



## **Rethink Mental Illness Consultation Response – Mental Health Act White Paper**

### **Consultation question 1:**

**We propose embedding the principles in the MHA and the MHA code of practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?**

*Your answer can be up to 500 words.*

Rethink Mental Illness welcomes the inclusion of the proposed Principles in the White Paper. We are confident that these Principles will result in a significant improvement in the ways that the Mental Health Act is governed and administered, and the effects that it has on the lives of the people subject to it.

Beyond the legislation itself and the Code of Practice, we suggest that the following settings be required to apply the Principles and embed their use into everyday practice.

Tribunal hearings and other settings where applications for discharge or reviews of detention are considered should be required to note the application of the principles to the care of the detained person, and should hold clinical staff to account on how the principles have been applied across the Care and Treatment Plan, as well as ensuring that they are considered as part of discharge planning.

We would like to see the Principles applied as a clear governing aspect of the Care and Treatment Plan as these are developed, reviewed, and managed. This will ensure accountability and the clear provision of evidence by clinical staff, in order to demonstrate how they have met the principles in their provision of care and treatment. The Care Quality Commission should include reviews of Care and Treatment Plans in their inspections, and should hold providers accountable to whether they have understood and are implementing the principles, as they currently do with the Mental Capacity Act.

Within Advance Choice Documents (ACDs), it may be helpful to provide guidance to providing care in accordance with the Principles alongside examples of Care and Treatment Plans, so that people filling out ACDs can see what kind of care they can request or refuse. Support from an IMHA to fill out an ACD will also be vital.

Beyond these suggestions for embedding the principles, we would also note that it is clear that staff training (at every level) will be a necessary aspect of reform of the Act. We suggest that the lessons of the Mental Capacity Act implementation in 2005,

in terms of the provision of free training by the government, are considered. This could ensure that staff training is shaped around the principles, and that there is a common basis to ensure that they become a part of the working culture on wards.

Finally, we would like to note that the Independent Review of the Mental Health Act and the Principles Topic Group recommended the inclusion of a purpose clause for the Mental Health Act, on the grounds that it would improve clarity for people who are detained (and the staff involved in treating them), assist in the interpretation of complex legislation, and ensure that detention was occurring in line with that purpose. We note that the White Paper does not contain a purpose clause, or suggestions that the government will develop one, and would like to encourage them to do so.

### **Consultation question 2:**

**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?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### **Consultation question 2a:**

**Please give reasons for your answer** (*up to 500 words*).

We believe that the most successful mental health treatment is preventative and community based. We have high hopes for the success of the NHS Long Term Plan in reducing the number of detentions under the Mental Health Act by ensuring appropriate access to community mental health services which will stop people with severe mental illnesses from reaching crisis point.

Rethink Mental Illness believes that the purpose of detention under the Mental Health Act should be to treat a person's mental illness, not merely to detain someone or remove them from society. We remain concerned about reports of people being detained under the Mental Health Act for long periods of time, seemingly without prospect of release and sometimes under regimes that lead to a deterioration in their condition, and support efforts to prevent this from occurring in the first instance.

We believe that the addition of a therapeutic benefit requirement will help to reduce detentions, but it must be accompanied by sufficient high-quality community services which can prevent detentions. We would like to be assured that 'therapeutic benefit' will have a broader meaning within the Act and be reinforced by the Code of Practice, and that this is not merely a requirement for medication, but rather for holistic treatment (including, for example, therapy).

We would be grateful if the government could also clarify that some mental illness which have previously been described as ‘untreatable’ (such as personality disorders, for example) can be managed through specific treatments, and that the addition of this criteria would not make people with such conditions unable to be detained. Considerable misinformation persists around this cohort. We recommend that the Department of Health and Social Care (DHSC) request that the National Institute for Health and Care Excellence review their products on personality disorders, with a view to updating them in line with best-practice clinical information and programmes, in time for any eventual revisions to the MHA Code of Practice.

It should be possible to take for granted that inpatient mental health units are therapeutic environments for all service users. But we still hear from service users and staff that these are not environments which foster recovery, particularly for those with complex mental health needs, and we would hope that this fact will not result in people not being admitted if they need to be. We welcome the funding that has been provided so far, including to ensure that dormitory wards are replaced in inpatient units. We hope that this ambition to update the mental health estate will be extended to repairing and replacing other outdated wards at scale.

Finally, we want to ensure that the meaning of this new criteria is only used to ensure that meaningful and high-quality therapeutic treatment is provided in hospital, not stretched by courts or clinicians to justify long-term detention or ‘warehousing’. We are keen to work with DHSC and others to develop these new criteria and ensure they are not a mechanism to deny or obstruct treatment for people in crisis.

### **Consultation question 3:**

**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?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### **Consultation question 3a:**

**Please give reasons for your answer (up to 500 words).**

Rethink Mental Illness support raising the threshold for detention under the Mental Health Act to ensure that people are only detained if there is a ‘substantial likelihood of significant harm’, provided that it is accompanied by sufficient support in community settings to manage people experiencing severe mental illness and to

ensure that their conditions do not deteriorate to the point where they need detention under the Act to keep them or others safe.

We are concerned that a cohort of people who may have met the previous threshold for detention may find that their conditions are not 'serious' enough to warrant detention under the new proposals, and therefore can only support this proposal if attention is devoted to the kind of comprehensive community mental health support which would ensure that these people are not left behind. As mentioned earlier, we have high hopes for the success of the NHS Long Term Plan in this regard. It is also important to note that some of those no longer detained under the MHA will be in need of voluntary inpatient care: MHA detention should not be seen as the only way to secure inpatient care for those who need it.

We believe this proposal would help to reduce the number of overall detentions under the Mental Health Act, and we support efforts to do so. Reductions in detentions would have the added benefit of ensuring that beds are available for people detained under the Act, that staff time in clinical settings is freed up, and that there are sufficient resources and space to enhance the therapeutic environment for people who are detained. This change will require careful management both to embed across the system and to ensure that it is appropriately supported, particularly with the community provision it will need to embed it.

We agree with the addition of 'welfare' into the detention criteria, in order to cover cases where people are experiencing serious symptoms which might not cross the threshold of threatening harm to themselves or others. We have heard of a number of such cases, particularly regarding people with bipolar disorder for example, who may experience serious non-physical harm as a result of manic episodes. That said, we would like to see how safeguards will be implemented to ensure that this addition does not inadvertently broaden the criteria for detention, as 'welfare' could be interpreted in a variety of ways.

Ultimately, we believe that changes to the detention criteria could make a minor difference to overall detention rates, but that the only way to meaningfully reduce detentions under the Act is through preventative and effective community mental health services.

#### **Consultation question 4:**

**Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal (see [table 1](#) for details)?**

##### **1) Patients on a section 3**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

## 2) Patients on a community treatment order (CTO)

- **strongly agree**
- agree
- disagree
- strongly disagree
- not sure

## 3) Patients subject to part 3

- **strongly agree**
- agree
- disagree
- strongly disagree
- not sure

## 4) Patients on a conditional discharge

- strongly agree
- **agree**
- disagree
- strongly disagree
- not sure

### Consultation question 4a:

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness agree with these proposals for changes to tribunal frequency. Access to the Mental Health Tribunal is one of the most important safeguards that people detained under the MHA, or subject to it within the community, can have. We frequently hear from service users that they feel that the tribunal is essential for ensuring oversight and accountability for their care and treatment, and to provide an independent assessment of the clinical rationale for their detention. While many find the experience of the tribunal to be stressful, the people we engage with and represent understand its vital importance.

The proposals outlined in the White Paper are rationalising and improving access to the tribunal, and we believe that they are fair for service users (who will for the most part see their access improve).

We anticipate that the impact of these changes will be positive overall, and will cut to the heart of improving choice and involvement in line with the ambition of the White Paper and the Independent Review of the Mental Health Act.

Alongside changes to the frequency of tribunals, we would like to ensure that the Mental Health Tribunal has sufficient access and remit to consider the statutory documents which the White Paper suggests, particularly the Care and Treatment Plan and Advance Choice Documents. Routine examination of these documents should become normal practice in the tribunal, as has been the case with the Care and Treatment Plan in Wales since its introduction.

Our advocates welcomed the proposed changes to the frequency of tribunals, but expressed concern that they were potentially counterbalanced by the proposed changes to hospital manager's hearings, which some of them saw as an important and less formal safeguard. That view was in itself balanced by the views of other stakeholders on hospital manager's hearings (as mentioned in our response to question 7a).

#### **Consultation question 5:**

**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?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

#### **Consultation question 5a:**

**Please give reasons for your answer (up to 500 words).**

We understand why this proposal is being suggested, but are concerned that if it were to be incorporated then it would mean that the level of scrutiny over CTOs was being reduced, and that this is contrary to proposals elsewhere in the White Paper about increasing oversight and accountability in order to reduce the use of Community Treatment Orders and ensure that they are managed sufficiently.

We believe that this proposal could be seen to imply that recalls should not be as scrutinised as other aspects of a CTO should be, and are concerned that this sends a troubling message which conflicts with our desire to enhance safeguards wherever possible. We don't believe that the number of CTO recalls which would spark such a tribunal are likely to be large – there were only 206 detentions following a recall from a CTO in 2019/20.

We note that the Independent Review noted that in many instances patients will be moved onto another CTO or discharged following a recall to hospital, and feel that removing the tribunal from these patients would be reasonable. But for those who return to detention, a tribunal (with the enhanced powers suggested in the White Paper) would provide an appropriate safeguard for people who may genuinely need one.

### Consultation question 6:

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 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### Consultation question 6a:

**Please give reasons for your answer** (*up to 500 words*).

We agree that, on balance, this is an appropriate amount of time, but have encountered reasonable concern from people with experience of detention under the Mental Health Act as to whether this is too long a period.

If implemented, we would expect statutory guidance to ensure that this does not become a target for health and local authorities to meet in the provision of all directed services. It's vital that services directed by the tribunal do not become subject to a routine 5-week wait, especially if they are simple or uncontroversial to provide. Guidance will need to be clear, for example, that if leave is directed by the tribunal then it would not normally take up to 5 weeks for it to be provided. We would expect the CQC and others to hold health and local authorities to account for the timely provision of tribunal directions. We would hope that statutory guidance will encourage services to notify patients of progress towards the final provision of that service, in order to keep them informed.

We believe that a 5 week wait for the provision of a complex or specialist service, particularly in the community, could perhaps be necessary, and that the imposition of a maximum waiting time would be helpful to ensure that services are provided where directed. We strongly support this element of the proposals, and believe it would make a significant difference in improving the transition of people detained under the Mental Health Act out of hospital and back into the community. We are also encouraged at the prospect of hospitals being held to account for failing to provide leave when they have been directed to do so, as this is a common issue identified by our advocates.



### Consultation question 7:

**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?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### Consultation question 7a:

**Please give reasons for your answer (up to 500 words).**

The Independent Review of the Mental Health examined evidence around the function, efficacy, and purpose of hospital manager's hearings closely, and came to the conclusion that they should be abolished. After taking evidence from our advocates and drawing on the experiences of staff and service users, we have reached a similar conclusion and so support this proposal.

Our advocates, and a former hospital manager who we engaged with, highlighted the fact that manager's hearings almost never resulted in discharge for the patient, which was demoralising for both the advocates and the patients themselves. With that in mind, they also highlighted the symbolic value of the hearing as an additional safeguard, and some expressed strong views that the hearings should not simply be ended. We have come to the conclusion that while there is value in a symbolic safeguard, there is much more in a practical and realistic one. Given the proposals to enhance the powers of the tribunal and the preparation and stress entailed by any hearing, we are prepared to accept the loss of hospital manager's hearings.

However, we note that the Independent Review concluded that there are examples of good practice occurring across the country within the role of the Hospital Manager, especially where they have broadened their brief to include engaging with people detained in the hospital and improving the quality of detention settings. In some cases, these are combined with non-executive director roles within a Trust. The Review recommended a Hospital Visitors role to maintain these pockets of good practice and to expand and formalise them. We would be disappointed if the removal of the role of the Managers in reviewing discharge requests resulted in the end of this informal quality improvement possibility.

As a result, we recommend that the Department of Health and Social Care and the Care Quality Commission commissions research to look at the prospect of formalising the involvement of lay members of local communities in improving quality within inpatient mental health detention. This research could take lessons from the pockets of good practice that the Independent Review highlighted around the country, and from comparable schemes such as the Prison Visitors scheme, which is funded by the Ministry of Justice.



We note that the White Paper states that the government is looking to existing mechanisms of quality improvement to meet this recommendation from the Independent Review, but we are not aware of any existing mechanism which would play this role in the same way.

We think it important not to miss the opportunity to involve lay members of the community in the life of their local inpatient units, which has the potential to encourage quality improvement in a way that sits below the level of formal regulation by the CQC.

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

Advance choice documents will follow a standard format and approach, and should include the following information about an individual's preferences, including on treatment and non-medical therapeutic approaches, as well as any other information deemed relevant by the individual:

- any treatments the person does not wish to consent to as well as their preferred clinically appropriate treatments
- preferences and refusals on how treatments are administered (for example refusal of suppositories, and preference for care staff of a particular gender, to avoid retraumatising them, given the relationship between gender-based violence and trauma)
- name of their chosen nominated person
- names of anyone who should be informed of their detention, care and treatment (including specific instructions on which individual should get what information)
- communication preferences
- behaviours to be aware of which may indicate early signs of relapse
- circumstances which may indicate that the person has lost the relevant capacity to make relevant decisions
- religious or cultural requirements
- crisis planning arrangements, including information about care of children/other dependents, pets, employment, housing etc
- other health needs and/or reasonable adjustments that might be required for individuals with a disability or learning disability and for autistic people

#### **Consultation question 8:**

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

*Your answer can be up to 500 words.*

Rethink Mental Illness are highly encouraged to see this helpful list of information categories which should be included in standard Advance Choice Documents, and support this effort to improve access to decision making in advance. Strengthening this right for people detained under the Mental Health Act was a major strand of our recommendations in both the *A Mental Health Act Fit for Tomorrow* and the *No*

*Voice, No Choice* reports, so we are pleased to see this proposal included in its current form.

With regard to the Nominated Person category, we would suggest including:

- The option of opting out of having a nominated person
- Whether they wish their nominated person to be consulted on care plans, in addition to rights around detention and discharge

As these will provide key links with our later suggestions on the powers of the nominated person.

We would like to note the following suggestions to accompany the proposed list of standard criteria.

An essential aspect of the process of completing an Advance Choice Document will be ensuring that Staff and service users are made aware of what is legally binding, and what is merely advisory or good practice. The Code of Practice should make this clear for staff and services, and guidance should accompany the document itself aimed at service users and using clear language. An Easy Read version is likely to be essential. It's clear that people will need sufficient support to consider and complete these lengthy documents. We'd like to see support provided by Independent Mental Health Advocates. Where decisions made in the ACD can be overridden, it's vital that the document explains how and why they may be overturned, and what the consequences of that may be. We would request that the document also signposts to Advance Decisions to be made under the Mental Capacity Act, and to guidance around those decisions and their consequences.

We've heard from a number of people with experience of detention under the Mental Health Act that they would like to be able to express a preference for the location in which they would prefer to be treated, if detention and treatment prove necessary in the future. This is partly to assist with crisis planning arrangements (as some locations will enable easier visiting by family members, for example) and partly to facilitate the continuation of closer relationships with staff if possible. It may also permit service users to disclose traumatic experiences in certain services, which would affect their recovery if they were sent back there.

We recognise that there may not always be a free choice between different services, and so a service user's preference for or against a particular location may not always be able to be fulfilled. But providing the opportunity to request a ward or hospital could make a significant difference to the future care of a service user, and could spark further conversations about managing past trauma.

### Consultation question 9:

**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?**

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

### Consultation question 9a:

**Please give reasons for your answer** (*up to 500 words*).

We agree with this approach, which brings the Mental Health Act in line with the approach in the Mental Capacity Act, ensuring simplicity in administering the system and for health professionals in considering the validity of an Advance Choice Document.

While we do not believe an authentication mechanism is a necessary part of the process of making an advance decision, and it may in many circumstances present a barrier to completing an Advance Choice Document, we do believe that authentication would be optimal for many inpatients, not least because it will prevent clinicians from easily overriding ACDs. We therefore support the emphasis in the White Paper on permitting authentication as part of the process but not requiring it. An optional process of authentication should be carefully managed to ensure that it remains truly optional and has the appropriate impact on care and treatment decisions – particularly given that there may be a financial cost if people feel they need to engage a solicitor to ensure that an ACD is appropriately authenticated.

Our *No Voice, No Choice* report (2018) made a strong case for improving access to and understanding of Advance Decisions under the current system among staff and service users, and highlighted a number of barriers to the uptake of Advance Decisions, ranging from a lack of understanding to staff capacity and time.

The subsequent evaluation report of a toolkit we piloted to encourage inpatient mental health units to create Advance Decisions in collaboration with their families, carers, and with staff, showed positive qualitative feedback around the process of creating an Advance Decision. In itself, this process can improve care planning and conversations around the preparation for discharge. But that evaluation also highlighted the complexity of the current law as a major continuing barrier to the implementation of binding Advance Decisions.

We would suggest that, as is the case with the Mental Capacity Act, capacity is presumed to be present for an Advance Choice Document unless proven otherwise. This can be a challenging process on mental health wards, especially where a patient may appear to have fluctuating capacity, so the introduction of ACDs provides an opportunity to reorient the way that staff and services approach choice

and involvement internally. We would like the government to lay out their plans to ensure ACDs are appropriately taken into account by clinicians when they are not authenticated.

Rethink Mental Illness would be happy to support the government in their work to implement statutory Advance Choice Documents, and to share our learnings and experience from the various projects we have conducted to test them over the past few years. We will be encouraging people to make authenticated ACDs if they can do so, given the likelihood of authentication reducing clinical objection to their choices.

We think that a care and treatment plan should include the following information:

- the full range of treatment and support available to the patient (which may be provided by a range of health and care organisations)
- for patients who have the relevant capacity and are able to consent, any care which could be delivered without compulsory treatment
- why the compulsory elements of treatment are needed
- what is the least restrictive way in which the care could be delivered
- any areas of unmet need (medical and social) for example where the patient's preferred treatment is unavailable at the hospital
- planning for discharge and estimated discharge dates (with a link to s117 aftercare)
- how advance choice documents and the current and past wishes of the patient (and family and/or carers, where appropriate) have informed the plan, including any reasons why these should not be followed
- for people with a learning disability, or autistic people, how Care (Education) and Treatment Reviews, where available, have informed the plan, including any reasons why these should not be followed
- an acknowledgement of any protected characteristics, for example any known cultural needs, and how the plan will take account of these
- a plan for readmittance after discharge for example informal admission, use of civil sections, or recall by the Justice Secretary

#### **Consultation question 10:**

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

*Your answer can be up to 500 words.*

We welcome the proposals to introduce statutory Care and Treatment Plans to the Mental Health Act, and believe that these will make a substantial difference to the lives of people detained under the Mental Health Act. We particularly welcome tribunal jurisdiction over the CTPs, and the associated accountability which should see a clear improvement in qualitative and quantitative outcomes for patients.

We suggest that the Care and Treatment Plan is organised around the proposed guiding principles, as a further method of ensuring these are embedded in the care of a person being detained. A CTP could also ask what the therapeutic benefit of proposed treatments will be, what outcomes are envisaged and how they will be measured, which will help to give clarity to patients.

We would ask that copies of CTPs are shared with patients, their Nominated Person with the consent of the patient, and their advocate as a matter of routine. This would help to support the person by make those around them more aware of the outline of their treatment, and would encourage conversations about information-sharing and involvement in care at an early stage.

**Q11. 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?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Rethink Mental Illness agree with this proposal. Under the proposals set out in the White Paper, urgent treatment could still be provided if it is necessary to save the person's life, or meets other criteria around preventing harm to others or a serious deterioration of the patient's condition.

As a result, we are confident that this will not create a loophole whereby people are detained without any treatment being possible. We believe that the right to make meaningful choices about one's care and treatment when detained, particularly if the person has the relevant capacity, also means a right to refuse treatment which clinicians may feel to be advisable or potentially beneficial.

As with all complex medical treatment, the vital approach to ensuring that a patient can make an informed choice is dependent on their understanding of the consequences of the treatment, and the balance of any prospective risks and benefits. We believe that this proposal will make a substantive difference by encouraging detailed conversations about care planning between clinicians and those they care for. The direction of travel with regard to enhancing involvement in care within the White Paper is undoubtedly positive, and we strongly believe that this proposal is a crucial part of it.

For patients who appear to lack capacity, we would highlight the approach outlined in the Mental Capacity Act of ensuring that capacity pertains to the decision at hand, and ensuring that the information needed to make a decision is available and accessible. We have concerns that this process is not fully understood even within services which frequently work with the MCA, and would urge the government to ensure that the implementation of this proposal is accompanied by a substantive programme of training and awareness-raising and that the CQC hold providers to account on their understanding and implementation of this issue.

### Consultation question 12:

**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?**

- **strongly agree**
- agree
- disagree
- strongly disagree
- not sure

### Consultation question 12a:

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness strongly agree with this proposal and the associated process outlined in the White Paper. In addition to providing a clear line of accountability for patients with regard to treatment decisions when they may feel their wishes have been unfairly or wrongly overridden, we believe that the method proposed has the added benefit of being swift and inexpensive to the system.

Overall, we feel that this will ensure that clinical staff are much more likely to engage with a patient on their wishes and preferences with regard to treatment, and to engage in care planning conversations rather than allowing treatment decisions to escalate to the level of the tribunal. It will help to reinforce proposed legal changes around Advance Choice Documents, and should support the integration of high-quality, decision-specific capacity assessments in mental health settings.

We are satisfied that the tribunal judge would not be required to undertake clinical decision-making in terms of proposing treatment, and feel that the proposals are appropriate to ensure that patients are supported to make binding choices in confidence, and that IMHAs and Nominated Persons will be able to bring challenges on behalf of a patient who may lack capacity.

### Consultation question 13:

**Do you agree or disagree with the proposed additional powers of the nominated person?**

- **strongly agree**
- agree
- disagree
- strongly disagree
- not sure

### Consultation question 13a:

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness was founded by carers for people severely affected by mental illness, and we have a long history of campaigning to improve their involvement in the care and treatment of their loved ones. We are proud that our Chief Executive was asked to chair the Topic Group for the Independent Review which devised these recommendations, and are very pleased that they have been adopted in the White Paper.

We strongly support the proposed additional powers for the Nominated Person (NP), which will move the role towards being a collaborative and active participant in the care of their loved one. We hope that these powers will encourage services to engage with NPs, and to use their experience and insight to contribute to care and treatment.

We would recommend that the government consider commissioning pilot programmes to explore the provision of support for NPs in exercising their new responsibilities, as is the case for Relevant Person's Representatives (RPRs) under the Mental Capacity Act. Qualitative engagement conducted by Rethink Mental Illness with our advocates has revealed that Nearest Relatives often struggle with their current role, and in understanding the complex information they are given and the difficult decisions they have to process.

We think that the proposed balance of safeguards for the new powers of the NP is correct, and will avoid the possibility of powers being exercised to the detriment of the detained person. While there is still potential for an inappropriate person to be selected as NP, that potential is greatly reduced from the current system. We note that the Independent Review recommended offering the option to patients to choose which powers (between the new proposed powers and the old system) were given to their NP, on the grounds that some would not want their NP knowing all the details of their care and treatment, and we support this enhanced choice.

We also would suggest that the option of permitting patients to choose what information is received about their care by their carers, families, and NPs is reinstated, as recommended by the Independent Review, and that this could sit separately from the NP/INP system.

Under the Mental Capacity Act, RPRs are required to exercise their powers in the 'best interests' of the person who lacks capacity, and a body of caselaw and guidance has built up around this term. We suggest that the incorporation of such a requirement could be of benefit to both NPs when they are exercising their powers, as well as anyone who supports them, and to the courts or the tribunal if it should prove necessary to displace an NP. We suggest that the government examine the possibility of adding in a requirement for NPs to exercise their powers in the best interests of the detained person.



#### Consultation question 14:

**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’)?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

#### Consultation question 14a:

**Please give reasons for your answer** (*up to 500 words*).

Provided that children under the age of 16 are provided with appropriate support if Gillick competent, in order to make such an important choice, Rethink Mental Illness support this proposal. We would hope that support in these circumstances includes the provision of advocacy support from a children’s advocate and/or an IMHA, and that advocacy support to navigate Mental Health Act detention is made available to children and young people in a consistent manner, as well as to their parents or carers.

Provided that a single consistent approach is adopted by the government, we do not hold a view on whether that approach for assessing capacity should be ‘Gillick’ competence or the Mental Capacity Act.

Our advocates expressed support for these proposals, provided the Nominated Person in question is over the age of 18 and that there is some method of verifying their relationship to a child to ensure that the relationship is not inappropriate.

#### Consultation question 15:

**Do you agree with the proposed additional powers of independent mental health advocates?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

#### Consultation question 15a:

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness are a provider of Independent Mental Health Advocacy services in England, and made contributions to the Topic Group on Advocacy as part of the Independent Review of the Mental Health Act. We strongly support that

proposed additional powers for Independent Mental Health Advocates (IMHAs), as we believe that they will make a significant difference in codifying good practice advocacy which may be happening already. These powers should also ensure that the new ACDs and CTPs can be exercised by those who may lack support from family members or carers, or may lack capacity to do so without the support of an IMHA.

We support permitting advocates to challenge treatment and appeal to tribunals, as we believe these will provide crucial protection for those patients who lack support elsewhere, particularly if there is a relevant ACD for the advocate to work from.

We note that the Independent Review argued in favour of providing IMHA support for patients in the community who are at risk of detention to complete ACDs, and would support proposals to this effect. Our advocates expressed concern that people in the community may miss out on advocacy support otherwise, and that ACDs would be less developed, and perhaps less practical as a result. They agreed that they would be well-placed to support people making ACDs.

Our advocates identified concerns over the availability of advocates if these new powers were to be exercised at scale (and we think that these concerns reflect well-known existing issues with the manner in which different local authorities and private providers commission advocacy services). We would recommend that the government look closely at standardising commissioning for advocacy services in order to support the uniform implementation of these new powers and ensure that the vulnerable people who most benefit from IMHA support are not inadvertently excluded by quirks of the commissioning system.

Ringfenced funding would be another means for ensuring that spend earmarked for advocacy services is actually spent on supporting these proposed new powers. We would recommend that the government strongly consider doing so, especially given the proposals on providing advocacy for voluntary inpatients and the further research looking at 'opt-out' advocacy. Voluntary inpatients are at great risk of experiencing coercion with regard to their detention status, and detained inpatients may simply never be made aware of their right to an IMHA. Rethink Mental Illness strongly support both of these proposals, and will be making a strong case in the approach to the next Spending Review for the requisite funding.

The support of independent advocacy is vital to ensuring that the overall ambition of the White Paper is realised. We believe that both of these additional provisions are vital to ensure that the positive proposals elsewhere are not undermined.

### Consultation question 16:

Do you agree or disagree that advocacy services could be improved by:

**1) enhanced standards**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

**2) regulation**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

**3) enhanced accreditation**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

**4) none of the above, but by other means**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### Consultation question 16a:

Please give reasons for your answer (up to 500 words).

We view independent advocacy as a vital safeguard to ensure that people detained under the Act can exercise their rights, contribute to their care and treatment through meaningful choices, and access the other safeguards which are present in the MHA. Crucially, the value of advocacy is weighted towards those who might otherwise struggle to access other safeguards, either because of the severity of their condition or because they lack other support mechanisms. In order for advocacy to be an effective safeguard for the most vulnerable, we believe that the IMHA role needs consistent national standards, potentially including regulation. That said, we would recommend that the matter is given further scrutiny, with particular consideration given to the constitution of the regulator. The CQC, for example, would not be appropriate as a regulator of advocacy.

Some concern has been expressed by advocacy providers about the potential burden that enhanced standards or regulation may bring to their business. This may particularly have an impact on smaller providers providing local or community advocacy services – precisely the kinds of providers who are best placed to provide models for effective culturally sensitive advocacy services. With that in mind, we suggest that any move towards the above proposals is accompanied with comprehensive support for the advocacy sector, including the provision of free training, financial support to adapt to enhanced accreditation or new regulations, and comprehensive guidance on best practice, which reiterates the case for ringfenced funding.

Our advocates raised concerns that the number of training providers available in the sector is currently very limited, which means a lack of flexibility. It also presents an opportunity to ensure that professional development stems from a single source, and the training providers will be a crucial element of government engagement as the regulations themselves change.

Enhanced standards were the subject of some discussion among advocates, with some making the point that it could raise service user confidence in the service. Others were concerned that people with lived experience of detention or similar may be put off, if for example they had previous convictions, by raised standards. All agreed that at the moment, services are extremely pushed for time, and so would need support for further professional development.

Advocates felt that further professionalisation, including perhaps the incorporation of a professional body could assist them in ensuring that their interventions were taken more seriously within services, which would be of benefit to their clients. But they were keen to stress that the most important aspect of their work was in their independence from the system, and additional formality in the role could potentially risk that independence.

We believe this merits further examination, and that the introduction of enhanced standards, accreditation, and regulation would have the potential to positively transform the advocacy sector if appropriately managed, funded, and implemented through consultation. We welcome consultation on this issue, and are happy to work with the government to further develop these proposals.

#### **Consultation question 17:**

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

*Your answer can be up to 500 words.*

Rethink Mental Illness welcome the opportunity to share our views on the interface between the Mental Health Act (MHA) and the Mental Capacity Act (MCA). This highly complex area of the law is nevertheless vital to the experiences of people who

may be subject to differing legal regimes, and has significant implications for the future direction of travel of mental health law and practice.

We are not convinced by the proposals made by the Independent Review of the Mental Health Act regarding the interface. We have the view that there is a significant risk that non-objecting, non-capacitous inpatients with mental illnesses would be at risk of detention under the Deprivation of Liberty Safeguards, which are soon to be replaced with the Liberty Protection Safeguards (LPS). As we highlighted on numerous occasions during the passage of the Mental Capacity (Amendment) Act, we do not believe that the LPS provides sufficient safeguards for people with fluctuating capacity or who are likely to respond to medical treatment – including people with mental illnesses.

Moreover, we feel that in practice, the concept of objection is extremely difficult to assess and measure. We therefore believe that predicating the Review's proposals on this concept is likely to create more problems than it solves. Given these risks, we feel that the Review's proposed interface is inappropriate.

With that in mind, we propose that the government closely examine the Review's 'five tests' for fusion law, with a view to conducting engagement after the passage of the new Mental Health Bill. There will never be a neat dividing line between the MCA and MHA short of fusion law itself, and while Rethink Mental Illness does not hold a formal position on fusion as a desirable destination, we feel that the 'tests' outlined by the Independent Review merit further work, engagement, and discussion.

In the meantime, we suggest that the interface between the MHA and the MCA remain as it currently is, with clinical choice between the two frameworks as appropriate, and a formal requirement to base that choice on the least restrictive option. We would urge the Department of Health and Social Care and the Care Quality Commission to commit further resources to enhancing and embedding understanding of capacity at a clinical level, and to training clinicians on which legal framework may be more appropriate in specific circumstances.

Rethink Mental Illness believe that the addition of mechanisms related to capacity into the Mental Health Act are a positive step, and that the addition of ACDs, in particular, should help to enhance clinical understanding of capacity in a mental health context. But it remains surprising that fourteen years after the passage of the Mental Capacity Act, the concept is so consistently poorly understood and implemented across mental health settings. Our advocates continue to express their frustration that clinical understanding is so poor on this issue, and only by raising that understanding can the interface between the two Acts be properly applied.

### Consultation question 18:

**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?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Rethink Mental Illness is highly concerned at the prospect of encouraging advance consent to informal admission within the Mental Health Act.

We have a number of concerns with the system of informal detention as it stands, particularly with regard to the prospect of coercion of voluntary inpatients, the lack of safeguards against inappropriate treatment, and the lack of advocacy support to ensure that admission is truly voluntary (rather than simply being recorded as such) and that the person in question is aware of their rights, and aware of the balance of rights and safeguards afforded to a voluntary inpatient as opposed to a detained one.

We have heard from a number of people with lived experience of informal detention about experiences where on reflection they feel that they were coerced into compliance with hospital regimes through the threat of formal detention. The CQC has repeatedly raised issues of locked wards and poor explanations of rights among mental health inpatients in their annual reports, which in itself presents the issue of *de facto* detention among 'voluntary' inpatients. While the proposed right for voluntary inpatients to access IMHAs will help address these issues, a prior consent to admission could blur the line between informal admission and MHA detention, making advocacy more difficult.

We are aware that there is a continuing social stigma attached to detention under the Mental Health Act, and that service users may understandably wish to avoid the shame of being detained under the Act. But we are unconvinced that this stigma is a sufficient reason to propose a mechanism by which people could voluntarily surrender their rights under Article 5 of the Human Rights Act.

We are also aware that there is a group of service users, particularly with cyclic disorders (namely bipolar disorder) who have struggled to get into hospital treatment in the past despite the fact that they knew their condition was deteriorating and wanted early intervention. To an extent we feel that the real issue may be about the struggle that people can sometimes have to access the services that they need, rather than the legal framework for doing so. Nevertheless, for this cohort, we believe that the addition of 'welfare' criteria to the detention threshold will make a substantial difference if it proves that they need detention (because it will permit clinicians to take non-physically dangerous factors into account, such as reckless spending, for example). Otherwise, we would reiterate our support for the NHS Long

Term Plan, and our belief that preventative and supportive secondary mental health treatment should sit in revitalised mental health community services.

Ultimately, we do not believe that this proposal is worth continuing, even with safeguards, and recommend that the government drop it.

**Consultation question 18b:**

**If agree, are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?**

*Your answer can be up to 500 words.*

Rethink Mental Illness will not recommend safeguards for this mechanism as we do not believe it should be implemented.

**Consultation question 19:**

**We want to ensure that health professionals are able to temporarily hold individuals in 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)?**

- 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

**Consultation question 19a:**

**Please give reasons for your answer** *(up to 500 words).*

Feedback from our advocates and others, combined with our general concern for the lack of safeguards available under the Mental Capacity Act, have led us to conclude that section 5 of the MHA should be extended to A&E.

Overall, we are convinced that the purpose of an extension of section 5 would be sufficient to cover these cases, provided it is not extended to allow forced treatment under the Mental Health Act, and that the time limit is not extended. We would also recommend that the Department of Health and Social Care examine how this extension could be integrated with enhanced provision of health-based Places of Safety, as a HBPOS will always be more appropriate for someone awaiting a formal Mental Health Act assessment than detention in an A&E unit for up to 72 hours.

We think that authorising senior clinicians to make use of this extension (providing they receive proper training to do so) is an appropriate safeguard, as our advocates expressed concern that staff without mental health knowledge or training could exercise this power. In practice, this may mean that powers are exercised by psychiatric liaisons, which may be appropriate.



### **Consultation question 20:**

**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?**

- **Yes**
- *No*
- *Not sure*

### **Consultation question 20a:**

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness strongly support increasing the pace of transfers between prisons and IRCs and secure care services. Having conducted engagement with our colleagues in prison services during the consultation undertaken by NHS England on this topic, we believe that a 28-day limit is appropriate and will make a significant difference if supported and implemented correctly. Prisons can exacerbate mental health problems, and we have encountered numerous examples of people who are unwell enough that they are in need of a transfer but not so unwell that this transfer is urgent, leading to delays lasting as long as months while a bed is secured.

We strongly support the introduction of an independent role to manage these transfers, and the implementation of that role is the main safeguard we feel is necessary before the statutory time limit can be introduced. This is in order to maintain the credibility of the time limit, and to ensure that it is appropriately managed from the start.

We have previously raised concerns that people who are transferred to mental health treatment from IRCs are automatically placed at high levels of security simply by virtue of their immigration status, rather than as a result of their mental health needs. We would urge the Home Office to end this practice, and to ensure that people placed into mental health treatment from IRCs are placed in settings which are best-suited to their mental health needs.

Our advocates raised concerns that a 28-day transfer time limit could be interpreted as a minimum target, which could affect those prisoners who might under current circumstances have been transferred more quickly into hospital. This is one reason for our recommendation to introduce the statutory role to manage transfers before the time limit is implemented.

## Question 22

**We want to establish a new designated role for a person to manage the process of transferring people from prison or an immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health.**

**Which of the following options do you think is the most effective approach to achieving this?**

expanding the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison/IRC transfers

creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison/IRC transfer process

an alternative approach (please specify)

*Please give reasons for your answer (up to 500 words).*

Rethink Mental Illness recommends the creation of a new role across NHSEI And HMPPS to manage the transfer process. We are conscious that Approved Mental Health Professionals have significant existing statutory workloads, which are likely to be subject to some changes as a result of the White Paper proposals.

We believe that the management of transfers between prisons, IRCs and hospitals should be prioritised within the prison system, and that the only way to effectively ensure that is the case is if it has dedicated resources and support from NHSEI and HMPPS. While AMHPs may have many of the requisite skills to fulfil this role, we believe that the centralisation of the role itself would make a significant difference in terms of outcomes.

## Consultation question 22:

**Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?**

*Your answer can be up to 500 words.*

Our advocates expressed concern that it is frequently very difficult to make contact with a social supervisor, and expressed support for strengthening the role. We believe that it is likely that this is because of high caseloads for social supervisors employed by local authorities, and low resourcing.

Nevertheless, we support the current practical arrangement for social supervisors, in that the majority are social workers employed by a local authority. We think there are clear benefits to continuing this approach, and believe that embedding the role of the social supervisor as a statutory one on the face of the legislation would bring clear additional benefits. Incorporating this vital role into the Act itself would ensure

sufficient attention is paid to it, including through the setting of professional standards and agreed ways of working.

### **Consultation question 23:**

**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?**

- *strongly agree*
- **agree**
- *disagree*
- *strongly disagree*
- *not sure*

### **Consultation question 23a:**

**Please give reasons for your answer (up to 500 words).**

While this is an extension of mental health treatment and restrictive practices into the community, Rethink Mental Illness agrees with it, as we acknowledge that there is a need to create policy to address case law on this issue. We believe that this proposal should only ever apply to the very small group of people who it is targeted at, and that they should be entitled to sufficient safeguards (including regular tribunal reviews) and community support (including advocacy services) in order to permit them to participate in the community as much as possible.

We would like to highlight the risk inherent in introducing this measure – as the continuing growth in Community Treatment Orders indicates, measures which are created to encourage the safe release of some patients into the community can easily become restrictive or overused interventions with unforeseen consequences. As a result, we encourage the government to keep this mechanism under review, and to collect data on the use of it, with regular reporting.

Regular tribunal reviews of the detention of this cohort would mean frequent opportunities to review the circumstances of their detention, and to reassess whether they can be discharged – as suggested below, we believe this is a necessary addition to the proposals.

Given the significance of this proposal, we would like to engage with it when the government has set out further details of how it will operate in practice. In addition to the safeguards suggested below, further scrutiny of this approach is clearly necessary to ensure that it will be used only when appropriate, and to detail the operation of it in practice.

### Consultation question 24:

**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?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### Consultation question 25:

**Beyond this, what further safeguards do you think are required?**

*Your answer can be up to 500 words.*

We request that this cohort of people be protected with the requirement that forced medical treatment cannot be given under a 'supervised discharge order'. We object to the possibility of allowing forced medical treatment for mental illnesses in community settings, albeit restrictive ones, and would suggest that alternative means are found to provide this cohort with medical treatment if necessary. Non-compliance with treatment should also not automatically result in recall to hospital – as is already the case with CTOs, where non-compliance can be seen as a sign of a worsening condition but is not in itself grounds for a recall.

Following advice from our advocates and Legal and Human Rights Advisory Panel, we also suggest that 'supervised discharge orders' be subject to tribunal reviews every six months, and that patients are provided with ongoing support from an Independent Mental Health Advocate.

### Consultation question 26:

**Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### Consultation question 26a:

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness has no formal position on this issue.

**Consultation question 27:**

**Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

**Consultation question 27a:**

**Please give reasons for your answer (up to 500 words).**

Rethink Mental Illness has no formal position on this issue.

**Consultation question 28:**

**Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people?**

- *Yes*
- *No*
- *Not sure*

**Consultation question 28a:**

**Please give reasons for your answer (up to 500 words).**

Rethink Mental Illness has no formal position on this issue.

**Consultation question 29:**

**We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

**Consultation question 29a:**

**Please give reasons for your answer (up to 500 words).**

Rethink Mental Illness has no formal position on this issue.

**Consultation question 30:**

**Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to people with a learning disability and to autistic people?**

*Your answer can be up to 500 words.*

Rethink Mental Illness has no formal position on this issue.

**Consultation question 31:**

**Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

**Consultation question 31a:**

**Please give reasons for your answer** (*up to 200 words*).

Rethink Mental Illness has no formal position on this issue.

**Consultation question 32:**

**We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### **Consultation question 32a:**

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness has no formal position on this issue.

### **Consultation question 33:**

**We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local ‘at risk’ or ‘support’ register.**

**Do you agree or disagree with this?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### **Consultation question 33a:**

**Please give reasons for your answer** (*up to 500 words*).

Rethink Mental Illness has no formal position on this issue.

### **Consultation question 34:**

**What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?**

*Your answer can be up to 500 words.*

Rethink Mental Illness has no formal position on this issue.

### **Consultation question 35:**

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

*Your answer can be up to 500 words.*

Some of the changes to the CQC’s ways of working, prompted by the coronavirus pandemic, have undoubtedly had positive consequences for people detained under the Mental Health Act. The fact that the CQC are now routinely engaging with advocacy providers for inpatient mental health services has given advocates more of a national voice, and allowed them to raise issues with the regulator. We think that



this should continue, and be formally included in the CQC's monitoring, alongside a return to in-person inspections as soon as possible.

We think that the CQC should monitor and report on the implementation of measures suggested elsewhere in the White Paper. For example, CQC have raised concerns over a number of years about the quality of care plans and the involvement of patients within these. As the system moves to implement statutory Care and Treatment Plans, the CQC should monitor the quality of CTPs, and engage with patients during inspections about the provision of elements of CTPs and their engagement with it. When ACDs are introduced, the CQC should look to extend their monitoring powers to include holding services to account on how they have incorporated ACDs, how they support patients to fill them out, and how requested or refused treatments are integrated into care.

We are aware that the CQC continues to request redevelopment of the mental health estate to improve safety and enhance human rights, for example around privacy. We support this call, and believe that the most significant change to improve safety across the mental health estate would be the redevelopment of antiquated facilities, to remove ligature points and improve lines of sight. Rethink Mental Illness strongly support government capital spending to make changes to the mental health estate, and will be making the case for further spending on an ongoing basis.

Alongside the White Paper we have produced an [impact assessment](#) in which we have estimated likely costs and benefits of implementing the proposed changes to the act.

### **Consultation question 36:**

**In the [impact assessment](#) we have estimated likely costs and benefits of implementing the proposed changes to the act. We would be grateful for any further data or evidence that you think would assist the departments in improving the methods used and the resulting estimates.**

**We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following:**

- different professional groups, in particular:
  - how the proposals may affect the current workloads for clinical and non-clinical staff, independent mental health advocates, approved mental health professionals, Mental Health Tribunals, SOADs etc
  - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
- service users, their families and friends, in particular:
  - how the proposal may affect health outcomes
  - ability to return to work or effects on any other daily activity
  - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered

- any other impacts on the health and social care system and the justice system more broadly

Please provide information (up to 500 words). You can also upload files when you [respond to the consultation](#).

Rethink Mental Illness will separately provide information to supplement the impact assessment on an ongoing basis.