

Reforming the Mental Health Act - response to the public consultation

The following organisations jointly submit this response to the public consultation on reforming the Mental Health Act:

Advocacy Focus
Advocacy for All
Advocacy Services North East Wales
Advocacy West Wales - Eiriolaeth Gorllewin Cymru
Asist Advocacy Service
Blackpool Advocacy Hub
Bristol Mind
Carers Federation
Cloverleaf Advocacy
Community Support Network South London
Connected Voice Advocacy
Disability Advice Service Lambeth
Dorset Advocacy
Jacqui Jobson Consultancy
Kate Mercer Training
Mind in Croydon's Advocacy Service
National Development Team for Inclusion
n-compass
National Youth Advocacy Service
Onside Advocacy Service
People First Independent Advocacy
Rethink Advocacy
Skills for People
South West Advocacy Network
Stockport Advocacy
Swindon Advocacy Movement
The Advonet Group
Vital
VoiceAbility
Warrington Speak Up
York Advocacy Hub
Your Voice Counts

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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?

It is important the principles are integrated into the overall regulatory framework and apply widely including to informal patients. They should also be reflected in specifications for services including NHS England commissioned mental health services and embedded in mental health professionals training.

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

‘Appropriate treatment’ has provided a low threshold and led to continued detention of many individuals who were clearly not benefiting. Further guidance on what constitutes ‘therapeutic benefit’ will be needed in the Code of Practice, to ensure this acts as an appropriate, consistent and sufficiently high threshold, and it should also apply to Part III of the MHA.

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

Overall, we welcome the spirit of the proposal and the objective of tightening the detention criteria. However, we are concerned the addition of the general term ‘welfare’ would broaden its scope and might be interpreted too widely. The government’s arguments in favour of changing the detention criteria for the civil sections of the MHA would appear to apply equally to Part III. The Mental Health Act white paper states that:

“We agree with the Review that the current wording within the Act, that detention is lawful for the interests of the patient’s ‘own health or safety or with a view to the protection of other persons’ is too ambiguous and may have contributed to growing risk aversion amongst some professionals, particularly with regard to patients with a learning disability and autistic people. We want to revise the Act to ensure it is more explicit about how serious harm must be, or how likely it is that the harm will occur, to justify detention and/or treatment.”¹

As the government acknowledges that the current detention criteria are ambiguous, contributing to growing risk aversion by professionals and potentially discriminatory in outcome, it would seem logical that they are not fit for purpose for any part of the MHA. Applying differential thresholds for Part III would have a disproportionate impact on the potential for discharge on those who are over-represented in the criminal justice system, such as black and minority ethnic people,² and also people with a learning disability and autistic people, as currently 2 in every 5 of those detained under the MHA are on a Part III

¹ [Reforming the Mental Health Act - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444444/Reforming_the_Mental_Health_Act_-_GOV.UK_(www.gov.uk).pdf) p.25

² [Layout 1 \(raceequalityfoundation.org.uk\)](https://www.raceequalityfoundation.org.uk/) p.21

section.³ The government needs to consider harmonising detention criteria across all parts of the MHA to avoid the potential for unintended consequences and discrimination.

It is disappointing that the white paper does not support the independent review's recommendation to explore how risk is assessed and weighted by different decision-makers and whether these can be more aligned. The criminal justice system itself is not solely focused on public protection as prison and probation services have objectives in relation to the rehabilitation and reintegration of offenders into the community. If there is concern regarding access to treatment for those in the criminal justice system, more consideration should be given to how they may be able to access hospital treatment on a voluntary basis, where they wish to do so.

Consultation question 4: Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal? (see Table1 for details)

a) Patients on a section 3

Strongly agree/ **Agree**/Disagree/ Strongly disagree/Not sure

b) Patients on a CTO

Strongly agree/ **Agree**/Disagree/ Strongly disagree/Not sure

c) Patients subject to Part III

Strongly agree/ **Agree**/Disagree/ Strongly disagree/Not sure

d) Patients on a Conditional Discharge

Strongly agree/ Agree/**Disagree**/ Strongly disagree/Not sure

Question 4a Please give reasons for your answer.

The independent review recommended automatic referrals should take place once every 12 months for Part III patients⁴ and therefore this should also apply to those on a conditional discharge.

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

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

Strongly agree/ Agree/Disagree/ **Strongly disagree**/Not sure

Consultation question 6a: Please give reasons for your answer.

We support the white paper's proposals that Tribunals should have wider powers to "determine if the current setting represents the least restrictive option or if other options are available that better support the recovery of the patient and their path to discharge".⁵ However, we think this proposal needs to go much further in enabling the Tribunal to perform this role.

³ [Learning Disability Services Monthly Statistics \(AT: February 2021, MHSDS: December 2020 Final\) - NHS Digital](#)

⁴ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](#) p.126

⁵ [Reforming the Mental Health Act - GOV.UK \(www.gov.uk\)](#) p.32

Firstly, it is useful to examine relevant practice elsewhere including the Court of Protection. The Tribunal will need, like the Court of Protection, to be able to exert sustained pressure on public bodies. This will necessitate a change in the Tribunal's mode of operation and the support provided by mental health lawyers, from episodic on-the-day decisions to detain/discharge to one that can re-convene regularly to check progress and exert pressure on public bodies to find solutions.

Further thought should be given to how indicative timescales might operate, which will be needed to maintain momentum, but as formulated in this proposal may not be effective. For example, for people who require community services to be in place to secure their discharge, it would be more effective for the Tribunal to direct that services be secured, or milestones achieved, in a timescale which it deems to be appropriate, rather than receive a positive or negative response within a time period set in statute. Where, for example, community services are readily available but some obstacles to immediate discharge exist, a period of 5 weeks or fewer may be appropriate. However, setting this in statute may mean that people who require services to be developed, as they are not readily made available, will not be helped by the requirement. This is especially relevant for people with a learning disability and autistic people, for whom setting up suitably individualised services and securing housing may take between several months and over a year. This proposal, suitably revised, could be extremely beneficial for people within this population, and we strongly support it.

The government should also provide the same or similar powers to the Tribunal in relation to restricted patients, as recommended by the independent review. It seems illogical that the Tribunal has powers to discharge a restricted patient absolutely but does not have a wider set of powers that relate to the steps towards discharge (e.g. leave, transfers). This should include the ability for the Tribunal to lift section 41 restrictions if satisfied they are no longer necessary to protect the public from serious harm, whilst continuing detention under section 37. The power to direct services in the community would also facilitate discharge of restricted patients, where the lack of care and support in the community is the primary barrier, helping avoid the use of scarce resources where detention is no longer necessary.

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 CTO?

Strongly agree/ **Agree**/Disagree/ Strongly disagree/Not sure

Consultation question 7a: Please give reasons for your answer.

Consultation question 8: Do you have any other suggestions on what should be included in a person's Advance Choice Document?

We welcome the proposal to introduce Advance Choice Documents (ACDs) into the MHA. As recognised in the white paper, ACDs would encompass treatment preferences (e.g. medication) but could also contain a range of other preferences and, further to the white paper's proposals, the following should be considered for inclusion:

- Environmental needs/preferences (especially in relation to people with a learning disability and autistic people)
- Personal preferences (e.g. comfort items, relaxation activities, clothing)
- Communication/language/interpretation requirements

- Traumatizing experiences and triggers
- Ethical choices/considerations
- Arrangements for looking after home, pets etc
- Visits home

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.

As the white paper proposes that ACDs should extend beyond issues of treatment preferences, this question may be more complex than it initially appears. For example, there is value in considering the wishes, feelings, and preferences of those who 'lack capacity' as part of somebody's care and treatment and it is valid to take into account all people's wishes, whether deemed to have 'capacity' or to 'lack capacity'. The principles of the Mental Capacity Act may have some relevance in their focus on supporting people to make decisions.

As we explain elsewhere in our response, particularly in relation to Question 18, the issue of consent is also central and must be freely given and informed. Empirical research in Australia has also identified two different motivations for preparing an Advance Choice Document - either to constrain clinicians, related to previous negative experiences of mental health treatment, or to authorise future involuntary treatment where the individual felt they made unsound decisions whilst unwell.⁶ Significantly, those who wanted to constrain clinical teams were in favour of legal enforceability whilst those who wanted to constrain themselves were not. The researchers also state that:

“It is difficult to see how a binding advance directive regime that binds the person making it is compatible with a post-CRPD conceptualisation of capacity, however an advance directive regime that binds the substitute decision makers, but not the person themselves, would be.”⁷

We believe this is an important distinction which needs to be given further consideration in the development of ACDs and we have some concerns around capacitous advance consent overriding objections in the present. It may depend on the nature and the level of weight given (legal or otherwise) to ACDs and to what extent 'capacity' plays a central role in their validity.

We are aware that in Scotland a distinction is made between an 'advance statement' and a 'personal statement' with differing authentication requirements.⁸ Others have also noted that “rather than straightforward fusion of MCA principles into the MHA, allowance must be made for some key differences between mental and physical healthcare.”⁹

⁶ [Laws | Free Full-Text | Consumers' Experiences of Mental Health Advance Statements \(mdpi.com\)](#) p.6

⁷ [Laws | Free Full-Text | Consumers' Experiences of Mental Health Advance Statements \(mdpi.com\)](#) p.3

⁸ [advance_statement_guidance.pdf \(mwcscot.org.uk\)](#)

⁹ [Advance decision-making in mental health – Suggestions for legal reform in England and Wales - ScienceDirect](#) p.163

Consultation question 10: Do you have any other suggestions for what should be included in a person’s Care and Treatment Plans?

It is important that people are meaningfully engaged in the development of their Care & Treatment Plan and that any individual communication needs to facilitate that involvement (e.g. BSL, Easy Read, language interpretation) are identified and met. For example, we are aware that some providers have blanket approaches to not providing information in Easy Read format. Care and Treatment Plans should also:

- follow existing care and support/treatment plans where the person has one
- set out what steps have been taken to reduce and alleviate the impact and stress of in-patient settings including recognition of environmental needs/preferences (especially relevant for people with a learning disability and autistic people)
- include information on physical health needs (and the person should have a physical health check upon admission)
- set out proposals for access to leave and the community
- include space to record disagreements or differences of opinion
- name specific carers who are responsible for meeting the needs of the person including staff who know the person well and have an opportunity to develop relationships (this is especially important for people with a learning disability or autistic people)
- name the Nominated Person and IMHA

It should also identify what assessments have taken place or need to take place and how the findings are being addressed within the Care and Treatment Plan. For example, the Care Quality Commission’s review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition proposed that:

“On admission, further assessments must take place, including for autism, sensory, mental health, physical health, trauma, learning disability and any other relevant assessments. This is to ensure that the objectives and care plan are meeting people’s needs. There must be a contract in place stating the timeframe for these assessments to take place.”¹⁰

Many restricted patients feel that they are generally unable to shape their care and treatment when some decisions are taken by Ministry of Justice civil servants with whom they have no relationship or interaction. As noted elsewhere in this response, we believe the government should consider giving more powers to the Responsible Clinician and Tribunal in relation to low-risk decisions. Consideration should be given to whether the approach of establishing co-produced Care and Treatment Plans soon after admission should also apply to informal patients.

Consultation question 11: 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

Consultation question 11a: Please give reasons for your answer.

We support this proposal which fits with the principle of choice and autonomy. It is important that people are given support and information about different treatment options and the potential impacts of treatment or non-treatment. We have heard feedback that individuals

¹⁰ [Out of sight – who cares? \(cqc.org.uk\)](https://www.cqc.org.uk) p.48

are not always provided with the time and space needed to come to their own decisions regarding their treatment. Respecting their wishes, even if experiencing serious suffering, provides more opportunity for exercising choice and responsibility.

Consultation question 12: Do you agree or disagree that, in addition to the power to require the Responsible Clinician to reconsider treatment decisions, a 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

We support this proposal which fits with the principle of choice and autonomy. Judicial oversight of compulsory treatment is recognised as important and a right to challenge this through appeal to a Tribunal makes this right more exercisable than judicial review to the High Court. We also believe there should be a statutory right to request a change of Responsible Clinician in accordance with the principle of choice and autonomy.

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.

The ability for the Nominated Person to access the Tribunal is an important safeguard, especially where a person lacks the capacity to make this application. We recognise the role of the Nearest Relative/Nominated Person and/or family members is particularly important in giving voice to that person. However, family members are not always able to access legal aid themselves to support representations to the Tribunal. The government should consider what other measures, such as entitlement to legal aid, might be needed to ensure the Nominated Person and/or family members can best support the 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.

If those under the age of 16 are given a right to choose a Nominated Person - it will be important that in the circumstances where they choose someone who does not have parental responsibility - that the staff responsible for their care and treatment pay additional attention where there is the need to engage positively with the family. Consideration also needs to be given to how any safeguarding concerns that relate to the choice of a Nominated Person are investigated. It will be necessary for the Code of Practice to provide further guidance on these matters.

Consultation question 15: Do you agree or disagree 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.

We support the expansion of the IMHA role to include support for clients to engage with planning their care and treatment including the proposed statutory Care and Treatment Plan and Advance Choice Documents. Advocates often provide valuable support in other decision-making processes such as CTRs and C(E)TRs, discharge planning, section 117 aftercare and Tribunal hearings - where they are aware these are taking place (often an advocate may only become aware of significant gateways and decisions through their presence on the ward).

The government must also consider the need for 'wrap-around' advocacy services which are able to support people in relation to relevant processes prior to and after admission which include, but are not limited to, MHA assessments, C(E)TRs and Advance Choice Documents.

We also agree with the conclusion of the independent review that "the statutory definition of IMHA advocacy should be amended to cover advocacy around care planning and advance choice".¹¹ The government should examine the legislation and regulations that apply to Independent Mental Capacity Act and Care Act advocates in revising the definition and functions of IMHAs. Through the process of revising the Mental Health Act and Code of Practice, it would be helpful to provide guidance to health and care professionals on the need to inform advocates of relevant decision-making processes, as noted above, so they can support the person to be fully involved.

We support the expansion of IMHA powers to challenge detention and to challenge treatment where the person lacks capacity and has an Advance Choice Document in place. We agree there may be circumstances where a person is not able to exercise their right to challenge in practice and this provides a further safeguard if an IMHA is able to do so on their behalf. Further guidance on how this might operate will be needed and also clarity on how this relates to the number of Tribunal challenges each person is entitled to.

Currently, an individual's ability to access an IMHA is overly dependent on the discretion of the care and treatment provider who can effectively act as gatekeeper for advocacy referrals. The existing legal obligations under section 130D of the MHA, to inform patients about their right to advocacy, is far too weak and the recent experience of the pandemic has demonstrated that. For example, the latest CQC monitoring report on the MHA "found wards where staff did not routinely refer any eligible patients to an IMHA, even where the patient lacked capacity to do so themselves. In the physical absence of the advocate on the ward, this effectively undermined some patients' right to advocacy at a very vulnerable time".¹² The CQC also concluded that "these experiences reinforce our view that the law should be able to compel services to refer patients to advocacy immediately on admission, and that the service should run on an 'opt-out' basis. This was recommended by the independent review of the MHA and we hope to see it taken up in future reform".¹³

The Act should provide an enhanced right to advocacy for all qualifying patients which legally obliges providers to notify the relevant advocacy service as soon as a patient is admitted and facilitate contact with an advocate so they can explain the service and the

¹¹ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](#) p.94

¹² [Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus \(COVID-19\) pandemic | Care Quality Commission \(cqc.org.uk\)](#) p.53

¹³ [Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus \(COVID-19\) pandemic | Care Quality Commission \(cqc.org.uk\)](#) p.56

patient can then decide whether to take this up. Essentially, this would mean enshrining the opt-out model of advocacy in law and we agree with the conclusion of the Department of Health in 2013 that “a provision to opt out would need a change to primary legislation”.¹⁴ Opt-out will be necessary to ensure advocacy support is available promptly and universally to support people in the formation of the new statutory Care and Treatment Plan. Opt-out is also a necessary safeguard for those who lack capacity, or have fluctuating capacity, for where closed cultures exist and for those in seclusion and segregation.

We also strongly support the extension of legal rights for advocacy to informal patients on an opt-out basis, in line with the independent review’s recommendation that “IMHA services should be ‘opt out’ for all who have a statutory right to it”.¹⁵ The review notes that “successive CQC reports and research evidence have found that patients who are in hospital voluntarily can be inadequately informed about their rights and status and subject to coercion to comply (with things like a ban on leaving hospital grounds, or taking medication) because of the threat of compulsory detention”.¹⁶ This is particularly important for children where a greater proportion are admitted as informal patients. A review by Welsh Government into the extension of IMHA to informal patients in Wales found that “the provision of the expanded IMHA services has been reported by all stakeholders as a positive development including staff providing services and those receiving support”.¹⁷

There also needs to be greater clarity about commissioning of IMHA. On the one hand, there can be a lack of equitable access to an IMHA when local authority commissioned services do not cover those in specialist services (e.g. secure, children’s, other NHS England commissioned specialised services). On the other hand, there can also be duplication where an independent/private provider or NHS England commission advocacy as well as the local authority. Resolving the problems of equitable access to advocacy (where some people are not covered by any commissioning) and the independence of advocates (where advocacy is also commissioned by the provider) becomes more urgent if the IMHA role and powers are to be enhanced.

In examining the continued disproportionate detention of Black people under the MHA, the independent review concluded that “we have to accept the painful reality of the impact of that combination of unconscious bias, structural and institutional racism, which is visible across society, also applies in mental health care”.¹⁸ As set out by the recent Commission for Equality in Mental Health,¹⁹ the government needs to address the wider social determinants of mental ill health and ensure culturally competent support and care across all mental health care.

Many of our services provide some form of culturally appropriate advocacy, either formally or informally, and we would welcome the opportunity to work with DHSC and others as the pilots proposed in the white paper are taken forward. One of the barriers for IMHAs effectively supporting people is a lack of access to interpretation services. It is important for the person-advocate relationship that conversations can be private with externally sourced interpretation rather than relying on ward staff, family or friends which can impede openness and the development of trust. We would welcome consideration of how the right to access

¹⁴ [Microsoft Word - postlegscrutiny2007.032.doc \(publishing.service.gov.uk\)](#) p.6

¹⁵ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](#) p.94

¹⁶ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](#) p.90

¹⁷ [the-duty-to-review-interim-report.pdf \(gov.wales\)](#) p.23

¹⁸ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](#) p.10

¹⁹ [Commission for Equality in Mental Health | Centre for Mental Health](#)

interpretation services, including BSL, within the hospital environment could be strengthened for both detained and informal patients.

Consultation question 16: Do you agree or disagree that advocacy services could be improved by:

- **Enhanced standards** Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure
- **Regulation** Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure
- **Enhanced accreditation** Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure
- **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.

Advocacy providers share a strong commitment to continuous quality improvement and are open to discussion with the government and others on what policy initiatives might be most effective in supporting that. It should be recognised there are strong foundations on which to build with most of the sector participating in the Quality Performance Mark (QPM) - a voluntary quality assurance scheme operated by the National Development Team for Inclusion (NDTi).²⁰ It is also widely expected that advocates undertaking statutory roles will either hold the relevant City and Guilds qualifications in advocacy or be working towards them within their first year of employment. There is widespread support for the current model of on-the-job training and qualifications and recognition that lived experience and empathy with the person's situation is valuable. It would be helpful for the MHA Code of Practice, in a similar way to the Mental Capacity Act Code of Practice²¹ and the Care Act statutory guidance,²² to set clear expectations that advocates will be appropriately trained and qualified.

One of the options highlighted in the white paper is regulation of either advocacy services, or advocates as a professional group, or both in combination. We recognise that regulation can be beneficial in setting baseline standards for all providers and supporting internal regimes for quality assurance and improvement.²³ We believe that any regulatory proposal, or enhanced standards/accreditation, in relation to advocacy should align with the following principles:

1. **Accountability:** supports good practice in line with agreed standards and provides a robust process for dealing with poor practice and complaints, thereby enhancing user and public confidence in advocacy services.
2. **Independence:** recognises in its composition and delivery the distinctive nature of advocacy, its role in providing independent support and representation for people's voices and rights, and the distinction between this and the delivery of health or care services.
3. **Equity:** must include a strong focus on ensuring that advocacy provision responds to the needs of diverse and minoritised people and communities. The implementation of any changes to accreditation, standards or regulation must ensure that grassroots and community organisations, including those which specialise in advocacy for

²⁰ [Introducing the Advocacy Quality Performance Mark | QPM | National Development Team for Inclusion \(qualityadvocacy.org.uk\)](#)

²¹ [Mental Capacity Act Code of Practice - GOV.UK \(www.gov.uk\)](#) p.184

²² [Care and support statutory guidance - GOV.UK \(www.gov.uk\)](#) section 7.43

²³ [Rapid literature review on effective regulation: Implications for the Care Quality Commission \(cqc.org.uk\)](#) p.12

people from minoritised communities, do not face disproportionate barriers to achieving them.

4. **Coproduction:** coproduced with people with experience of using advocacy services, advocates and advocacy providers.
5. **Integration:** build on existing principles and quality standards, particularly the Quality Performance Mark and ensure that any scheme is scalable to all statutory advocacy.
6. **Proportionality:** ensure that the benefits of the scheme justify the direct and indirect costs and are funded to ensure that the burdens of any scheme do not unduly detract from direct service provision.

An initial analysis would suggest that regulation of advocacy services, in a similar manner to other health and care services, would be more straightforward to develop in the short-to medium-term than regulation of advocates as a professional group. Any move towards regulation should be scalable to all statutory advocacy services. The regulatory body would also need to know and understand advocacy and uphold its independence from the wider health and care system and the professionals within it. As the most important role of the advocate is to support people to have their voice heard, this can sometimes result in legitimate professional differences with health and care professionals who are responsible for care and treatment.

In relation to other means to improve advocacy services, we welcome the white paper's commitment to strengthening the commissioning of advocacy services and would welcome further collaboration with DHSC, ADASS, LGA, NHS England and others in this area. The commissioning and procurement of advocacy plays an important role in shaping its quality, but practice is not consistent.

Effective commissioning practice needs to:

- be based on a forward-looking multi-year analysis of need which is coproduced with people who use mental health services, rather than procurement on the basis of historical patterns of use
- consider the needs of people who face disproportionately poor mental health services including people from a range of racially minoritised backgrounds and people with learning disabilities and autistic people
- take a proactive and preventative approach which responds to local community needs by commissioning a range of advocacy support not limited to meeting statutory requirements, nor restricted to people in hospital or on a CTO
- ensure adequate provision to support people in private and independently run hospitals, rather than leaving the purchasing of advocacy to the hospital proprietor who may have conflicts of interest. As noted earlier, there is also inequity in advocacy provision across NHS England specialised commissioned services (e.g. across the three high secure services).

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?

We support the conclusion of the Law Commission report in 2017 that “the Liberty Protection Safeguards should not apply to arrangements carried out in hospital for the purpose of assessing, or providing medical treatment for, mental disorder within the meaning it is given by the Mental Health Act”.²⁴

A recent report by the Kings Fund into clinical decision-making at the interface of the Mental Health Act and the Mental Capacity Act found very varied practice which “raises the question about how the Acts are understood and applied individually, even before the question of how they are understood at the interface”. It concluded that “the current status quo, however, is resulting in people being unlawfully deprived of their liberty and not afforded their appropriate rights”.²⁵

We therefore believe that change to the interface is required and that a more binary approach would assist clinical decision-making which is clearly struggling with the current legal complexity. In making a choice between the MHA and MCA, we strongly favour use of the MHA as it is specifically designed for use in psychiatric in-patient settings and contains more relevant and appropriate legal safeguards for circumstances where there is not explicit consent for treatment and/or deprivation of liberty. Subject to implementation of the proposed reforms of the MHA in the white paper, these will include:

- the four guiding principles of choice and autonomy, least restriction, therapeutic benefit, the person as an individual
- regular reviews of treatment and detention including access to assessment by an independent medical practitioner (SOAD)
- ability to challenge detention and/or treatment before a First Tier Tribunal including regular automatic referral
- right to support from an Independent Mental Health Advocate and a Nominated Person who can initiate challenges to detention and/or treatment (in certain circumstances)
- access to section 117 aftercare which may help facilitate discharge
- ability to make a complaint to the Care Quality Commission (CQC) and greater level of scrutiny over use of the MHA by the CQC

Furthermore, one of the major objectives of the MHA reforms is to reduce the numbers of people in psychiatric in-patient settings who do not need to be there, particularly people with a learning disability and autistic people. However, there is a risk that encouragement to use the Liberty Protection Safeguards (LPS) for those who lack capacity to consent/object, where the criteria for those who can be deprived of their liberty is drawn more widely than in a reformed MHA, could lead to similar adverse outcomes as at present just under a different legal regime.

We recognise that there are examples where the Court of Protection has helped to secure better outcomes for those in long-term detention and it would be beneficial to examine these cases more closely, as noted earlier, to ensure the Tribunal is more able to direct public bodies to facilitate discharge.

²⁴ [Law Commission Mental Capacity and Deprivation of Liberty](#) p.155

²⁵ [Understanding clinical decision-making at the interface of the Mental Health Act \(1983\) and the Mental Capacity Act \(2005\) \(york.ac.uk\)](#) p.41

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 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

Consultation question 18a: Give reasons for your answer.

Informal admission and treatment, by definition, needs to be with the ongoing consent of the person for the whole duration of their stay in hospital. Consent is not full, informed and freely given consent if it is to apply in perpetuity with no option for someone to subsequently change their mind and withdraw consent. If, at the time of admission or at any point afterwards, a person objects to detention, ignoring this objection would be wrong and is contrary to the principles of choice and autonomy outlined in the white paper. Appropriate legal structures and safeguards must be in place if someone is to be deprived of their liberty and treated against their will. As referenced in our response to question 8 concerning Advance Choice Documents, it has been observed that:

“It is difficult to see how a binding advance directive regime that binds the person making it is compatible with a post-CRPD conceptualisation of capacity, however an advance directive regime that binds the substitute decision makers, but not the person themselves, would be.”²⁶

If agree:

Consultation question 18b: Are there any safeguards that should be put in place to ensure that an individual’s advance consent to admission is appropriately followed?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

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 MHA?

- a) Rely on section 4B of the Mental Capacity Act only
- b) Extend section 5 of the Mental Health Act so that it also applies A&E, accepting that section 4B is still available and can be used where appropriate.

Consultation question 19b: Please give reasons for your answer

We have not responded to question 19.

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 explain your answer

²⁶ [Laws | Free Full-Text | Consumers' Experiences of Mental Health Advance Statements \(mdpi.com\)](#) p.3

We have not responded to question 20.

Consultation question 21: 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 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 NHSEI or across NHSEI and HMPPS to manage the prison/IRC transfer process
- An alternative approach (please specify)

Consultation question 21a: Please give reasons for your answer

We think there are advantages to this role being located within the organisations (NHSEI & HMPPS) that already play a key role in the secure transfers process and which have the levers to overcome delays in the process. We are also aware that some restricted patients are detained in environments that are overly restrictive for their current circumstances because their status means they have to be detained in a certain kind of secure ward of which there is limited availability. This can also have a 'bed blocking' effect and extend waiting times for those transferring from prison.

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?

We have not responded to question 22.

Consultation question 23: For restricted patients who are no longer therapeutically benefitting 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.

We welcome acknowledgement that many restricted patients may experience prolonged detention without therapeutic benefit and there could be a role for a new power of supervised discharge. However, the white paper gives insufficient consideration overall to how the human rights of forensic patients should be safeguarded alongside issues of public protection. There is a risk that if Part III remains relatively unreformed compared with the rest of the MHA, it will be seen as increasingly discriminatory and not protecting the human rights of those who come under it.

For example, Professor George Szmukler at the Institute of Psychiatry, Kings College London, has critiqued sections 37/41 for being discriminatory against forensic patients compared with other offenders due to the potential for indeterminate detention. In his view:

“A second principle follows from the need to eliminate discrimination against offenders with an impairment of mind when compared to non-disordered offenders convicted of a similar offence with a similar level of seriousness (based, for example,

on the degrees of harm and culpability). The management of those with a mental impairment should be, as far as possible, on an equal basis with other offenders. Most importantly, the total duration of a deprivation of liberty (in hospital or prison) or a restriction of liberty (following discharge to the community) imposed by a sentence or court order for an offender with an impairment of mind should be no longer than that imposed on a non-disordered offender.”²⁷

The government must consider wider reforms to Part III in addition to the proposals for ‘supervised discharge’. For example, the government should reconsider the following recommendations by the independent review (which unfortunately were not supported in the white paper):

- Decisions concerning leave and transfer of restricted patients should be categorised by the Ministry of Justice according to risk and complexity. Straightforward and/or low risk decisions should be taken by the responsible clinician. The Ministry of Justice would have 14 days to override this decision.
- The powers of the Tribunal should be expanded so that they are able, when deciding not to grant an application for discharge, to direct leave or transfer.
- There should be a common framework for assessment of risk across criminal courts, clinicians and the Justice Secretary. The assessment needs to be regularly reviewed (at least annually and before every Tribunal hearing). Every patient should have written into the Care and Treatment Plan what their risk levels are.²⁸

If agree:

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?

In line with our previous points on the Tribunal, whatever powers are available for the Secretary of State to vary or amend the conditions should also be available to the Tribunal. We also assume that those on a ‘supervised discharge’ order would have a right to an advocate in the same way as those who are conditionally discharged. This right must be explicit and access to an advocate must be facilitated.

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

We welcome the white paper’s acknowledgement that people with a learning disability and autistic people have suffered from inappropriate detention and the government’s intention to address this. The white paper contains important measures which we support. These include creating a duty on commissioners to ensure adequacy of supply of community services; placing C(E)TRs on a statutory footing, expecting that these be carried out in advance of

²⁷ George Szmukler, International Journal of Mental Health and Capacity Law, 2020, p.40

²⁸ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/438443/modernising-the-mental-health-act-final-report-from-the-independent-review.pdf) p.204-5

detention and that it is demonstrated that all options other than admission must be considered and exhausted for a person to be admitted; and requiring dynamic risk registers.

We applaud the government's *intention* in proposing that learning disability and autism not be considered mental disorders warranting detention under section 3. However, we are concerned that there could be *unintended* consequences and this may not achieve the desired reduction in detentions, but instead result in more people being detained under the Liberty Protection Safeguards, either in the first instance, or following assessment under section 2. If this occurs, it will mean people being detained with fewer protections and routes to challenge their detention than would be available to them if detained under the MHA.

We are concerned that the white paper proposals, whilst largely welcome, are insufficient to prevent unnecessary, and frequently traumatic, detention of people with learning disabilities and autistic people and will not ensure better community-based support to prevent the purported need for detention.

We believe that a more fulsome response combining the following elements is needed:

1. Ensuring effective national leadership and governance

There has been insufficient progress on the Transforming Care programme over many years and a wide variation in performance across different geographic areas.²⁹ Ministerial oversight, drive and accountability for a change programme with clear, transparent milestones, and resource to support local action and a remit to unblock obstacles is needed.

2. Commissioning and planning

We welcome the proposals to create a duty on commissioners to ensure adequacy of supply of community services and the recognition of the role of pooled budgets. Consistent with NICE recommendations,³⁰ this needs to go further to address the barriers which occur between the NHS and local government. It should do this by requiring, or at least encouraging, local authorities and CCGs/ICs to jointly designate a single lead commissioner with expertise relating to people with learning disabilities and autistic people to oversee strategic commissioning for this population. Local authorities and CCGs/ICs should, through the lead commissioner, ensure a local strategy and plan to address in-patient detention and stem future inappropriate admissions by building community-based capability and capacity.

3. Supporting the individual and their family

People with learning disabilities and autistic people who are in-patients should have a single named individual who is accountable for driving and co-ordinating work to ensure their discharge and keeping them informed and at the centre of decisions. Advocacy can play a critical role in supporting people with a learning disability and autistic people, including those detained under the MHA. However, the availability and quality of advocacy for people in this situation varies. We have set out, including in evidence to Baroness Hollins' independent review, how this must be addressed through changes to the commissioning and delivery of advocacy.³¹ We welcome the review by DHSC and NHS England of current advocacy provision for people with a learning disability and autistic people to identify areas for improvement. We are in discussion with both bodies and have committed our support to this.

²⁹ [NHS England » Learning disability and autism programme: data and information](#)

³⁰ [Overview | Learning disabilities and behaviour that challenges: service design and delivery | Guidance | NICE](#)

³¹ A published paper based on this evidence is available at <https://www.voiceability.org/assets/download/Advocacy-with-people-with-learning-disabilities-and-autistic-people.pdf>

4. Investment

There is a high financial as well as an extreme human cost attached to in-patient services to people with learning disabilities and autistic people. The white paper should recognise, however, that an increased financial investment is needed through the transition period, including parallel running costs, to build community capacity and capability while people remain within in-patient services.

5. Regulation

We discuss this further under question 35.

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

Whilst we welcome many of the proposals (see question 26a), the proposed reforms do not go far enough in reducing the need for in-patient provision, nor in ensuring that it is used for the best effect and for the shortest time necessary only when it is strictly required. The reasons for this are explained in our response to:

- question 17a and 28a where we outline how inappropriate detention under the MHA may only be replaced with detention using the Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards (LPS)
- question 26a in which we question whether removing learning disability and autism from being considered mental disorders warranting detention under section 3 will achieve the intended outcome
- question 26a in which we set out additional measures which are required to provide adequate safeguards. We believe these hold equally true for people with a learning disability and autistic people who do and do not have a mental health condition

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

One potential unintended consequence is that whilst the MHA might be used less frequently to detain people with a learning disability and autistic people, it could lead to increasing use of the Mental Capacity Act and Liberty Protection Safeguards and with fewer checks and balances. This is why we strongly recommend that only the MHA be used in psychiatric in-patient settings. However, even if this option is chosen, there is still potential for greater use of DoLS/LPS in relation to people with a learning disability and autistic people in a variety of community settings that amount to a deprivation of liberty. This will need to be monitored closely by CQC and others once the MHA reforms are implemented.

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

The government's proposals for different detention criteria for civil and forensic patients, also meaning a differential threshold for discharge, needs further interrogation and may have unintended consequences and be discriminatory.

In the white paper, the government acknowledges "the considerable concern about admission of people with a learning disability and autistic people to mental health hospitals under the Act, where such an admission could become protracted or may not result in someone receiving an appropriate therapeutic intervention" and that "both learning disability and autism are lifelong conditions, which cannot be removed through treatment".³² In-patient settings are often unsuitable and can trigger, rather than reduce, behaviour that challenges and create situations where deterioration justifies prolonged detention in a continual cycle. As noted earlier, the potential for section 37/41 to act as an indeterminate sentence poses real risks for those people with a learning disability or autistic people.

There needs to be increased forensic community-based capacity and expertise to support people with a learning disability and autistic people who are in contact with, or at risk of contact with, the criminal justice system. This would help to address needs and to prevent escalation of potential offending, hospital placement or custodial sentences. There must be much more focus in the reforms on making community alternatives to custody or admission a reality. For those who have 'capacity', more provision could be made for those who might voluntarily want to receive psychiatric in-patient treatment.

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 autistic people?

If different detention criteria apply for civil patients and those under Part III, particularly in relation to people with a learning disability and/or autistic people, there is a risk that a perverse incentive might be created for diversion into the criminal justice system and then detention/treatment under Part III of the MHA.

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 Clinician 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

We welcome the proposal to give C(E)TRs statutory force. However, since one of the primary aims of C(E)TRs is to prevent hospital admission through arranging appropriate care and support in the community, it may be equally or more important that they apply to other public bodies (eg local authorities, CCGs/ICs, NHSE) who are responsible for arranging this.

³² [Reforming the Mental Health Act - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/reforming-the-mental-health-act) p.82

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.

We strongly agree with the proposal to create a new duty on local commissioners. A lack of community services is a critical factor in the continuing failure to adequately and safely support people with learning disabilities and autistic people. This includes accommodation-based services, early intervention, support for families, intensive support, crisis interventions and community forensic input. It is vital that the duty also includes the provision of housing.

It is also vital that this duty is discharged in a coordinated manner to ensure that people do not fall through the gaps. There should be a requirement for NHS, local authority commissioners (for adult social care, children and families, including education) and directors of housing to work together.

To be effective it will require adequate financial investment, including parallel running costs where required for a transitional period, as community services are being enhanced. It will also require monitoring. For example, market shaping duties on local authorities under the Care Act are in place, but their adequacy and impact varies.

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.

We support the creation of local dynamic risk registers. To be effective they must go beyond those at immediate risk of admission to hospital and drive proactive responses from public bodies rather than be a passive record. They must also be actively used to understand population needs and feed into immediate, medium- and long-term plans to enhance community-based capability and capacity.

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?

As set out in our response to 26a, there must be a framework for effective joint commissioning with a designated single lead commissioner who has expertise in relation to people with learning disabilities and autistic people and is able to draw in funding being spent by NHS England on in-patient provision. It is imperative that the government addresses the perverse financial incentives and conflicts of interest engendered by the ‘market’ for in-patient provision for those with a learning disability and autistic people. The Lancaster University 2017 report ‘A Trade in People: The inpatient healthcare economy for people with learning disabilities and/or Autism Spectrum Disorder’ found that:

“Our data indicates that inpatient rates are being influenced by the decisions of healthcare entrepreneurs to locate in areas where house prices are lower and that once there, the length of their stay in hospital will be influenced by the care infrastructure that is in place. Namely the numbers of people who are inpatients, the number of CQC registered settings and the number of s117/CHC packages of care.

If considered in conjunction with the experiences of people with learning disabilities and their families and the content of a number of the Transforming Care Plans, it is clear to us that the way in which the healthcare economy has been encouraged to develop by recent governments turns people into commodities and liabilities. For local authorities and CCGs they are liabilities that they have often sought to export to other areas and for independent hospitals they are a commodity and source of millions of pounds of income and profit.”³³

The CQC robustly implementing ‘Right support, right care, right culture’, particularly in relation to commissioning and new development,³⁴ would help to address the current market failures.

Consultation question 35: How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?

We agree with the white paper that the CQC should have a wider role to consider the effectiveness of joint working. This would be helpful in identifying and highlighting gaps in community-based support, planning and commissioning of services which may be resulting in unnecessary hospital admissions and delays in discharge. It will be important to explore how these enhanced powers could best take account of the fact that often people from many different localities are placed into a single hospital and so there may be many local area systems playing a role.

In ‘Right support, right care, right culture’, the CQC has set out a well-considered basis for regulation of providers of support to people with a learning disability and autistic people. Whilst the framework applies equally to new registrations and existing providers, we understand that the CQC holds itself back from the full use of its powers to de-register services which fail to meet its standards, due to concerns about a lack of alternative provision. It may be that taking a wider system approach will enable CQC to act more robustly in relation to services which are below standard, while at the same time placing more pressure on the service systems which feed and maintain them; both changes could help to ensure that people do not remain trapped in poor services.

One of the safeguards against poor care is access to advocacy but this can be impeded within institutions where a ‘closed culture’ has developed. We believe it is important that the CQC engages consistently with advocacy providers, who can provide feedback and intelligence on mental health services. This occurs in many areas and we are in discussion with CQC about how this can be strengthened.

We recommend that CQC take a more active monitoring and enforcement role concerning access to advocacy. This was also recommended by the CQC in its recent review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition³⁵ and by the independent review.³⁶ It is necessary to be attuned to whether access genuinely amounts to the person receiving the service and the CQC should specifically audit whether those in seclusion and segregation are able to meet and be in contact with their advocate. The term ‘access’ can fall within a spectrum from, at

³³ [A-Trade-in-People-CeDR-2017-1.pdf \(lancs.ac.uk\)](#) p.21

³⁴ [Right support, right care, right culture How CQC regulates providers supporting autistic people and people with a learning disability | Care Quality Commission \(cqc.org.uk\)](#) p.7

³⁵ [Out of sight – who cares?: Restraint, segregation and seclusion review | Care Quality Commission \(cqc.org.uk\)](#) p.49

³⁶ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](#) p.94

one end, having sight of a telephone number, to, at the other end and the level which is actually needed, active engagement and the timely facilitation of advocacy. Monitoring access to advocacy would be more straightforward if people's legal right to advocacy was strengthened within the MHA, including opt-out. For many people, opt-out is the only way to make access to advocacy a meaningful entitlement.

The CQCs Key Lines of Enquiry³⁷ do include questions assessing whether the service facilitates access to advocacy. We understand, however, that the CQC takes into account the provider's dependence on the wider service system for the commissioning and supply of advocacy services. Widening the powers of the CQC to consider joint working may help where there are gaps in advocacy provision which cannot - and ought not - be addressed by the provider alone.

Consultation question 35: In the impact assessment, we have estimated the 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 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 impact the current workloads for clinical and non-clinical staff, Independent Mental Health Advocates, Approved Mental Health Professionals, Mental Health Tribunals, SOADs etc; and
- 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;
- How the proposals may improve the ability for individuals 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; and
- Any other impacts on the health and social care system and the justice system more broadly.

Alternatively, please email your response to MHAconsultation2021@dhsc.gov.uk and include what question you are responding to and your organisation (if appropriate).

The Impact Assessment (IA) makes a number of assumptions in relation to advocacy which are based on a relatively narrow evidence base. In particular, we question the assumptions on current level of uptake (the IA assumes 40%) and that opt-out will not make a significant difference to the level of uptake. Our experience suggests that uptake of advocacy varies significantly between local authority areas and that where contracts currently provide for an opt-out model, referrals are likely to be higher in those local authority areas. We would welcome the opportunity to work more closely with government and commissioners on further refinement of the Impact Assessment.

³⁷ [Key lines of enquiry, prompts and ratings | Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications/key-lines-of-enquiry-prompts-and-ratings)