

# Reforming the Mental Health Act: Centring Human Rights

BIHR's response to the Mental Health Act consultation, calling for pre-existing human rights legal duties to be properly embedded into the planned reform of the Mental Health Act, on paper and in practice.



## Mental Health Act 1983

CHAPTER 20

ARRANGEMENT OF SECTIONS

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April 2021



# REFORMING THE MENTAL HEALTH ACT: CENTRING PEOPLE'S HUMAN RIGHTS

April 2021

“If the Mental Health Act is not written with the human rights principles at the centre, how can we expect the European Convention on Human Rights Articles [i.e., our human rights which are part of UK law] to have full impact on practice? This is the problem with the reforms - they are not written with human rights at the centre.”

Attendee at our session for people accessing (or trying to access) mental health services and loved ones.

## 1. Executive Summary

The 2017-2018 Review of the Mental Health Act in England and Wales shone a spotlight on a number of human rights issues that reflect the lived experience of the people we work with at the British Institute of Human Rights. These include long periods of detention that are not of therapeutic benefit, concerns around people accessing mental health services and their loved ones having little say over their care, treatment and recovery. From our experience of supporting people in the system, both those trying to access support, families, advocates, and staff members, the evidence is that the Mental Health Act is used in unsuitable, and often discriminatory, ways.

In January 2021, the UK Government published a White Paper which sets out reform proposals intended to tackle the above issues as well as a host of other concerns. Our submission works through some key human rights considerations associated with the reform proposals. We amplify the voices of the people we work with and set out what is required for mental health law reforms to ensure the human rights of people, and their loved ones, accessing or trying to access mental health services are respected and protected, rather than breached.

Our submission argues that for these proposed reforms to have any real impact on the rights of those accessing or trying to access mental health services they must be properly implemented, staff must be fully supported, and adequate funding must be provided. Our submission sets out recommendations to ensure that pre-existing human rights legal duties are properly imbedded into the planned reform of the Mental Health Act, on paper and in practice. This could truly transform the implementation of mental health law from an experience which too often risks rights, to one in which people's human rights are centred.

## 1.1 About BIHR

The British Institute of Human Rights (BIHR) is a charity working in communities across the UK to enable positive change through human rights. We work to support people with the information they need to benefit from their rights; with community groups to advocate for better protections in their areas or interest groups; and with staff across public services to support them to make rights-respecting decisions. This enables us to call for the development of national law and policy which truly understands people's experiences of their human rights. We work with over 2,000 people using public services and their community groups, and the staff members delivering them. Our recommendations are directly informed by people's real-life experiences of the issues.

## 1.2 BIHR's Evidence

Since the publication of the White Paper, we at BIHR, together with partners, have gathered evidence on whether or not these reforms will improve the human rights protections of people and their loved ones accessing or trying to access mental health services. Together with NSUN (the National Survivor User Network) we ran interactive evidence gathering sessions and an online (Easy Read) survey giving people the opportunity to share their views and experiences of working with the Act or accessing mental health services. Our submission amplifies these voices in two distinct groups:

1. **People:** People accessing (or trying to) access mental health services, or who have previously accessed mental health services, and their family members and people who care about them.
2. **Staff working in mental health:** People working in organisations with legal duties to respect and protect rights, including those working in mental health services (including private, charitable, or voluntary bodies), and advocates and campaigners working in the area of mental health.

### BIHR's Key Findings

- 90% of people who responded to our research said that they agreed with the four guiding principles, but many suggestions were given on what else should be included or was missed, including respect for human rights, empowerment and more choice.
- 61% of people who responded to our research said that the plans to include these principles in the Mental Health Act and the Mental Health Act Code of Practice was good but not good enough. This rose to 90% amongst people who are accessing, have accessed or are trying to access mental health services. Suggestions for where else these

principles should be included in staff training and inductions, on care plans and visibly in hospitals.

- 79% of people who responded to our research said that including information about human rights in the Mental Health Act will help make sure that staff think about human rights.
- 43% of people thought that the plans to change Community Treatment Orders (CTOs) did not protect the right to liberty, 33% were not sure.
- 37% of people thought that the plans to create the “Patient and Carer Race Equality Framework (PCREF)”, the development of culturally appropriate advocacy for people of all ethnic backgrounds and the plans to change CTOs did not protect the right to be free from discrimination, 40% were not sure.
- On introducing statutory ‘Advance Choice Documents’, implementing the right for an individual to choose a ‘Nominated Person’ and expanding the role of ‘Independent Mental Health Advocates’, 39% of people thought this does not protect the right to be free from inhuman and degrading treatment (22% were not sure) and 18% thought this did not protect the right to private and family life (58% were not sure).

## 1.3 BIHR’s Recommendations

Our overall recommendations:

- Any reform to mental health law should be centred around respect for people’s human rights. The suggested guiding principles and the reforms that fall under them are seen as a welcome step forward. Whilst these principles are based on human rights principles, the legal duty under the Human Rights Act is not directly referenced. At BIHR, our experience over 20 years, and especially with the Coronavirus Act 2020, has shown that when the duty to protect, respect and fulfil human rights is referred to directly in legislation and codes of practice, there is increased awareness of this duty which leads to improved rights protection for people and their loved ones. **79% of people involved in our research think that the legal duties under the Human Rights Act should be directly referred to in the new Mental Health Act.** It is not enough for policy and law makers to assume that laws will be applied compatibly with human rights, as required under the Human Rights Act. Our submission therefore recommends that the legal duty to apply mental health law compatibly with people’s human rights, should be directly and centrally referred to in the new law, the Code of Practice and in all consultation processes, training and other implementation that follows. It is important that people know that regardless of changes to the Mental Health Act, their human rights must be respected, protected and fulfilled.

- The guiding principles are welcomed; however, our submission argues that it is essential that these principles are not just referred to on paper (in the Act and the Code of Practice) but are fully implemented throughout all mental health services (and other services such as physical health care, police etc). **61% of people and staff involved in our research thought that the plans to include the guiding principles in the Mental Health Act and the Code of Practice were good, but not good enough. This rose to 90% amongst people who are accessing, have accessed or are trying to access mental health services.** Our response sets out suggestions based on our evidence gathering for ensuring these principles are implemented in practice including:
  - ensuring people accessing, or trying the access, mental health services (and their loved ones) are made aware of these principles in an accessible way;
  - including these principles in care plans and making them visible in mental health services;
  - integrating these principles in community care and within organisations involved in mental health care, such as the Care Quality Commission (CQC), National Institute for Health and Care Excellence (NICE) guidelines, voluntary sector, user/carer organisations.
  - Staff must also be fully trained and supported to provide services that are guided by these principles.

## Our human rights and reform specific recommendations:

- To uphold the **right to liberty (Article 5, Human Rights Act)**, the guiding principle of least restriction must not only be included in the new Mental Health Act and the Mental Health Act Code of Practice, but steps must be taken to ensure the principle is implemented in practice. **Our research showed that 61% of people felt that the principle being included only on paper wasn't enough.** Our response sets out suggestions based on our evidence gathering for ensuring the right to liberty is respected, protected and fulfilled, including:
  - a greater investment in community mental health services which are created with and for the people they exist to support;
  - access and funding for independent advocacy;
  - time limits on Community Treatment Orders (CTOs); and
  - an accessible and speedy complaints process for anyone under a CTO.
- To uphold the **right to be free from discrimination (Article 14, Human Rights Act)**, the issues of structural and institutional discrimination in services more widely, and in mental health services in particular, should be recognised and addressed. **Our research shows that 37% of people thought that the plans to create the “Patient and Carer Race Equality Framework (PCREF)”, the development of culturally appropriate advocacy and the plans to change CTOs did not protect the right to be free from discrimination;** 40% were not sure. Our response sets out suggestions based on our evidence gathering for ensuring the right to be free from discrimination is respected, protected and fulfilled, including:

- properly funded and implemented advocacy; and
  - ensuring the voices and experiences of groups that are affected by discrimination are at the forefront of any reforms.
- To uphold the **right to be free from inhuman and degrading treatment (Article 3, Human Rights Act)**, the guiding principle of therapeutic benefit must not only be included in the new Mental Health Act and the Mental Health Act Code of Practice, but steps must be taken to ensure the principle is implemented in practice. **Our research shows that only 23% of people thought that the plans in the White Paper would protect the right to be free from inhuman and degrading treatment.** This is concerning as the right to be free from inhuman and degrading treatment is absolute, meaning any interference with it is unlawful. Our response sets out suggestions based on our evidence gathering for ensuring this right is respected, protected and fulfilled, including:
    - only using detention under the Mental Health Act when it is of therapeutic benefit to and there is no other way to provide the support;
    - ensuring that community mental health services work with and for the communities they exist to support; and
    - providing accessible information on rights and clear processes for when people feel that they are at risk of inhuman or degrading treatment (or any other rights abuse).
  - To uphold the **right to private and family life (Article 8, Human Rights Act)** the guiding principle of choice and autonomy must not only be included in the new Mental Health Act and the Mental Health Act Code of Practice, but steps must be taken to ensure the principle is implemented in practice. **Only 24% of people felt that introducing statutory 'Advance Choice Documents', implementing the right for an individual to choose a 'Nominated Person' and expanding the role of 'Independent Mental Health Advocates', would protect the right to respect for private and family life** (which includes physical and mental wellbeing, choice and involvement in decisions that affect you). Our response sets out that to ensure that the right to private and family life is respected, protected and fulfilled, including:
    - fully funded and independent advocacy services should be provided for anyone accessing mental health services; and
    - crucially, more power and support should be given the voices of people with lived experience of accessing, or trying to access, mental health services.

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## 2. Introduction and Methodology

Following on from an independent review<sup>1</sup> which took place in 2017-2018 and stated that the Mental Health Act (MHA) did not work as well as it should do, the government published a White Paper<sup>2</sup> in January 2021 on plans to change and update the MHA. This response centres the views and experiences of both people who are affected by mental health law and policy (people who access, have accessed or are trying to access mental health services (and their loved ones)) and people who use mental health law in their professional lives (staff working in mental health services, advocates and community groups).

As mentioned above, many of the issues raised in the 2017 review of the MHA are human rights issues, including long periods of detention without therapeutic benefit, the lack of choice and involvement of people in their care, treatment and recovery, and discrimination. Therefore, any reform to the MHA and the way that mental health services are delivered in England and Wales must have human rights at their core.

### 2.1 About BIHR

The British Institute of Human Rights (BIHR) is a charity working in communities across the UK to enable positive change through the practical use of human rights law beyond the courts. We share this evidence of change and people's lived experiences to inform legal and policy debates.

We work with three main stakeholder groups:

1. **People:** People accessing (or trying to) access public services, their family members and people who care about them.
2. **Advocacy and Community Groups:** Formal advocates (e.g., IMCA, IMHA etc.), self-advocates, and other community, campaigning, and advocacy groups.
3. **Staff:** People with legal duties to respect and protect rights. This includes those working in public services and in private, charitable or voluntary bodies delivering public services.

Our direct work enables us to call for the development of national law and policy which truly understands people's experiences of their human rights. We work with over 2,000 people across our stakeholder groups each year, across the UK, including devolved nations. Our submission, analysis and recommendations are directly informed by our organisation's unique expertise of human rights practice and people's real-life experiences of the issues, together with a programme of public engagement to collect data and experiences specifically for this consultation.

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<sup>1</sup> Modernising the Mental Health Act: Increasing choice, reducing compulsion, Final report of the Independent Review of the Mental Health Act 1983, December 2018, available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/778897/Modernising\\_the\\_Mental\\_Health\\_Act\\_-\\_increasing\\_choice\\_reducing\\_compulsion.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice_reducing_compulsion.pdf)

<sup>2</sup> UK Government White Paper: Reforming the Mental Health Act, January 2021, available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/951398/mental-health-act-white-paper-web-accessible.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf)

In order to gather the evidence for this response, in March and April 2021, BIHR worked with partners NSUN (the National Survivor User Network) to provide people with a platform to share their views and experiences of working with the MHA or accessing mental health services. NSUN is an independent network of people and groups who have and do experience mental distress who want to change things for the better. Our methodology for this submission included:

1. An online evidence gathering and upskilling session on 26 March 2021 for people who work in mental health services or are mental health advocates or campaigners. This was attended by 68 people.
2. A second online session, held on 1 April 2021, for people who access, have accessed or are trying to access mental health services (and their loved ones). This was delivered in an accessible style with Easy Read slides and was attended by 42 people.
3. An open online survey in Easy Read asking the same research questions as in the online sessions. 7 people answered the survey.

In this submission, we have combined, analysed, and presented the data from across our two workshops and survey as well as offered our own expertise and experience of over two decades of working to embed human rights in mental health services.

### **3. The Mental Health Act and the Human Rights Act: explaining the relationship**

The Human Rights Act 1998 applies to all areas of public service decision making and delivery, including mental health services. The way the Human Right Act (HRA) interacts with the Mental Health Act (MHA) will continue, regardless of reforms made to the MHA and the MHA Code of Practice.

Section 6<sup>3</sup> of the HRA makes it unlawful for a public authority to act in a way which is incompatible with the human rights set out in the HRA (these are often referred to as Convention rights or Articles). A public authority, for the purposes of the HRA, is “any person certain of whose functions are functions of a public nature.”<sup>4</sup> It therefore includes traditional public bodies such as the NHS and the range of private, charitable, and other organisations who deliver public services. This reflects the reality of how public power is held across the UK.

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<sup>3</sup> Section 6(2), Human Rights Act 1998 [United Kingdom of Great Britain and Northern Ireland], 9 November 1998, available at: <https://www.legislation.gov.uk/ukpga/1998/42/section/6>

<sup>4</sup> Ibid

Section 3 of the HRA<sup>5</sup> means that primary legislation (Acts of Parliament) and subordinate legislation (e.g., Regulations) must be read and applied in a way which is compatible the human rights in the HRA as far as it is possible to do so.



A public body will only have a defence to not doing this if an Act of Parliament states they could not have acted differently. In practice this should be rare, and there have been less than 50 changes to laws in the last 20 years to make them human rights compliant, as there is almost always a way to apply laws in a way that upholds human rights.

Staff working in mental health services use many different pieces of legislation in policy and practice, including the MHA. The HRA means all staff working

in mental health services should apply and interpret the laws they use every day in ways that protect people's human rights. The Mental Health Act cannot be applied in a way that is incompatible with human rights law. Again, this will continue to be the case regardless of any reforms.

The 16 rights (also called "Articles") protected by the Human Rights Act can be divided into two types:

- Absolute human rights which can never lawfully be limited or restricted, and non-absolute rights.
- Non-absolute rights can be limited or restricted in limited circumstances, but any restriction on a non-absolute right must be:
  1. lawful,
  2. legitimate and, crucially,
  3. proportionate, i.e., it must be the least restrictive option available.

Therefore, in mental health services, it is never lawful to restrict an absolute right (such as the right to be free from inhuman and degrading treatment) and any restriction of a non-absolute right (such as the right to liberty) must be lawful, for a legitimate reason and the least restrictive option available. Our submission offers recommendations based on an understanding of the above.

<sup>5</sup> Section3, Human Rights Act 1998 [United Kingdom of Great Britain and Northern Ireland], 9 November 1998, available at: <https://www.legislation.gov.uk/ukpga/1998/42/section/3>

## 4. Evidence from people\*

\*People accessing (or trying to) access mental health services, their family members and people who care about them.

### 4.1 Human Rights and the Guiding Principles

- 95% of people involved in our research think that including information about human rights in the Mental Health Act will help make sure that staff think about human rights.
- 90% of people said that they agreed with the four guiding principles.
- However, 90% of people said that the plans to include these principles in the Mental Health Act and the Mental Health Act Code of Practice were good but not good enough.

The people who attended our session for those who are accessing, have accessed or are trying to access mental health services (and their loved ones) raised that they felt that human rights were often not fully respected in mental health services. They felt that the planned reforms do not go far enough to ensure the protection of human rights for people who are accessing or trying to access mental health services.

When asked if including information about human rights in the Mental Health Act (MHA) will help make sure that staff think about human rights, 95% of people felt that this would help. As seen above, it was agreed by most that the inclusion of the four new guiding principles is welcome, however concerns were raised that some key things were missing. These include:

- making explicit reference to upholding human rights as a legal requirement,
- empowerment, co-production, and having people's voices listened to and properly taken into account (both during this reform process and beyond).

There were concerns raised that the suggested reforms, including the guiding principles, must be more than paper policies and be fully embedded in practice in order for them to have any real impact. People accessing, or trying to access, mental health services and their loved ones felt that they should be made aware of these principles in an accessible way. The principles should be included in care plans and made visible in mental health services. Ideas were also shared around integrating these principles in community care and within organisations involved in mental health care, such as the CQC, NICE, voluntary sector and user/carer organisations. Staff must also be fully trained and supported to provide services that are guided by these principles. There was an overarching theme that the views and rights of people accessing, trying to access, or who have accessed mental health services, should be central to not only this consultation, but also to any steps taken in the future.

## 4.2 The Right to Liberty

The right to liberty protects against extreme restrictions on our movement.

This right is a **non-absolute** right. This means it can only be limited or restricted if the restriction is lawful, legitimate and, crucially, the least restrictive option available.

Only 12% of people thought that the plans to change Community Treatment Orders protected the right to liberty; 35% were not sure.

Again, here there were concerns that the guiding principle of “least restrictive” would remain a mere paper policy and that the “recommendations contain enough wiggle room for Community Treatment Orders (CTOs) to continue as they are now”.

People who attended our session suggested that to limit the restriction of the right to liberty, there should be greater investment in community mental health services which work with and for the communities they exist to support. This means that people can access support without restricting their right to liberty through detention in hospitals or similar treatment units or settings. In line with human rights, any restriction of a person’s the right to liberty should only happen when it is the least restrictive option available to meet the legitimate aim, and in accordance with the law.

Many suggested that if CTOs are to continue, they should only be used when they are the least restrictive option available. Further:

- people should have the support of an advocate whilst under a CTO,
- they should be able to change the terms of the CTO through a tribunal process and
- there should be a time limit beyond which a full review of a CTO should be held.

There was also agreement that there should be an accessible and speedy complaints process for anyone under a CTO.

Those at the session also agreed that steps must be taken to address the racial inequalities within the use of CTOs and detention under the MHA. The group felt that issues that disproportionately effect certain groups should be reformed in collaboration with those individuals - their voices and experiences need to be at the very forefront ensuring the right to be free from non-discrimination (which is set out in Article 14 in the Human Rights Act, discussed below, and is protected by the Equality Act).

## 4.3 The Right to be Free from Discrimination

This right to be free from discrimination means that you should be able to enjoy all the other rights included within the Human Rights Act without

discrimination. This right protects against discrimination for any reason, or an intersection of different reasons.

Only 27% of people thought that the plans to create the “Patient and Carer Race Equality Framework (PCREF)”, the development of culturally appropriate advocacy for people of all ethnic backgrounds and the plans to change CTOs protected the right to be free from discrimination. 33% were not sure.

Those attending our session thought the issue of structural or institutional discrimination in services more widely, and in mental health services in particular, should be recognised and addressed. Concerns were raised around the recently published Sewell Report<sup>6</sup> and the lack of recognition of systemic discrimination, particularly racism more widely. As one attendee said:

“The issue of structural or institutional discrimination is never adequately addressed either in law or in practice (this was apparent with the Sewell Report). Unless it is, or at least there is a move towards this, we're never going to be truly recognising, let alone addressing, the real experience of discrimination.”

There was a feeling that the steps included in the White Paper to address discrimination, such as the development of culturally appropriate advocacy for people of all ethnic backgrounds and communities, should be a commitment and not “subject to appropriate funding.” To properly support the right to be free from discrimination, these initiatives need to be properly funded and implemented consistently across England and Wales. Advocacy in general must be fully funded and independent.

The White Paper focusses on racial discrimination, however, issues were also raised around discrimination that affects different groups such as autistic people, people with learning disabilities and people who identify as LGBT+. It was felt that this should also be addressed. It was felt that staff should be fully trained in these areas and again, issues that disproportionately affect certain groups should be reformed in collaboration with those individuals - their voices and experiences need to be at the very forefront.

## 4.4 The Right to be free from Inhuman and Degrading Treatment

This right protects against being treated in a way that causes serious mental or physical harm or humiliation including deliberate harm (abuse) and unintentional harm (neglect). This right is an **absolute right**, it is never lawful

<sup>6</sup> See the Runnymede Trust’s open letter to Boris Johnson regarding the Sewell report:

[https://docs.google.com/forms/d/e/1FAIpQLSfrDvAHqXfArUqBYP7\\_4dfQGqI5s7pAYVkfCc6Sj2KFgc1TmQ/viewform](https://docs.google.com/forms/d/e/1FAIpQLSfrDvAHqXfArUqBYP7_4dfQGqI5s7pAYVkfCc6Sj2KFgc1TmQ/viewform)

to treat someone in an inhuman or degrading way or allow inhuman and degrading treatment to occur.

On introducing statutory 'Advance Choice Documents', implementing the right for an individual to choose a 'Nominated Person' and expanding the role of 'Independent Mental Health Advocates', only 13% of people thought this protects the right to be free from inhuman and degrading treatment (33% were not sure).

There were worries that the guiding principle of therapeutic benefit would remain only a paper policy if not properly implemented. Those attending the session felt that people should only be detained under the MHA when it is of therapeutic benefit to them and there is no other way to provide the support. They felt that focus should be placed on properly funded community mental health services and that people should be able to have a say in their care and treatment.

Concerns were raised that sometimes the views and choices of people accessing mental health services are ignored by mental health staff and services, which can lead to them facing treatment which they feel is inhuman and degrading, such as Electroconvulsive Therapy (ECT). Therefore, any newly introduced Advanced Choice Documents should be fully respected.

## 4.5 The Right to Private and Family Life

The right to private and family life is very wide. It protects ideas around autonomy and choice (having a say in your care and treatment), privacy and having contacted with your family members and loved ones. This right is a **non-absolute** right. This means it can only be limited or restricted if the restriction is lawful, legitimate and crucially the least restrictive option available.

No one involved in the research thought the proposals mentioned above (about the 'Advance Choice Documents', choosing a 'Nominated Person' and expanding the role of 'Independent Mental Health Advocates') would positively protect the right to private and family life; 85% of people were not sure.

There was a general feeling that Advance Choice Documents are an improvement on the current position and could better protect people's autonomy. However, there were worries that these would not be respected by mental health services and that people would still be subject to inhuman and degrading treatment during their care and treatment. Concerns were also raised around the nominated person being used in a coercive or abusive way by family members.

The group felt that properly funded and independent advocacy services should be provided for anyone accessing mental health services. Those involved in our research felt that these commitments on paper to increased advocacy support would be mere lip service if they are not properly funded. This would go some way to protect both the right to be free from inhuman and degrading treatment and the right to private and family life. It was suggested that these should be opt-in instead of opt-out.

Overall, it was felt that more power and support should be given to the voices of people with lived experience of accessing (or trying to access) mental health services. People should be supported to share their views and this process should be made as accessible as possible.

## 4.6 Experiences and views people shared with us

“Fundamentally, staff need to understand our basic rights as people and not view us as someone that they know best what to do for.”

“Total commitment [to the right to private and family life] throughout the system is the only way to value it. That includes the necessary resources to implement and to monitor and rectify breaches.”

“[The planned reforms] feel a bit empty without budget planning ahead of it.”

“The culture of the mental health system needs to change, staff culture needs to change, we know of active racists working on wards and of psychologists and psychiatrists who deny racism exists, and pathologise LGBT+ identities. Advocacy needs to be funded and independent, too many advocates will not confront systems they are paid by.”

## 5. Evidence from mental health staff\*, advocates and campaigners

\*Those working in public services or private, charitable, or voluntary bodies delivering public services.

### 5.1 Human Rights and the Guiding Principles

- 68% of staff think that including information about human rights in the Mental Health Act will help make sure that staff think about human rights.
- 87% of staff said that they agreed with the four guiding principles.
- However, 45% of staff said that the plans to include these principles in the Mental Health Act and the Mental Health Act Code of Practice was **good but not good enough**.

The majority of staff felt that including information about human rights in the Mental Health Act (MHA) will make sure that staff think about human rights. This is also true of BIHR's experience over the last 20 years, and especially with the Coronavirus Act 2020, which has shown that when the duty to protect, respect and fulfil human rights is referred to directly in laws, there is increased awareness and importance put on this duty (more on this below).

As with the people accessing (or trying to access) mental health services, most staff agreed that the inclusion of the four new guiding principles are welcome. There were again concerns raised that some key things were missing, including:

- empowerment,
- positive risk taking,
- increased choice and
- a real commitment to reducing discrimination.

Again, it was agreed that the suggested reforms, including the guiding principles, must be more than mere on paper policies for them to have real impact. It was noted that staff must be fully trained on these principles and all other reforms or changes made, and that they should be made central to the practice and policy of Mental Health Trusts.

It was also agreed that these principles should be included within care plans and made fully accessible to people when they come into contact with mental health services, whether in an inpatient or community setting. Suggestions included:

- leaflets;
- information in GP surgeries; and
- that the principles should be a part of any discussion with people accessing services and their family/loved ones.

## 5.2 The Right to Liberty

The right to liberty protects against extreme restrictions on our movement. This right is a non-absolute right. This means it can only be limited or restricted if the restriction is lawful, legitimate, and (crucially) the least restrictive option available.

31% of staff thought that the plans to change Community Treatment Orders protected the right to liberty, 35% were not sure.

Similar issues regarding the right to liberty were raised by staff as were by people accessing (or trying to access) mental health services. There were again suggestions that the best way to provide the least restrictive mental health support, and thus fully respect and protect the right to liberty, is to invest in community mental health services which work with and for the communities they exist to support.

Concerns were raised that plans in the White Paper do not seem to address the issues with CTOs that have been flagged as problematic, such as black men being disproportionately affected by them, and that they are often seen as being coercive by those affected by them. However, it was also noted that removal of CTOs may mean longer hospital stays.

## 5.3 The Right to be free from Discrimination

This right to be free from discrimination means that you should be able to enjoy all the other rights included within the Human Rights Act without discrimination. This right protects against discrimination for any reason, or an intersection of different reasons.

Only 14% of staff thought that the plans to create the “Patient and Carer Race Equality Framework (PCREF)”, the development of culturally appropriate advocacy for people of all ethnic backgrounds and the plans to change CTOs protected the right to be free from discrimination, 45% were not sure.

As with the people accessing (or trying to access) mental health services, there was agreement that steps toward the protection of the right to be free from discrimination need to more than just paper policy. It was suggested that there needs to be a cultural shift in wards and frontline services and that staff should receive training around this.

Staff involved in our research said that there should be more of a focus on person centred approaches and service user involvement and implementation of their feedback. It was also suggested that there should be more voice given to carers.

It was made clear again that there needs to be investment in community services. Concerns were raised that many of the plans that plan to tackle discrimination such as culturally appropriate advocacy is “subject to funding”.

## 5.4 The Right to be free from Inhuman and Degrading Treatment

This right protects against being treated in a way that causes serious mental or physical harm or humiliation including deliberate harm (abuse) and unintentional harm (neglect). This right is an **absolute right**, it is never lawful to treat someone in an inhuman or degrading way or allow inhuman and degrading treatment to occur.

On introducing statutory ‘Advance Choice Documents’, implementing the right for an individual to choose a ‘Nominated Person’ and expanding the role of ‘Independent Mental Health Advocates’, 45% of staff thought this protects the right to be free from inhuman and degrading treatment (20% were not sure).

As with people accessing, or trying to access, mental health services, staff working in mental health services also felt that people should only be detained under the Mental Health Act (MHA) when it is of therapeutic benefit to them.

It was raised here that there needs to be increased accountability and a move away from too much power being given to a single clinician in many processes. Staff also raised the issue of overcrowded and ill-suited hospital facilities, stating that they had experienced in-patients sleeping in corridors, on sofas and in lounge area/dining rooms when wards are full. This raises significant human rights concerns.

## 5.5 The Right to Private and Family Life

The right to private and family life is very wide. It protects ideas around autonomy and choice (having a say in your care and treatment), privacy and having contacted with your family members and loved ones. This right is a **non-absolute** right. This means it can only be limited or restricted if the restriction is lawful, legitimate and crucially the least restrictive option available.

38% of staff thought the above proposals (mentioned in the right to be free from inhuman and degrading treatment) would protect the right to private and family life (44% were not sure).

Staff were clear that investment in community services was a way to better protect both the right to be free from inhuman and degrading treatment and the right to private and family life.

Echoing the evidence provided by people accessing (or trying to access) mental health services, staff agreed that the choices and autonomy of people should be protected. It was agreed that this means advance choice documents need to be kept up to date and implemented and respected throughout mental health services.

## 5.6 Experiences and views staff shared with us

“There is a real tension in the White Paper where the focus is ostensibly on redressing the balance of power, but the framework isn’t explicitly rights based in my view.”

“I think "subject to funding" is not good enough - these initiatives need to be properly funded and implemented consistently, and all new measures should be actively informed and developed by those it directly impacts.”

“We need to start from a position of a duty to provide community and mental health services to prevent hospital detention”.

“We need properly funded mental health services with resources, staff and capacity to meet demands on the services.”

## 6. BIHR's Position and Recommendations

As noted previously, many of the issues raised in the 2017 review of the Mental Health Act are human rights issues. These include:

- including long periods of detention that are not of therapeutic benefit,
- concerns around the Mental Health Act being used in unsuitable, and sometimes discriminatory, ways, for example, black people are four times more likely than white people to be detained, and
- people within mental health services having a lack of say over their own care and treatment. This was also evident in our evidence gathering.

As explained in [Section 3: The Human Rights Act and the Mental Health Act](#), the legal duty on public services, including mental health services, to protect, respect and fulfil human rights has existed since the passing of the Human Rights Act 1998 (HRA). This duty applies to laws passed before and after the HRA, including mental health law. However, human rights training or capacity building is not given as standard in mental health settings, nor has this understanding of how the HRA works with mental health law and policy been integrated in service development and delivery.

Over the last year we have trained over 3,000 public officials, a large percentage of whom work in mental health services, the majority have never received human rights training before. For example in a recent survey conducted with staff working with children and young people's mental health services, prior to a BIHR human rights session only 15% of respondents had attended human rights training before.<sup>7</sup> Increased awareness raising, training support and implementation of this pre-existing legal duty to protect, respect and fulfil human rights is essential - not only to the success of these reforms but also in ensuring that the people accessing (or trying to access) mental health services currently have their rights protected.

An important first step in ensuring human rights are at the heart of the MHA reform is to directly refer to the legal duty under the Human Rights Act in the reformed Act. Our research shows that 79% of people overall think this is important, this rises to 90% of people who are accessing (or trying to access) mental health services. At BIHR, our experience over 20 years and especially with the Coronavirus Act 2020 has shown that when the duty to protect, respect and fulfil human rights is referred to directly in laws, it means that there is increased awareness and importance put on this duty.

For the changes suggested by the White Paper to have any real impact on the everyday delivery of mental health services, they must be properly implemented. This means staff must be fully supported, and funding must be provided to do so, and people must be able to know their rights and have meaningful ways to discuss, challenge and improve care and treatment. Our recommendations below set out how people's legally protected human

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<sup>7</sup> See more on this in The British Institute of Human Rights, *The Human Rights Act: A powerful tool for ensuring rights are made real in the UK*, available at: <https://www.bihr.org.uk/Handlers/Download.ashx?IDMF=260f1a54-4592-4380-9411-ea657b2e0368>

rights can be centred during this consultation and in any next steps, including the eventual new law.

## Our overall recommendations:

- Any reform to mental health law should be centred around respect for people's human rights. The suggested guiding principles and the reforms that fall under them are seen as a welcome step forward. However, although these are based on human rights principles, the legal duty under the Human Rights Act is not directly referenced. At BIHR, our experience over 20 years, and especially with the Coronavirus Act 2020, has shown that when the duty to protect, respect and fulfil human rights is referred to directly in legislation and codes of practice, there is increased awareness of this duty which leads to improved rights protection for people and their loved ones. **Our research shows that 79% of people think that the legal duties under the Human Rights Act should be directly referred to in the new Mental Health Act.** The legal duty (coming from the Human Rights Act) to apply the Mental Health Act in a way that is compatible with human rights as far as possible, should be directly referred to in the new law, the Code of Practice and in all consultation processes and training that follows. It is important that people know that regardless of changes to the MHA, their human rights must be respected, protected and fulfilled.
- The guiding principles are welcomed. However, our submission argues that it is essential that these principles are not just referred to on paper (in the MHA and the Code of Practice) but are fully implemented throughout all mental health services (and other services such as physical health care, police etc). **Our research shows that 61% of people overall thought that the plans to include these principles in the Mental Health Act and the Code of Practice was good but not good enough. This rose to 90% amongst people who are accessing, have accessed or are trying to access mental health services.** These principles should be fully implemented in practice through:
  - ensuring people accessing, or trying the access, mental health services (and their loved ones) are made aware of these principles in an accessible way;
  - including these principles in care plans and making them visible in mental health services;
  - integrating these principles in community care and within organisations involved in mental health care, such as CQC, NICE, voluntary sector and user/carer organisations.
  - Staff must also be fully trained and supported to provide services that are guided by these principles.

## Our human rights and reform specific recommendations:

- To uphold the **right to liberty (Article 5, Human Rights Act)**, the guiding principle of least restriction must not only be included in the new Mental Health Act and the Mental Health Act Code of Practice, but steps must be taken to ensure the principle is implemented in practice. **Our research showed that 61% of people felt that the principle being included only on paper wasn't enough.** Our evidence gathering has found that in order to ensure the right to liberty is respected, protected and fulfilled, there must be:

- a greater investment in community mental health services which are created with and for the people they exist to support;
  - access and funding for independent advocacy;
  - time limits on Community Treatment Orders (CTOs); and an accessible and speedy complaints and review processes for anyone under a CTO.
- To uphold the **right to be free from discrimination (Article 14, Human Rights Act)**, the issue of structural or institutional discrimination in services more widely, and in mental health services in particular, should be recognised and addressed. **Our research shows that 37% of people thought that the plans to create the “Patient and Carer Race Equality Framework (PCREF)”, the development of culturally appropriate advocacy and the plans to change CTOs did not protect the right to be free from discrimination**, 40% were not sure. Our evidence gathering suggests that to ensure the right to be free from discrimination is respected, protected, and fulfilled, there must be properly funded and implemented advocacy and the voices and experiences of groups that are affected by discrimination must be at the forefront of any reforms.
  - To uphold the **right to be free from inhuman and degrading treatment (Article 3, Human Rights Act)**, the guiding principle of therapeutic benefit must not only be included in the new Mental Health Act and the Code of Practice, but steps must be taken to ensure the principle is implemented in practice. **Our research shows that only 23% of people thought that the plans in the White Paper would protect the right to be free from inhuman and degrading treatment.** This is concerning as the right to be free from inhuman and degrading treatment is absolute, meaning any inference with it is unlawful. Based on our evidence gathering, suggestions for ensuring this right is respected, protected and fulfilled, include
    - only using detention under the Mental Health Act when it is of therapeutic benefit and there is no other way to provide the support;
    - ensuring that community mental health services work with and for the communities they exist to support; and
    - providing accessible information on rights and clear processes for when people feel that they are at risk of inhuman or degrading treatment (or any other rights abuse).
  - To uphold the **right to private and family life (Article 8, Human Rights Act)**, the guiding principle of choice and autonomy must not only be included in the new Mental Health Act and the Mental Health Act Code of Practice, but steps must be taken to ensure the principle is implemented in practice. **Only 24% of people felt that introducing statutory ‘Advance Choice Documents’, implementing the right for an individual to choose a ‘Nominated Person’ and expanding the role of ‘Independent Mental Health Advocates’ would protect the right to private and family life.** In order to ensure that the right to private and family life is respected, protected and fulfilled, fully funded and independent advocacy services should be provided for anyone accessing mental health services. Crucially, more power and support should be given the voices of people with lived experience of accessing, or trying to access, mental health services.