 56A
f) the availability of alternatives to detention and involuntary treatment
g) take-up of independent mental health advocacy
h) the cultural appropriateness of independent mental health advocacy
i) access to and use of advance choice documents
j) what steps will be taken to reduce racial disparities and other disparities in that unit or service.

(3)Where a responsible person is appointed in relation to all of the mental health units operated by a relevant health organisation, the responsible person must publish a single policy under subsection (1) in relation to those units or services

(4)Before publishing a policy under subsection (1), the responsible person must -

(a) consult any persons that the responsible person considers appropriate;
(b) have regard to the following matters -

(i)the views, wishes and feelings of people from racialised communities who have been detained
(ii) the views, wishes and feelings of people with other protected characteristics who have been detained

(5)The responsible person must keep under review any policy published under this section.

(6)The responsible person may from time to time revise any policy published under this section and, if this is done, must publish the policy as revised.

(7)If the responsible person considers that any revisions would amount to a substantial change in the policy, the responsible person must consult any persons that the responsible person considers appropriate before publishing the revised policy.

Section 120G Training in racial disparities and other disparities based on protected characteristics

(1)The responsible person for each mental health unit or service must provide training for staff that relates addressing racial disparities and other disparities based on protected characteristics in that unit or service.

(2)The training provided under subsection (1) must include training on the topics covered in section 120F(2)

(3)Subject to subsection (4), training must be provided—

(a)in the case of a person who is a member of staff when this section comes into force, as soon as reasonably practicable after this section comes into force, or

(b)in the case of a person who becomes a member of staff after this section comes into force, as soon as reasonably practicable after they become a member of staff.

(4)Subsection (3) does not apply if the responsible person considers that any training provided to the person before this section came into force or before the person became a member of staff—

(a)was given sufficiently recently, and

(b)is of an equivalent standard to the training provided under this section.

(5)Refresher training must be provided at regular intervals whilst a person is a member of staff.

(6)In subsection (5) "refresher training" means training that updates or supplements the training provided under subsection (1).

Section 120H Recording of use of the Mental Health Act 1983 broken down by race and other demographic information

(1)The responsible person for each mental health unit or service must keep a record of the use of the Mental Health Act 1983, broken down by race and other demographic information

(2)The record must include the following information—

(a)the number of people admitted (including as informal inpatients)

(b) the number of people received into Guardianship

(c) the number of community patients

(d)the reason for each admission, Guardianship or in the case of a community patient, the community treatment order

(e)the duration of each admission, Guardianship or in the case of a community patient, the community treatment order

(f)the protected characteristics of the patient (if known);

(g)the patient's mental disorder (if known);

(h)whether the patient has a learning disability or autistic spectrum disorders;

(g) whether patient choice was overridden (in relation to admission or treatment)

(j) where the patient is detained what alternative to detention were considered

(3)The responsible person must keep the record for 3 years from the date on which it was made.

(4)This section does not permit the responsible person to do anything which, but for this section, would be inconsistent with—

(a)any provision of the data protection legislation, or

(b)a common law duty of care or confidence.

(5)In subsection (4) “the data protection legislation” has the same meaning as in the Data Protection Act 2018 (see section 3 of that Act).

Section 120I Statistics prepared by mental health units and services

(1)The appropriate national authority must ensure that at the end of each year statistics are published regarding the data captured in Section 120H Recording of use of the Mental Health Act 1983 broken down by race and other demographic information.

(2)In this section “ the appropriate national authority ” means—

(a)in relation to services or unit whose area is in England, the Secretary of State;

(b)in relation to units or services whose area is in Wales, the Welsh Ministers.

Section 120J Annual report by the Secretary of State

(1)As soon as reasonably practicable after the end of each calendar year, the appropriate national authority must conduct a review of the data collected under Section 120H Recording of use of the Mental Health Act 1983 broken down by race and other demographic information

(2)Having conducted a review under subsection (1), the appropriate national authority must publish a report that includes their conclusions on the progress made in reducing inequalities in the use of this Act on people who have protected characteristics with particular reference to race

(3)In this section " the appropriate national authority " means—

(a)in relation to services or unit whose area is in England, the Secretary of State;

(b)in relation to units or services whose area is in Wales, the Welsh Ministers

Right to assessment and treatment

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

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

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

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

After Clause 54, insert

Clause 55 Right to assessment and treatment

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

"Part 8B

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

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

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

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

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

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

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

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

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

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

Section 125H Refusal of an adult mental health needs assessment

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

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

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

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

(b) there is an authorised person to make the decision on the adult's behalf;

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

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

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

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

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

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

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

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

(subject to any further refusal under this section)

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

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

(1) Where a child or young person presents to, or is referred to, a local authority or NHS hospital or Community Mental Health Service requesting an assessment of their mental health needs, the local authority, or integrated care board must assess –
(a) Whether the child or young person does have needs for care, support or treatment
(b) whether those needs should be met in a hospital, the child or young person's residence or community setting.

(2) Where the parent or carer of a child or young person presents to a local authority or NHS hospital or Community Mental Health Service requesting an assessment of the child or young person's mental health needs, the local authority, or integrated care board must assess –
(a) Whether the child or young person does have needs for care, support or treatment
(b) whether those needs should be met in a hospital, the child or young person's residence or community setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- CASE 1 - the local authority is satisfied, in the case of a refusal given by a young person, that the young person lacks capacity to decide whether to refuse to have the assessment;

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

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

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

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

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

(subject to any further refusal under this section).

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

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

(1)If—

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

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

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

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

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

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

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

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

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

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

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

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

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

(subject to any further refusal under this section).

Pilot of Treatment Appeals

Explanatory statement: This creates a regulation making power that would permit the piloting of treatment appeal in the Mental Health Tribunal

After Clause 33, insert -

Clause 34 Pilot of Treatment Appeals

In the Mental Health Act 1983, after Part V, section 77, insert -

s.77A Pilot of Treatment Appeals

(1) Regulations may make further provision about applications to the First-Tier Tribunal, in particular about the powers of the Tribunal to:

a. Consider and determine questions relating to care and treatment during the course of an application or reference made under sections 66-71 (applications and references relating to discharge)
b. Consider and determine questions relating to care and treatment other than during the course of an application or reference made under sections 66-71 (applications and references relating to discharge)

(2) Regulations may make provision about pilot schemes relating to subsection (1)(a) or 1(b)”