Mental Health Alliance

A Mental Health Act fit for tomorrow

An agenda for reform

June 2017

Research undertaken by Rethink Mental Illness

Rethink Mental Illness.

Contents

Who we are

The Mental Health Alliance is a coalition of more than 65 organisations that came together in 2000 to provide a focus for campaigning on common concerns about reform of the Mental Health Act, up to and during the passage of legislation through Parliament.

While we welcomed some of the changes that were introduced through the 2007 amendments, we have continued to champion the need for comprehensive reform.

Foreword

The Mental Health Act 1983 sets out the legal framework for compulsory powers in England and Wales. It has a huge impact on the lives of individuals needing mental health treatment and their families and loved ones.

The Mental Health Alliance is a coalition of more than 65 organisations that came together in 2000 to provide a focus for campaigning on common concerns about reform of the Mental Health Act, up to and during the passage of legislation through Parliament. While we welcomed some of the changes that were introduced through the 2007 amendments, we have continued to champion the need for comprehensive reform.

The Alliance survey, the first of its kind, gathered the views of over 8,000 individuals including those with lived experience, families, carers, and loved ones and professionals. The survey focused on the underlying principles of the Mental Health Act and how people's rights are currently protected, where it is working well and what could be changed and improved.

Whilst a majority of respondents agreed that there are circumstances when involuntary treatment in hospital may be necessary, the survey reveals deep concerns that people's dignity, autonomy and human rights are overlooked. When asked about additional rights that are needed, respondents highlighted rights to treatment, choice of treatment and place of treatment, information, and to have a voice – among many other things.

The Mental Health Act is not fit for purpose. We urgently call for a review of the Act, so that together we can protect the rights and improve care for some of the most vulnerable people in the health system.

We want to thank everyone who responded to this important survey, Alliance members and the team at Rethink Mental Illness who worked with the Alliance in developing, disseminating and analysing the survey.

Suzanne Hudson, Chair

Andy Bell, Vice Chair

Alison Cobb, Vice Chair

June 2017

Executive summary

- The Mental Health Alliance undertook the first national survey on attitudes towards the principles behind the Mental Health Act.
- Over 8,000 individuals – people with personal experience of mental illness, professionals, carers, family and friends – responded to our survey.
- **The survey reveals deep concern that people's dignity, autonomy and human rights are overlooked when the Mental Health Act applies.** The Act is therefore failing the people who most need protecting.
- **Respondents told us that people are denied opportunities to be involved in their care,** along with their family, friends and carers. It is clear that 'Advance Decisions' are not promoted and respected.
- **A majority of respondents agreed that compulsory treatment in hospital is sometimes necessary when people pose harm to themselves or others.** However, they were clear that important principles are currently flouted, that genuine parity between physical and mental health is needed. They gave strong support to the prospect of Advance Decisions being respected under the Mental Health Act.
- **The survey showed that legislation is needed urgently to address unintended consequences of the Act.** The outmoded 'nearest relative' allocation system, for example, causes intolerable misery and delay for people at their most vulnerable.
- The Government must deliver a fundamental review of the Mental Health Act. The Act is now over 30 years old and not fit for purpose.
- The sheer scale and range of responses to our survey shows the demand for reform. The questions not fully answered also underline the urgency for more research to be carried out with the people whose voices are too-often ignored.
- The Mental Health Alliance believes reform is urgently needed and is committed to helping the Government to conduct a review of the Act.

Background

The Mental Health Act

The Mental Health Act (MHA) 1983 is a crucial piece of legislation setting out the legal framework for compulsory powers in England and Wales. Scotland and Northern Ireland have different mental health legislation. The Act sets out when someone can be admitted, detained, and treated in hospital against their wishes.

The Act is now over 30 years old. It was amended in 2007 and the changes introduced included new Community Treatment Orders (CTOs) and a right to access advocacy.

The Act is accompanied by a Code of Practice. This is an important document as it offers statutory guidance, and professionals who do not follow it can be challenged in court. It was updated in 2015[1], but the scope of the Code is limited by the text of the Act itself.

Implementation of the Act

There are several causes for concern about the implementation of the Mental Health Act.

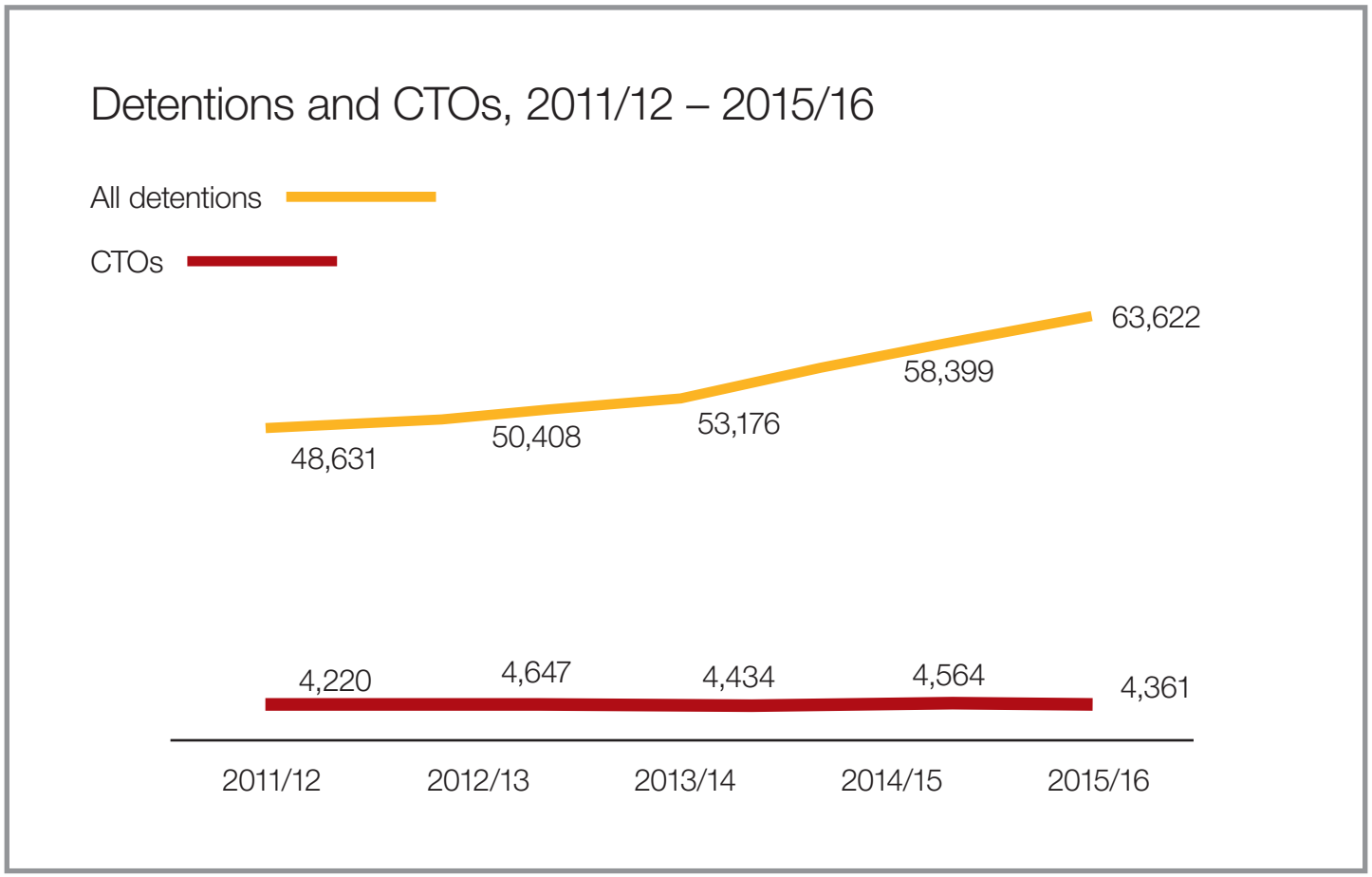
Official statistics show that detentions under the Mental Health Act have risen overall.[2] Over 63,000 people were detained under the Act in 2015/16 in England - a 47% increase over the past decade.[3] 2% of people in contact with mental health services are currently detained under the Mental Health Act. In the financial year 2014/15, the number of detained patients in England outnumbered informal patients for the first time.[4]

Annual reporting by the Care Quality Commission (CQC), the regulator of the Act in England, indicates that people detained under the Mental Health Act are poorly involved in their own care. 12% of patients interviewed by the CQC were not informed of their right to an Independent Mental Health Advocate, and 29% of patient records showed no evidence that service users were involved in their care planning.

Community Treatment Orders are intended to reduce the number of people detained in hospital, and to promote their recovery.[5] There are concerns that CTOs do not achieve these aims. 4,361 CTOs were issued in 2015/16, a decrease of 4% since the previous year.[6] The number of CTOs issued has remained relatively stable over the past five years.

1. Department of Health (2015) *Mental Health Act 1983: Code of Practice*
2. NHS Digital (2016) *Mental Health Bulletin: 2015-16 Annual Report*
3. NHS Digital (2016) *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual Statistics, 2015/16*
4. CQC (2016) *Monitoring the Mental Health Act in 2015/16*
5. Department of Health (2015) *Mental Health Act 1983: Code of Practice* page 328
6. NHS Digital (2016) *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual Statistics, 2015/16* page 17

Figure 1: All detentions and CTOs, 2011/12 - 2015/16 (NHS Digital, 2016)



The potential for reform

Since the inception of the Mental Health Act in 1983, there have been huge changes to the health policy landscape. This includes the passing of the Human Rights Act 1998, the Health and Social Care Act 2012 (which heralded a new rights-based approach to healthcare), and the introduction of the Mental Capacity Act 2005.

The Mental Capacity Act introduced 'Advance Decisions' which allow the recording of any medical treatments someone does not want to be given in the future. These decisions are legally binding as long as they are 'valid' and 'applicable', but if you are sectioned a healthcare professional does not have to follow it.

The 2005 Act was later amended by the introduction of the Deprivation of Liberty Safeguards, which provided a framework for the authorisation of deprivations of liberty in hospitals and care homes for those who lacked the mental capacity to consent to the arrangements. The UN Convention on the Rights of Persons with Disabilities, ratified by the UK in 2009, commits the Government to promoting and protecting the rights of disabled people, including people with mental health problems, as full and equal citizens.

The principles behind the Mental Health Act, and the ways in which it has been implemented in practice, do not reflect the best interests of vulnerable people affected by mental illness. The increasing number of people detained shows that problems in the legislation have far-reaching consequences for people with mental illness.

A new Mental Health Bill was mooted almost twenty years ago. A Government-commissioned committee recommended an Act based on fundamental principles of non-discrimination and patient autonomy. However, subsequent draft bills were not consistent with these principles. After extensive lobbying by the Mental Health Alliance and others the Bills were abandoned in favour of amending the 1983 Act.[7]

There have been more recent signs of a political willingness to review the Mental Health Act. In 2015, the Coalition Government published a Green Paper on learning disabilities, autism and mental health conditions, *No voice unheard, no right ignored*.[8] This sought views about the potential for legislative reform of the Act. The government response to the Green Paper highlighted consensus around the need for increased community-based provision, better engagement of service users and families, joint commissioning, ensuring accountability and transparency for individuals and their families.[9]

There has been little progress since. In a potentially relevant development, the Law Commission recently concluded its review of Deprivation of Liberty Safeguards and recommended they be replaced.

In February 2016, the prospect of major reform was raised again. The Independent Mental Health Taskforce's publication, *The Five Year Forward View for Mental Health*,[10] recommended that the Department of Health work in conjunction with a broad range of stakeholders to review the Mental Health Act.[11] The previous government accepted this recommendation.[12] The Conservative Party 2017 manifesto contained a commitment to reforming the Mental Health Act.

7. Mental Health Alliance (2007) *A history of mental health reform*
8. Department of Health (2015) *No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions*
9. Department of Health (2015) *Government response to No voice unheard, no right ignored* page 35
10. Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health*
11. Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health* page 63
12. HM Government (2017) *The Government's response to the Five Year Forward View for Mental Health* page 21

The research

The research within this report was commissioned by the Mental Health Alliance. The Alliance commissioned a new survey on principles that could underpin a new Mental Health Act. Rethink Mental Illness, a member of the Alliance, was commissioned to design, disseminate and analyse the survey in collaboration with the Alliance.

The Mental Health Act survey ran from 1 November to 18 December 2016. An impressive 8,631 people responded.

Survey design and dissemination

The ten survey questions were designed to capture views on principles that are either implicit in the Act or that could be introduced. Much of the survey asked similar questions in different ways, in order to highlight conflicting individual views on aspects of the Act. Respondents were also given the opportunity to provide additional comments on their experiences.

The survey was designed with extensive input from the Alliance steering group and a panel of people with personal experience of the Mental Health Act.

The survey was promoted by members of the Alliance who used their own communication networks to ensure maximum participation with the research.

The survey was primarily promoted online. To enhance participation, the Alliance also:

- Produced a paper survey, which could be downloaded and returned by Freepost.
- Disseminated a discussion guide designed to facilitate group discussion or individual reflection. 152 survey respondents indicated that they were submitting information based on a group discussion.
- Engaged secure care users: there were four workshops in secure care hospitals using the national 'Recovery and Outcomes Network' that is managed by Rethink Mental Illness. The Network provides forums for secure care residents to discuss issues relevant to their needs and experiences.

Profile of survey respondents

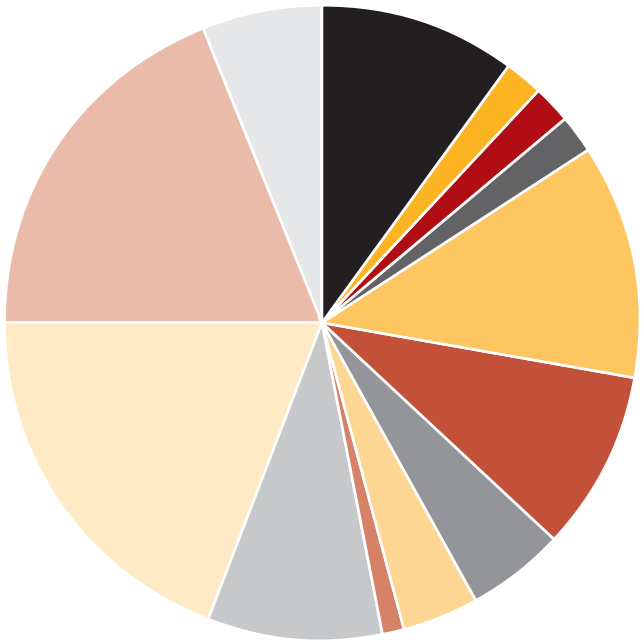
The survey received 8,631 responses from a wide range of groups:

- 46% were currently receiving treatment for mental illness (4,017 people)
- 14% had previously been detained under the Mental Health Act (1,218 people)
- 0.5% were currently detained under the Mental Health Act (44 people)
- 44% were carers, family or friends of someone with a mental illness (3,803 people)
- 26% were professionals (2,281 people)[13]

Professional respondents ranged from psychiatrists to mental health advocates.

13. *These numbers add up to more than 100% because people can be members of more than one category*

Figure 4: Professional respondents by occupation



Allied Mental Health Professional (AMHP)	10%
Psychiatrist	2%
Approved clinician	2%
Hospital manager	2%
Mental health nurse	12%
Social worker	9%
Psychologist	5%
Independent mental health advocate (IMHA)	4%
Independent mental capacity advocate (IMCA)	1%
Health professional	9%
Voluntary sector organisation	19%
Other mental health professional	19%
Legal professional	6%

Demographics

61% of all respondents (5,286 people) answered the demographic questions. Of these:

- 70% were female (3,769 people)
- 13% were LGBTQ+ (698 people)
- 8% were BME (412 people)

Overall, the Alliance engaged well with some groups who are often underrepresented in mental health research (particularly respondents who are LGBTQ+).

However, we did not succeed in engaging all of the groups of respondents we intended to. For example, we struggled to engage with BME respondents and men. Respondents based in Wales were not proportionally represented in the response.

Particularly given the disproportionate number of BME people detained under the Mental Health Act, this makes a strong case for further research to ensure those under-represented in this research have their voices heard.

As with all research, the outcomes should be viewed as indicative of a range of perspectives which reflect the differing backgrounds, personal experiences, and critical analysis that respondents have brought to this survey.

Safeguarding people's rights

We asked how well the Mental Health Act protects the rights and dignity of people who are detained.

The majority of survey respondents believe that the Mental Health Act does not protect the rights of the people who are detained under it.

Human Rights

The Human Rights Act 1998 (HRA) sets out 16 legally enforceable human rights that apply to everyone in the UK, including people experiencing mental health issues. The HRA requires both central government and public services to respect and protect these rights, including in mental health settings.

The majority of respondents who said they had 'personal experience of mental illness' do not believe their human rights are sufficiently protected by the Mental Health Act.

People who have previously been detained under the Mental Health Act were most likely to say that their rights were not protected. Patient-facing professionals who work closely with people who are detained were most likely to say that their rights were sufficiently protected.

'I am confident that my human rights would be protected under the Mental Health Act if I were to be detained under it'

- 58% of people who have been previously detained disagreed
- 54% of BME respondents disagreed
- 60% of LGBT respondents disagreed
- 44% of professionals disagreed

The majority (53%) of previously-detained respondents do not believe that the Mental Health Act protects them sufficiently from inhuman or degrading treatment (Article 3 of the Human Rights Act).

Dignity

The right to be free from inhuman and degrading treatment is central to protecting dignity (Article 3 in the HRA). This is an absolute right, which means such treatment is never permissible.

The majority of people who have been previously detained do not believe they were detained in a dignified way under the Act.

"…it was extremely humiliating and led me to become far more distressed than I otherwise would have done…there was no need for six nurses to enter the bathroom when I wasn't being violent…"

Recently-detained respondent

There were differences in the views of patient-facing professionals, especially clinicians, and people who had previously been detained under the MHA.

'People are currently treated with dignity when detained under the Mental Health Act'

- 61% of people who have been previously detained disagreed
- 41% of professionals disagreed with this statement (33% 'don't know')'

"As a police officer, I have often been drawn into incidents where the police are being required to referee disputes between patients and staff, where mental health practice has not ensured the rights of patients. Patients who are not legally detained have been reported to the police for causing damage whilst trying to leave because staff are holding them without consent."

Serving police officer

Parity with physical health

The majority of all survey respondents believed that the rights of people living with mental illness are not protected and enforced as well as the rights of people living with physical illnesses.

'The rights of people living with mental illness are protected and enforced as effectively in law as those for people living with a physical illness'

- 80% of people who have previously been detained disagreed
- 81% of LGBT respondents disagreed
- 67% of BME respondents disagreed

"It is particularly unfair that people with physical issues can make stipulations about their future treatment and this will always be followed. Yet the same option is not available for people with mental health issues."

Respondent currently receiving mental health treatment, also a carer

We specifically asked respondents about Advance Decisions. This is because an advance decision to refuse treatment for a mental illness can sometimes be over-ridden if you are sectioned under the Mental Health Act.

68% of respondents to our survey believed that Advance Decisions should be treated in the same way under both the Mental Health Act and the Mental Capacity Act, and that such decisions should not be overridden if they are valid and made with capacity.

"I have bipolar disorder and have an Advance Decision. I have also been admitted to a psychiatric hospital on a voluntary basis when I needed to be in a place of safety. Being able to make such decisions about my mental health is more empowering than being forcibly admitted to a hospital under a section."

Respondent currently receiving mental health treatment

Principles underpinning the Mental Health Act

We asked about the implicit principles behind the Mental Health Act, and about the specific aspects of the Act which are used to ensure compliance by people who are detained.

A majority of respondents agreed that compulsory treatment in hospital was sometimes necessary, and that it may be necessary to restrict a person's human rights for their own or others' safety.

There is an interesting tension between this and responses to questions about Advance Decisions (see page 15). However, our survey did not establish the specific circumstances in which people think this may be necessary. Some comments explain individuals' reasons for agreeing or disagreeing, but overall this area needs further exploration.

Treatment without consent

The main underlying principle of the Mental Health Act is that it is sometimes necessary for people with a mental illness to be detained in hospital and treated with or without their consent, for their health or safety, or for the protection of others.

"I specialise in the treatment of anorexia nervosa. I firmly believe that use of the MHA has saved the lives and led to the recovery of many of my patients. It is unfair to expect such seriously physically and psychologically unwell patients to make these decisions for themselves."

Psychiatrist

In general, people, including those who had previously been detained under the Act, agreed with the following statement:

It is sometimes necessary to treat someone in hospital against their wishes, even when they have the ability to make decisions for themselves and say they do not want to be treated in hospital

- 64% of all respondents agreed
- 56% of BME respondents agreed
- 68% of professionals agreed
- 64% of previously-detained respondents agreed

"I was sectioned more than 10 years ago but I realise now that it was in my best interests for my safety. It is always difficult to accept help when feeling so bad, but generally, the decision made by the doctors/professionals is not undertaken lightly. I fully appreciate the need to section some people under certain circumstances."

Previously-detained respondent and carer

There was less agreement when respondents were asked a similar question framed around mental health treatment and capacity.

Are there circumstances in which someone should be treated against their wishes if they have the capacity to make decisions about mental health treatment but refuse it?

- 50% of respondents agreed
- 48% of previously-detained respondents agreed
- 54% of professionals agreed

This suggests that some people who agree with detention for treatment may not want people who have capacity to make treatment decisions to be forced to have treatments that they refuse. Our qualitative survey evidence suggests that more support should be given for enhancing decision-making power for those detained under the Act. This includes giving more legal weight to Advance Decisions to refuse treatment, which could include an appeal mechanism.

Restriction of human rights

Respondents believed that the restrictions of human rights were sometimes necessary in order to protect people from themselves, or to protect others.[14]

It is sometimes necessary to restrict a person's human rights for their own safety

- 73% of all respondents agreed
- 80% of professionals agreed
- 63% of previously-detained respondents agreed

These proportions rose when asked about the protection of others:

It is sometimes necessary to restrict a person's human rights for other people's safety

- 86% of all respondents agreed
- 89% of professionals agreed
- 81% of previously-detained respondents agreed

> **"The Mental Health Act straddles uncomfortable ground between protecting patients from themselves and increasingly from an uncaring and stigmatising public and UK press, which sees the MHA as primarily there to protect 'them' from 'us'."**
>
> Previously-detained respondent

People who participated in the secure care workshops felt that restrictions of rights could be essential for keeping people safe. However, they questioned whether it was necessary for detention to last as long as it often does. They described risk aversion and immovability on the part of the Ministry of Justice (which supervises the leave and discharge of people on forensic sections).

With support for the restriction of rights in some circumstances, respondents also felt that specific mechanisms which are involved in the restriction of rights could be necessary and appropriate in some circumstances.

14. The HRA makes it clear that some rights are absolute and can never be restricted, such as being free from inhuman treatment (Article 3). However, other rights, such as liberty or private life (including autonomy) can be restricted provided the safeguards set out in the HRA are met.

Physical restraint and isolation

Most agreed that physical restraint is sometimes necessary. It is noteworthy that previously-detained respondents, who may have first-hand experience of restraint practices (which can be extremely distressing), felt that the use of restraint was sometimes necessary.

There are circumstances where people detained under the Mental Health Act might need to be physically restrained

- 73% of respondents overall agreed
- 81% of professionals agreed
- 69% of previously-detained respondents agreed

Seclusion was seen as less appropriate than restraint for keeping people safe.

There are circumstances where people detained under the Mental Health Act might need to be placed in isolation (secluded)

- 62% of respondents overall agreed
- 69% of professionals agreed
- 59% of previously-detained respondents agreed

Further exploration of the specific circumstances in which people thought restraint and seclusion might be necessary is required, especially in light of recent research that points to the possibility of eliminating reliance on force in mental health settings.[15]

Discharge with conditions and Community Treatment Orders

Respondents agreed that discharging people with conditions attached can be important, but they also agreed that this should only happen when all other options had been exhausted.

Discharging people to the community with some conditions on their treatment can be an important part of keeping people safe and well

- 83% of all respondents agreed
- 77% of previously-detained respondents agreed
- 84% of professionals agreed

"...She was not placed on a Community Treatment Order on discharge, did not take her medication and as a result [...] has caused immense damage to herself and those around her. I think when a patient has no insight they should be treated compulsorily for their own good."

Parent of previously-detained person

Nevertheless, respondents felt that discharge with conditions should only be used when all other options had been exhausted.

15. Mind (2013) *Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England*

Conditions should only be attached to a discharge when all other options have been exhausted.

- 74% of all respondents agreed
- 73% of previously-detained respondents agreed
- 78% of professionals agreed

This is complemented by the survey qualitative data in the survey which indicates that CTOs are often overused, and are used without sufficient support beyond discharge.

"I'm very concerned CTOs are being used for far too long, often over two years, and they are often used to 'dump people' in the community with just medication but otherwise very little correct support in the community."

Hospital manager

The case for urgent change

Mental and physical health are not treated equally by the law. Urgent legislative steps should be taken to address mechanisms within the Mental Health Act that are discriminatory and have serious consequences.

The survey responses highlight some consensus around breach of rights and principles to aspire to in the Act. These are issues that we believe can only be addressed through a fundamental review of the Mental Health Act with rights at its core. Our respondents also highlighted specific mechanisms that are discriminatory and damaging to the recovery of people subject to the Act. These issues should be dealt with urgently and include the 'nearest relative' rules and Advance Decisions.

"My ability to accept or refuse treatment should be equal for physical and mental health and not be arbitrarily deprived of it when I have capacity just because it happens to be a mental illness. Nothing will ever change, and provision of mental health care will never improve while we have a MHA that designates us as less than full human beings with fewer rights."

Respondent currently receiving mental health treatment

Advance Decisions

The overwhelming majority of respondents, including professionals, agreed that Advance Decisions should be treated the same under both the Mental Health Act and the Mental Capacity Act (MCA). Under the MCA, advance decisions are legally binding, and can include refusals of treatment. However, these decisions do not have legal weight if you are sectioned under the MHA.

Advance decisions should be treated the same under both Acts

- 68% of all respondents agreed with this statement
- 73% of previously-detained respondents agreed
- 74% of LGBT+ respondents agreed
- 68% of professional respondents agreed

There is particular support for the idea that people can always make decisions among previously-detained respondents:

With the right support people can always make their own treatment decisions, either in advance or at the time

- 53% of all respondents agreed with this statement
- 60% of previously-detained respondents agreed
- 53% of BME respondents agreed

'Nearest relative'

There was overwhelming support among our respondents for the right to specify who from those close to them should be involved in making decisions.

This statement was framed in the context of the 'nearest relative' role within the Act. This role has statutory rights and powers, and the process by which nearest relatives are selected is based on a fixed hierarchy of relationships.

To what extent is it important that a person is able to specify which individual(s) close to them (e.g. partner, friend, family member) is/are involved in these decisions?

- 86% of all respondents said it was very important

Respondents shared their stories, without prompting, of the system being abused by local authorities and mental health trusts, and of times when this outdated system has caused immense damage.

"Her psychiatrist and social workers used the Mental Health Act to displace me as nearest relative and put my mum in care. They abused the Act and my mum was subsequently abused in care."

Carer

"The legal nearest relative hierarchy is flawed as often power is given to someone with whom there may be all kinds of issues even when you are not unwell so this can be an abuse."

Professional, voluntary sector organisation

Additional rights

We asked respondents to indicate if there were any additional rights that they thought people should have when people first become unwell. Among the issues mentioned were: a strong voice for individuals and families/friends, access to treatment, choice of treatment and right to refuse, choice of treatment location, information, wider/holistic support around social care, housing, and money.

Some respondents who had experienced the secure care system stated there should be more tribunal appeal opportunities than offered currently.

Funding pressures

Funding was cited by many survey respondents as a barrier to good mental health treatment. It was acknowledged that ward staff were clearly overworked and often suffering from staff shortages and funding limits which can impact involvement and treatment. Adequate funding and resource are key to a recovery-oriented mental health system.

"So much of this depends on the resources in the system. The MHA is only ever going to be a framework that tells you where to put the resources. If community care, consultant psychiatry and inpatient wards are properly funded, patients should have no complaints about the protection of their human rights. The MHA would be a minimum standard but no-one should even know it exists because the standards they actually see would go far beyond those minimum standards. The fact that we're now leaning heavily on the Act to defend patients' rights is a sign that we've cut funding so much that we no longer have a culture that takes patients' rights into account by default."

Previously-detained respondent

However, it was also acknowledged that problematic, archaic, and discriminatory aspects of the Act can only be altered through legislative action. Many respondents in secure care pointed out that the Mental Health Act has not been thoroughly reviewed for nearly a decade, and that this means it is in danger of reflecting outmoded conceptions of mental health.

Conclusions and recommendations

Our research makes a powerful and considered case for the Government to carry out a comprehensive review of the Mental Health Act.

The Act is the only piece of healthcare legislation that starts from the premise that the individual is not in control – so it does not seek to maximise autonomy or decision making. The Code of Practice has laudable aims but does not guarantee rights. Ultimately, primary legislation is needed to redress the balance between physical and mental health care rights.

What the survey tells us

- Our survey shows support for the Act's main purpose. A majority of respondents agreed that it is sometimes necessary to treat someone in hospital against their wishes and restrict their human rights for their own or others' safety.
- However the survey does not tell us what people think the circumstances and thresholds should be for using compulsion. This fundamental ethical and legal question needs further exploration.
- People clearly believe that the current Act is failing to protect people's dignity and rights. How rights should be upheld and balanced, in both the framing of the law and its operation, needs further exploration.
- There is strong support for Advance Decisions to be respected under the Mental Health Act.
- There is strong support for people being able to specify which individuals close to them are involved in decisions. Respondents cited problems with how their 'nearest relative', as defined in the Act, is selected.
- Community Treatment Orders, seclusion, and physical restraint are used too readily in some mental healthcare settings when respondents believe they should only be used as a last resort. This echoes other recent research.

What needs to happen next

- The Government should set out clear terms of reference and a timetable for a fundamental review of the Mental Health Act.
- Any review must include urgent reform to the outmoded way that a 'nearest relative' is allocated, support for people to make their own decisions (including the role of Advance Decisions) and a review of CTOs.
- The Department of Health, prior to the drafting of any legislation, should undertake consultative research with groups of people who are most affected by the Act.
- The Mental Health Alliance would welcome the opportunity to work with Government on reforming this crucial legislation.

Contacts for further information

Suzanne Hudson (CEO, Bipolar UK)
Chair of the Mental Health Alliance

Andy Bell (Deputy CEO, Centre for Mental Health)
Vice Chair of the Mental Health Alliance

Alison Cobb (Senior Policy and Campaigns Officer, Mind)
Vice Chair of the Mental Health Alliance

Danielle Hamm
Associate Director of Campaigns & Policy, Rethink Mental Illness

List of members

This report is supported by the majority of Alliance members.

African Caribbean Community Initiatives (ACCI)
The Afiya Trust
AWAAZ Manchester
BACP
Bipolar UK
British Association of Social Workers
British Institute of Human Rights
British Medical Association
British Psychological Society
Carers UK
Centre for Mental Health
Church of England Archbishops Council
The College of Occupational Therapists
Confederation of Indian Organisations
Disability Rights UK
Diverse Cymru
East Dorset Mental Health Carers Forum
Enabling Assessment Service (London)
Family Action
General Medical Council (GMC)
Gofal
Hafal
Homeless Link
HUBB Mental Health User Group
Jami
Justice
The King's Fund
The Law Society
Liberty
Local Government Information Unit (DHN)
Maan Somali Mental Health Sheffield
Manchester Race and Health Forum
McPin Foundation
Mencap
Mental Health Foundation
Mind
Nacro
National Autistic Society
NHS Confederation Mental Health Network
National BME Mental Health Network
NUS - National Union of Students
OCD Action
Pathway
Perceptions Forum
Race on the Agenda (ROTA)
Refugee Action
Rethink Mental Illness
Revolving Doors Agency
Richmond Fellowship
Royal College of GPs
Royal College of Nursing
Royal College of Psychiatrists
Samaritans
SANE
SignHealth
SIRI Behavioural Health
Social Action for Health
Social Perspective Network
Southdown Housing Association
Survivors Trust
Together: Working for Wellbeing
Turning Point
UK Council for Psychotherapy
UK Advisory Network (UKAN)
United Response
West Dorest Mental Health Forum
Women at Wish
Young Minds

www.mentalhealthalliance.org.uk

facebook.com/rethinkcharity

twitter.com/rethink_

www.rethink.org

Registered Charity Number 271028.