Witness Name: Dr Sarah Hughes
Statement No: **WITN0433001**
Dated: 2 April 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR SARAH HUGHES

I, DR SARAH HUGHES, of Mind, 2 Redman Place, E20 1JQ will say as follows: -

INTRODUCTION

1. I am the Chief Executive Officer of Mind (the National Association for Mental Health charity no: 219830). I joined Mind as CEO in January 2023. Prior to this, I was CEO of the Centre for Mental Health from 2017 to 2022 and Chief Executive of Mind in Cambridgeshire, Peterborough and South Lincolnshire from 2004 to 2016. During my time as CEO of the Centre for Mental Health, I served as a Topic Group Chair for the Independent Review of the Mental Health Act 1983, with a focus on patient autonomy. I have over 30 years of experience in mental health and social care.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 Request dated 12 March 2026 (the "**Request**"). The Request was made following Mind's request to submit a written statement of evidence by letter dated 6 March 2026.

3. Pursuant to the Request, this statement addresses Mind's analysis of how policies and practices may contribute to service gaps and the management of risks of violence in respect of those with psychosis/schizophrenia, who are non-concordant with medication, or who lack insight into their mental health condition, among other matters.

4. Given the breadth of the matters covered, this statement has been prepared collaboratively, drawing on the expertise of colleagues across Mind's policy,

legal, and equity functions. The evidence, analysis, and conclusions set out in this statement represent Mind's institutional position, and do not reproduce the legal advice received. Nothing in this statement is intended to waive, or should be construed as waiving, any legal professional privilege attaching to communications between Mind and its legal advisers.

BACKGROUND

National Mind

5. Mind is the leading mental health charity in England and Wales with offices in London and Cardiff ("**Mind Cymru**") where over 300 staff are employed. Since 1946, when Mind was established, the organization has been pushing for understanding, support and respect to end mental health stigma and discrimination alongside people affected by mental health problems.

6. Mind's mission is to give high-quality information and support to people experiencing mental health problems. This ranges from those seeking someone to talk to, to people who experience enduring and severe mental health problems that may lead them to be detained under the Mental Health Act 1983 (the "**MHA**"). Mind pursues this mission through a variety of front-line services, information and advice, policy influencing, public campaigns, intervention in cases and participation in public inquiries that have the potential to improve the law for people with mental health problems.

7. National Mind operates four staffed helplines dealing with welfare benefits, emotional support, general information about available mental health assistance, and a legal advice service that offers general advice to adults over 18 by telephone, email and letter about mental health, social care and health provision in the community, mental capacity, discrimination and housing issues related to mental health. In 2024/25, Mind's helplines responded to approximately 116,000 queries.

8. Mind publishes a range of information on our website aimed at supporting people with their mental health. In 2024/25, our mental health information was accessed 22 million times. The number of people visiting Mind's website for

information and support relating to being sectioned in mental health hospitals significantly increased, with nearly one million views in 2022/23.

Local Minds

9. Mind has a federated structure. Alongside national Mind, which focuses on national policy and influencing work and national programmes, there is a network of 99 affiliated 'local Mind' associations across England and Wales (including Nottinghamshire Mind) which provide front-line support to people experiencing mental health problems.

10. This is delivered through a range of services including counselling, help with employment, benefits advice, advocacy in community and hospital settings, and specialist services for bereavement, housing and homelessness, victims of abuse, and refugees and asylum seekers as appropriate to the needs of local communities. Some of these services are commissioned by NHS or social services.

11. Each local Mind is an independent charity with its own name, CEO, board of trustees and strategy. In 2020/21, at the height of the pandemic, local Minds delivered mental health services to over 406,000 individuals. This increased to 664,346 individuals in 2024/25, which makes Mind the largest provider of mental health services after the NHS.

12. Mind also operates over 170 charity shops across England and Wales which employ people with lived experience of mental illness as well as volunteers.

Mind's policy experience and expertise

13. Mind has particular experience and expertise in the mental health system that is directly relevant to the matters under consideration by this Inquiry. Through its information and advice services, Mind has direct knowledge of the experiences of people living with severe mental illness ("**SMI**"), including those who come into contact with community mental health teams, crisis services, and inpatient settings. Mind's policy and legal teams have, over many years,

engaged with the legislative and regulatory frameworks governing mental health care and detention, including the operation and reform of the MHA and associated statutory guidance.

14. Mind has also worked with NHS trusts, integrated care systems, and other statutory bodies to identify systemic failings in mental health care and advocate for improvements. This breadth of operational, legal, and policy experience means that Mind is well placed to assist the Inquiry in understanding how the mental health system is designed to assess and manage risk, where gaps and failures in that system may occur, and the broader impact of those failures on individuals, families, and the public.

MIND'S RESEARCH AND ANALYSIS

15. Mind's evidence to this Inquiry is organised around a central position: that the mental health system frequently fails people before they reach crisis point, and that this failure falls disproportionately on racialised communities. The sections that follow address service access, gaps in community mental health care, and the policies and practices that contribute to those gaps, including the management of risk of violence. Mind's position, developed through its policy work, legal work, and direct engagement with people with lived experience, is that preventing serious harm requires sustained upstream investment and structural reform, not adjustment to crisis response alone.

Service access

16. The Care Quality Commission's ("**CQC**") latest State of Care report (2024/25) [WITN0433003] summarises data showing increased demand for mental health services and continuing long waits. In 2024/25, there was an average of 453,930 new referrals to secondary mental health services every month. This is an increase of 15% from 2022/23, when there was an average of 394,781 new referrals to secondary mental health services each month.

17. The CQC's own survey of patients, the Community Mental Health Survey 2024 [WITN0433004], found that a third of respondents (33%) reported waiting three months or more between their assessment and first appointment for treatment,

14% reported waiting more than six months, and two-fifths (40%) of respondents felt that the waiting time was too long.

18. Issues with the quality of crisis care are long-standing. Mind's 2011 crisis care inquiry 'Listening to experience: an independent inquiry into acute and crisis mental health care' [WITN0433005] heard some very positive experiences of Crisis Resolution Home Treatment Teams ("**CRHTTs**"), but also major frustrations and problems to do with the capacity of teams, their responsiveness, the effectiveness of their help, and their role in gatekeeping acute hospital admissions. Since then, under the NHS Five Year Forward View for Mental Health [NHSE0000002] and subsequent policy, crisis care provision was expanded, including 24/7 crisis teams. However, the CQC's Community Mental Health Survey 2024 [WITN0433006] heard similar problems with accessing crisis help. The CQC reported in October 2025 that the number of urgent and very urgent referrals to crisis services had risen steeply in 2023/24 and 2024/25, but that a falling proportion of very urgent referrals were being seen within the expected four hour window [WITN04330003].

19. Mind's own engagement with people with experience of the Mental Health Act (carried out in 2018, to feed into the Independent Review of the Act) found that service access was the overwhelming issue of concern, as explored in the publication titled 'Mental Health Act Review: Mind's engagement and influence' [WITN0433007]. This engagement took place in the context of the Independent Review, which was commissioned in part to address longstanding racial inequalities in the use of the Act, as highlighted by the Government at the time. That people can reach a point of being unable to keep themselves or others safe and still be unable to access adequate help is, in Mind's view, one of the most serious consequences of that systemic failure.

20. Need for and access to services is not experienced equally. Racialised communities are among those who experience health inequalities, both in the social determinants that affect mental health and in the barriers they face in accessing support when they need it. The Centre for Mental Health's 2024 report, 'Pursuing Racial Justice in Mental Health' [WITN0390143], shows that

people from racialised communities can encounter numerous barriers to accessing mental health services, including discriminatory practices, poor understanding of cultural differences, and stigma surrounding mental illness, meaning that some people only become known to services in times of crisis.

21. The Patient and Carer Race Equality Framework ("**PCREF**") [DHSC0000105] was developed to address this. However, it remains a long way from being fully embedded in practice. The CQC reported in 'Monitoring the Mental Health Act 2024/25' [CQCM0029115(page 9)] that "*during 103 monitoring visits (to locations and wards) between January and March 2025, staff in more than three-quarters (77%) of services said they had not heard of PCREF*".

22. The picture is compounded by the relationship between racism and trauma. Research commissioned by the NHS Race and Health Observatory and carried out by the Centre for Mental Health and Coffee Afrik CIC titled 'Trauma-Informed Care and Racialised Communities' [WITN0433008] found that trauma in racialised communities is widespread, interconnected and rooted in racism; that public services often reproduce trauma rather than alleviate it; that trauma-informed care is inconsistently applied and rarely anti-racist; and that community-led care is vital but chronically underfunded. Racism does not only cause psychological harm, it also stops people from getting help when they need it.

Gaps in community mental health care

23. The Community Mental Health Service Framework (NHS England, 2019) [DHSC0000092] set out a vision for better and more comprehensive services for people with SMI, but it has not been fully implemented. Mind supports the inquiry report by the Health and Social Care Committee into community mental health services and its critique and recommendations [WITN0409068].

24. The evidence consistently shows a gap between what good community mental health care requires (holistic, person-centred, relational support, with genuine involvement of the patient and their networks in decisions about their own care) and what people actually receive. The Independent Review of the Mental Health Act's final report 'Modernising the Mental Health Act' (2018)

[DHSC0000024(page 57)] highlighted how little say detained patients have in their care and treatment, and that many of its recommendations were "*essential to driving culture change, to ensuring shared decision making becomes routine practice, and that patients' own expertise is acknowledged and valued*". Recent research from 2024 (Ahmed et al. (2024) 'Barriers and enablers to shared decision making in assessment and management of risk: A qualitative interview study with people using mental health services') sets out the value of shared decision making and its enablers and barriers in risk assessment [WITN0433009].

25. People interviewed in the research on shared decision making in risk assessment were generally not involved in their own risk assessment and management but expressed willingness to be involved and for their family/friends to be involved too. While changes in a person's capacity, or their understanding of their mental health (for example during an episode of psychosis), will affect their ability to engage, tools such as advance statements and joint crisis planning enable patients to have a greater say and clinicians to better understand their patients' preferences and meet their needs.

26. Shared decision making is far from being routine practice. In the CQC's Community Mental Health Survey [WITN0433004], over a third (38%) of respondents reported that they did not have a care plan and 43% had not had a review meeting to discuss their care. Over a third (36%) reported having no choice in how their care was delivered and around a quarter were not supported to make decisions (23%) or felt in control of their care (28%).

27. One factor in people's engagement with mental health services is the extent to which the support offer is helpful in addressing what is most important to the person. Sometimes this will involve non-clinical services such as peer support. Yet in the CQC's Community Mental Health Survey [WITN0433004], respondents reported low levels of help or advice in accessing this type of support. Nearly half (44%) said they received no help or advice in joining a group or activity; 69% received no support in finding work; and 67% did not receive advice on finances or benefits. Respondents were also asked a series

of questions to understand their experience of crisis care support. Of those respondents that contacted the crisis team, 1 in 4 (25%) had to wait too long to get through and 36% of respondents did not receive the help they needed.

28. Support in these areas should not be dependent on the person accepting medication or the clinician's assessment of their experiences and needs. This is particularly important where there is a gap between a clinician's assessment of need and the individual's own understanding of their condition. Where access to services is conditioned on acceptance of a clinical formulation, people who do not share that formulation, whether because of their cultural background, their previous experiences of services, or their own understanding of their condition, may be effectively excluded from care. That exclusion can itself contribute to deterioration. Approaches such as Assertive Outreach can help to manage this tension by supporting engagement without making access contingent on perceived compliance.

Community mental health pathways (including EIP, crisis, assertive outreach)

29. The pathways through which people with SMI are meant to receive community-based support (including Early Intervention in Psychosis ("**EIP**"), crisis resolution services, and assertive outreach) are components of the Community Mental Health Framework described above. In Mind's view, the question for this Inquiry is not whether these pathways exist in design, but whether they function in practice for the people who need them most: those with psychosis or schizophrenia, those who are not concordant with medication, those who lack insight into their condition, and those who present with a risk of violence. The evidence set out below suggests that for these groups in particular, the gap between the pathway as designed and the pathway as experienced is widest.

Mind's analysis of how policies and practices may contribute to service gaps and the management of risks of violence in respect of those with psychosis/schizophrenia, non-concordant with medication, or lacking insight into their mental health condition

30. The period 2020 to 2023 was shaped significantly by the Covid-19 pandemic and its aftermath, which affected both the population requiring mental health services and the workforce providing them. It was also a period of implementation of commitments made in the NHS Long Term Plan 2019, of which the Community Mental Health Framework is particularly relevant to this Inquiry.

31. The Community Mental Health Framework replaced the Care Programme Approach. While it contains a number of positive approaches to community mental health care, as noted above it has not been fully implemented. NHS England also published guidance on providing acute inpatient care in 2023 (NHS England: 'Guidance on acute inpatient mental health care for adults and older adults') [NHSE0000515]. This guidance sets out an ambitious vision for inpatient care but Mind's experience is that a significant gap between policy intent and practice on the ground remains and continues to deepen.

32. In 2022, most sections of the Mental Health Units (Use of Force) Act 2018 came into force. That Act, also known as 'Seni's Law', is intended to protect patients in mental health units from inappropriate use of force and to introduce greater accountability and transparency. It was introduced following the death of Olaseni Lewis, a young Black man who died after being subjected to prolonged prone restraint by police officers in a mental health unit.

33. Despite the Act's commencement, the use of force remains a pervasive feature of mental health inpatient culture. Mind considers that the disproportionate use of force, particularly against Black patients, is a significant factor in the distrust of inpatient services among racialised communities, and that full implementation of Seni's Law is necessary if inpatient services are to be made safe for all patients.

34. The **PCREF** [DHSC0000105] was also a significant development during this period. Mind's analysis of PCREF and its implementation is set out at paragraphs 20 and 117.

35. Since 2020-2023, the Mental Health Act 2025 has been passed. Full implementation will take a number of years, but Mind notes that some of the practices it promotes (including shared decision making between clinicians and patients) do not require formal commencement and could be adopted without delay.

36. In 2024, the government published statutory guidance on discharge from mental health settings (DHSC Statutory Guidance (2024): 'Discharge from mental health inpatient settings') [PHSO0000010]. This includes guidance in relation to groups who may face particular challenges on discharge, including those experiencing homelessness.

37. The principal NHS policy development since 2023 is the Ten Year Plan published in 2025 [NHNB0019524]. Of particular relevance to this Inquiry, the Plan includes a commitment to develop a Modern Service Framework ("**MSF**") for people with SMI. This is to be based on a 24/7 neighbourhood care model. The Plan states that the Government will "*improve assertive outreach care and treatment to ensure 100% national coverage in the next decade, with a focus on narrowing mental health inequalities*" [NHNB0019524(page 35)]. Mind welcomes this commitment and considers that the timeframe for delivery of the MSF will be critical to its effectiveness.

Mental Health Act reform

38. Mind broadly welcomed the reforms contained in the Mental Health Act 2025, while considering that the opportunity for more far-reaching reform was not fully taken. Aspects that Mind particularly welcomed include the introduction of statutory care and treatment plans, greater access to advocacy, the nominated person provisions, and greater patient involvement in treatment decisions, with more legal weight given to patients' choices. Requirements on clinicians to consider patients' wishes and feelings, and to consult with people close to them, along with enhanced safeguards around overruling refusal of treatments, should make it more likely that the care and treatment provided meets the person's needs and that therapeutic relationships are promoted.

39. Mind considers that further reform would have been beneficial in a number of areas. In particular, Mind advocated for a right to assessment and treatment in the community, the abolition of CTOs, specific provisions to tackle the well-evidenced racial inequalities in how the Act is used, and further safeguards for children and young people. A right to assessment and treatment would address the situation where people are unable to access help when they need it. Mind's position is that there should be a duty on the relevant local authority or NHS mental health service to provide an assessment when requested, whether by the person themselves or by a third party on their behalf. Assessment would be carried out on a voluntary basis, or on a best interests basis where the person lacked capacity to consent to it. A corresponding duty to provide the care and treatment identified as necessary following assessment would then apply.

Right Care Right Person

40. The introduction of the Right Care Right Person ("**RCRP**") National Partnership Agreement in 2023 [HOMF0000017] and its subsequent implementation represents a significant change to the practice of police involvement in mental health crisis care, and is relevant to the recommendations of this Inquiry.

41. At the heart of RCRP is a threshold to help the police decide when to respond to mental health calls. The threshold for a police response to a mental health-related incident is: to investigate a crime that has occurred or is occurring; or to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm [HOMF0000017].

42. RCRP brought together local health, police, third sector, and social care partners to agree on a pathway that allowed the police to step back from attending:

    42.1. Concern for welfare calls;

    42.2. Walkouts from healthcare facilities (i.e. A&E) and abscondment from mental health settings;

42.3. Transportation of people with mental health problems; and

42.4. Handovers to healthcare following the use of section 136.

43. In theory, Mind supports policies like Right Care Right Person that try to get people support from the right agency. However, Mind has had significant concerns from the beginning with how this policy has been implemented in practice.

44. Changing the way people are supported in a crisis is complex and requires careful planning, partnership working, funding and effective oversight. During the initial rollout of the policy, Mind was concerned about the pace at which police forces were being encouraged to implement the change and whether this would allow public service partners the time to establish how they could deliver the change safely, without anyone falling through the gaps. At the time of rollout, RCRP was understood to be implemented informally and without system-wide planning. We are aware of serious incidents of failure related to that implementation of RCRP.

45. An additional concern was the lack of funding committed to accompany the rollout of RCRP. Many agencies have faced decades of underfunding and are struggling to keep pace with the surge in demand for mental health support. The resulting workforce gaps in mental health services mean many cannot increase their support overnight. Mind continues to see the impact of these changes, where health and other services are struggling to fill the gaps left by police withdrawal without any additional funding.

46. Since the policy's introduction there have been numerous coroners' reports that have made reference to RCRP, either referencing the application of the policy as playing a part in the lead-up to someone's death, or referencing learnings from a person's death to be applied in the context of the RCRP policy.

47. Currently, Mind continues to see a mixed picture across England & Wales with regard to the implementation of RCRP. Some areas have established strong partnership working and clear pathways that are understood by all local

agencies. However, in other areas Mind is aware of misapplications of thresholds by police; poor communication between partners; a lack of clarity on who holds responsibility for responding to someone in crisis and what escalation protocols are in place; and health services continuing to struggle to meet the increased demand without sufficient resource.

48. The Inquiry should consider how any recommendations it makes on inter-agency working sit within the policy context that has developed since 2023. In Mind's view, RCRP has exposed a structural problem that predates it: the absence of sufficient, well-resourced health provision to fill the space that police withdrawal creates. Recommendations that focus on inter-agency protocols and thresholds without addressing this underlying resourcing gap risk repeating the experience of RCRP itself: sound in principle, but ineffective in practice because the capacity to deliver is not there. Mind returns to this in its recommendations below.

Mind's policy analysis and systemic observations in respect of risk assessment and inter-agency working

49. Mind's position on risk assessment in the context of the risk of violence by mental health patients follows from its broader understanding of what effective mental health care requires. Risk of violence is not a fixed characteristic of an individual, to be identified and managed only through standardised tools. It is dynamic, situational and contextual. The capacity to assess it accurately, and to reduce it, is inseparable from the quality of the therapeutic relationship between services and the patient. The evidence set out below supports that position and identifies specific ways in which current practice falls short of it.

50. In September 2024, the Health Services Safety Investigations Body ("**HSSIB**") published an interim report on assessment of suicide risk and safety planning [WITN0433010] during their investigations into inpatient mental health settings. While not directly concerned with assessing the risk of violence, there were general findings that are relevant to consider.

51. HSSIB's interim report highlights the National Institute for Health and Care Excellence ("**NICE**") (2022) guidance on 'Self-harm: assessment,

management and preventing recurrence' [WITN0433011]. NICE guidance specifically prohibits the use of risk assessment tools and scales to predict future suicide or repetition of self-harm, either to determine who should or should not be offered treatment, or to decide who should be discharged. It equally prohibits global risk stratification into low, medium or high risk categories for any of those purposes. Instead, it states that assessment should focus on the person's individual needs and how to support their immediate and long-term psychological and physical safety, with mental health professionals undertaking a risk formulation as part of every psychosocial assessment.

52. The HSSIB report [WITN0433010(page 8)] stated that:

> "*On 21 October 2022, following the publication of the updated NICE guidance mentioned above, the National Clinical Director for Mental Health wrote to the Chief Medical Officers of all mental health trusts in England to highlight the importance of taking a person-centred approach to psychosocial assessments and safety planning. The communication asked trusts to move away from risk assessment tools that stratify an individual's risk of suicide or self-harm. The aim of the letter was to support the culture and practice change required to move towards more person-centred approaches to safety planning for people with mental health needs. However, there was no national guidance for mental healthcare providers on how to do this. New NHS England guidance due to be completed in April 2025 will provide this.*"

53. HSSIB found that, contrary to national guidelines, risk assessment tools providing a 'high, medium, or low' risk score continued to be used. They also found that staff described a fear of being blamed if a risk assessment or risk stratification was not completed and a patient later came to harm.

54. HSSIB noted that the successful implementation of person-centred approaches to patient safety assessment and planning is dependent, among other things, on an organisation's leadership cultures, the people working

within the organisation, and the emphasis on involving patients and carers in the assessment and planning process.

55. These findings about person-centred approaches to safety assessment were made primarily in the context of risk of self-harm. Mind considers that the same principles apply (and the same failures occur) in the assessment of risk of violence toward others. Although the HSSIB findings relate primarily to suicide risk, the underlying principles of dynamic, contextual assessment, and the importance of strong therapeutic relationships are directly applicable to mitigating the risk of violence. Both domains show that improving quality of care, fostering engagement, and tailoring interventions to the individual are more effective than relying on standardised tools or risk scores. In other words, lessons from suicide-prevention practice can inform violence-prevention strategies.

56. The emphasis on the need for person-centred and relational approaches to risk assessment is supported by specific evidence relating to people potentially at risk of being violent towards others (O'Rourke et al, 'Violence within mental health services: how to enhance risk management') [WITN0433012]. These risks should be understood as highly dynamic, situational and contextual, rather than something to be objectively assessed from a neutral perspective.

57. A stronger therapeutic relationship with someone can both support a more accurate assessment of potential risks and is also likely in and of itself to be a protective factor against those risks. The quality of relationships professionals hold with a patient's family and wider social network can also be critical. As such, factors such as whether services are culturally appropriate, trauma-informed, and staffed by skilled and values-led professionals will play a critical role in the ability of services to both assess and manage risk effectively.

58. Research consistently shows that the majority of people with mental health conditions are not violent, and where violence does occur it is typically associated with a combination of situational, social, and clinical factors rather than mental health diagnosis alone. The evidence base is well-established in the UK context specifically. Analysis of over 100 UK public inquiries into

homicides by people with mental illness identified poor risk management, communication failures, and inadequate care planning as the dominant recurring themes (O'Rourke, citing Parker & McCulloch) [WITN0433012].

59. A review of UK public inquiries between 1988 and 1997 found that 65% of such homicides were considered preventable, with investigators concluding that improved risk assessment tools would have only a marginal role, and that the primary lever was improved quality of mental health care overall (O'Rourke, citing Munroe & Rumgay) [WITN0433012]. This conclusion is reinforced by the UK-based National Confidential Inquiry into Suicide and Homicide by People with Mental Illness ("**NCISH**"), which has tracked outcomes across England and Wales over two decades and similarly identified care quality and sustained engagement as critical variables.

60. Systematic evidence on Assertive Community Treatment (primarily drawn from US trials) demonstrates that more intensive, relational community care is associated with significantly lower rates of hospital admission, reduced homelessness, and better engagement with services compared to standard community care [WITN0433013]. Collectively, this evidence supports Mind's position that the capacity to reduce adverse outcomes, including risk of harm, is closely bound up with the quality of therapeutic relationships and the continuity of care provided.

OTHER MATTERS

Community-based mental health care

61. Mind's position and understanding as to what is meant by 'community' in respect of a) community-based mental health care and b) patients being treated in the community includes: locality, social networks and holistic support, as well as connection to culture and identity is thus:

62. Community mental health care can be considered simply as care that takes place outside of a hospital setting. However, Mind's position is that good quality and effective community mental health care goes beyond this definition, and is holistic because people with SMI often have complex needs and face

greater degrees of stigma and social isolation that are not conducive to maintaining good mental health.

63. Many people who are more severely affected by mental health problems experience co-occurring issues with employment, housing, money, relationships and other practical, social and economic elements of their lives. To support people to stay well in the community and avoid the need for hospital admission, it is essential that the care provided is holistic and accounts for the multiple factors that contribute to someone's mental health.

64. Alongside this, good quality care in the community depends on strong relationships between mental health professionals, patients, and their support networks. It is vital that patients and their support networks are involved in care planning decisions if they are to play a central role in supporting someone to stay well.

65. Finally, a successful community-based approach to mental health care understands and responds to the individual's culture and identity, providing tailored support to meet their needs.

66. The sections that follow address specific areas where Mind considers that current practice, research, and policy fall short of this vision, and where change is most needed.

Research and investigation

67. The evidence on relational approaches to mental health care consistently shows that building strong therapeutic relationships between professionals, patients, families and carers supports better engagement and better outcomes. Mind's position is that this relational foundation is not merely good practice but is likely to be more effective at managing risk than more narrowly clinical approaches, precisely because it is within the context of a trusted relationship that risk can be most accurately assessed and most meaningfully reduced.

68. Mind also considers that the significant decline in dedicated assertive outreach provision in the NHS over the past three decades requires systematic analysis. In particular, there has been no thorough national examination of the relationship between declining resourcing of dedicated assertive outreach provision and patient outcomes, including the outcomes for those who disengage from services and go on to cause harm to themselves or others. Mind would welcome a recommendation from this Inquiry that such an analysis be undertaken.

Local versus national approaches

69. The following reports identify significant variation across the country in the quality of mental health care. The reports highlight inconsistencies in commissioning, access, care planning, the quality of facilities, staffing levels, staff mix and training, approaches to restrictive practices and risk assessments, among other things:

69.1. CQC State of Care report [WITN0433003];

69.2. CQC Monitoring the Mental Health Act in 2024/25 [CQCM0029115];

69.3. HSSIB investigations into mental health inpatient settings [WITN0433010]; and

69.4. Lord Darzi's Independent Investigation of the National Health Service in England [NHFT0017605].

70. National Mind's ongoing discussions with local Mind CEOs and service leaders consistently echo these findings. They report that poor resourcing, fragmented communication, and workforce pressures undermine care quality and risk management, contributing to inconsistent patient experiences and preventable adverse outcomes. These local insights reinforce the patterns highlighted in the CQC, HSSIB, and Darzi reports, demonstrating that systemic shortcomings remain widespread across services.

Information sharing

71. Mind does not have a fully developed position on the legal framework governing information sharing in multi-agency working where a patient does not consent, or has withdrawn consent, to such sharing. What Mind can say with confidence is that information sharing failures between services, and between services and families or carers, are a recurrent and well-evidenced source of harm.

72. The HSSIB investigation into transitions from children's to adult mental health services found that communication and information sharing changed when a young person reached 18, with the result that safety risks were not always discussed, and families and carers were not involved in safety planning or risk mitigation. Mind considers that this reflects a broader pattern in which information sharing between agencies and with families is treated as discretionary rather than integral to safe care.

73. Mind's position, developed through its work on the Independent Review of the Mental Health Act and its 2011 crisis care inquiry, is that the most effective mechanism for managing information sharing in complex or crisis situations is not to resolve the question reactively (at the point at which a patient lacks capacity or withdraws consent) but to build the structures for information sharing in advance, when the person has capacity and is not in crisis.

74. Jointly developed crisis plans and advance statements allow patients to specify in advance what information they wish to be shared, with whom, and in what circumstances. Mind considers that the routine use of such tools would both respect patient autonomy and substantially reduce the situations in which services face difficult decisions about sharing without consent.

75. Evidence shows that joint crisis planning reduces the need for detention and compulsory treatment, which suggests it also reduces the circumstances in which contested information sharing decisions arise. In my experience as chair of the topic group for the Mental Health Act Review, the group contributed to the development of the model for advance care directives, supporting both patient autonomy and safer, more consistent decision making in practice.

76. As to how a patient's lack of capacity, insight or medication concordance should influence information sharing decisions, Mind would note that, as set out in more detail below, insight and mental capacity are distinct legal concepts. A patient's lack of insight into their condition does not establish that they lack capacity to make decisions about information sharing. Mind's position is that information sharing decisions in circumstances of contested capacity should follow the framework established by the Mental Capacity Act 2005, applied decision-specifically and with appropriate involvement of families and carers where the patient has consented to this in advance or where it is in their best interests.

Measures to reduce the risk of serious violence

77. A crucial part of reducing the risk of serious violence by mental health patients is ensuring people with a mental health need get support early enough. The overwhelming message Mind heard during the Mental Health Act review was that people could not get the help they needed when they asked for it. Either they were not taken seriously, or the options were not there. In Mind's experience, people from racialised communities are particularly affected. In particular, people have repeatedly told Mind how they struggle to access culturally appropriate support in the community, as noted in Mind's 2024 briefing to MPs on the Mental Health Bill [WITN0433014].

78. People can be refused help in the community and then be detained in hospital against their will when their mental health deteriorates further. In some cases, this denial of care can lead to serious harm to self or others. There is also often a lack of support in the community when people leave hospital, putting their recovery and safety at risk.

79. Mind's position is that significant reform of, and investment in, mental health services is required to ensure people get the right support for their needs at an early stage and do not fall between service gaps as their mental health deteriorates.

Assessment and re-assessment of the risk of violence

80. Mind considers that it is important to collaborate with the patient in assessing and reassessing risks to themselves and others, and their involvement in planning for their safety. People's family and friends are also crucial to this process, as observed by Ahmed et al [WITN0433009].

81. As discussed above, risk of violence should be assessed on an ongoing basis by those professionals best placed to do so, rather than being seen as a discrete event. Risk needs to be understood as dynamic, situational and contextual, and the ability to both assess and manage risk effectively is highly dependent on the quality of relationships that professionals are able to develop with patients and their families and wider social networks. In addition, staff training, ongoing reflective practice, and the involvement of families and advance care directives are all critical to effective assessment and mitigation of risk.

Circumstances in which detention may be justified

82. Mind's position is that detention under the Mental Health Act is a serious interference with a person's liberty and should only ever be used as a last resort, where less restrictive alternatives have been genuinely considered and are not available.

83. The criteria for detention rightly incorporate risks to the health and safety of the patient and others, alongside the need for admission to hospital for assessment or treatment of a mental health problem. Where those criteria are met and no less restrictive alternative (including voluntary admission) is available, detention will be lawful and justified. However, Mind considers that lawfulness and justification are a floor, not a ceiling.

84. A detention that is technically lawful may nonetheless reflect a failure of community services to provide adequate support at an earlier stage, and Mind's experience is that this is frequently the case. The existence of grounds for detention should therefore prompt not only a decision about whether to detain, but a wider question about what earlier intervention could have

prevented that point being reached. Mind returns to this in its recommendations below.

Reform of detention in the Mental Health Act 2025

85. Mind welcomes the requirement for stronger justification for detention in the reform of the Mental Health Act 2025. In respect of any detention decision, Mind would expect there to be substantive justification with a clear, evidenced rationale for what is therapeutic, what constitutes risk, and for the level of harm it is believed would ensue if the person were not detained.

86. Mind also welcomes greater responsibility among services to engage with people about their treatment needs and preferences prior to detention. Reforms introducing duties to engage with the patient in care and treatment planning, in treatment decisions, and through the legal weight given to patients' wishes made at the time or in advance, are relevant to this.

87. However, it is important that detention criteria do not become, in practice, admission criteria, and that hospitals only treat people with ever greater levels of acuity or turn away any other people who seek admission voluntarily.

Mental capacity

88. As noted in paragraph 76, the concepts of 'insight' into one's mental health condition and 'capacity' to make a decision in relation to one's care are distinct concepts and should not be conflated. A person's lack of insight into their condition (or their non-acceptance of the clinical view of their condition) does not in itself demonstrate that they lack capacity to make a specific decision about their care or treatment. Although 'insight' is a common feature in psychiatric practice, it notably has no statutory footing in the Mental Health Act 1983 or the Mental Capacity Act 2005.

89. Capacity under the Mental Capacity Act 2005 must be assessed on a decision-specific basis, by reference to whether a person is able to understand, retain, use and weigh the information relevant to that decision. Mind's position, as confirmed by case law, is that a person cannot properly be found to lack

capacity merely because they do not accept a clinician's formulation of their mental health condition, and Mind would be concerned by any conflation of these two distinct concepts in clinical practice.

Assertive outreach: Mind's view on declining use of assertive outreach teams

90. Mind has not carried out its own research on assertive outreach, but notes that there is international evidence (Marshall M, Lockwood A. 'Assertive community treatment for people with severe mental disorders') [WITN0433013]) of the effectiveness of assertive community treatment, which is set out in the NHS England Guidance to Integrated Care Boards ("**ICBs**") on intensive and assertive community mental health care [DHSC0000101]. In my early career, I worked for the mental health organisation that introduced assertive outreach to the UK from the US in the 1990s, which has informed my understanding of its principles and potential benefits.

91. The picture in England is complex: there has been significant variation across the country and over time in how assertive outreach capacity is organised, with some areas maintaining dedicated Assertive Outreach Teams and others integrating assertive outreach functions into general community mental health teams. This variation may reflect a combination of factors, including the ending of the requirement for dedicated teams following the close of the National Service Framework, the absence of an agreed national model, and a lack of ongoing national oversight. Assertive community treatment is resource-intensive and, where assertive outreach functions have been absorbed into general teams rather than maintained as a dedicated resource, they have been particularly vulnerable to financial and demand pressures.

92. NHS England has been clear that "*while ICBs are not required to commission assertive outreach teams, meeting the needs of individuals [who generalist teams and staff may struggle to engage] requires dedicated resource*" [DHSC0000101(page 21)]. Mind does not have a fixed position on the ideal configuration of such resource, but supports NHS England in that the onus of responsibility for engagement should sit with services, and that lack of

engagement may be the result of factors such as *"the service offer not being what they want or need; reflective of previous poor treatment; [and] a lack of cultural relevance/understanding*" [DHSC0000101(page 4)].

93. The implication of this is that reducing situations where services are not able to effectively engage someone requires widespread improvement of mental health services, including full implementation of PCREF, as opposed to just focusing on assertive outreach to individuals. However, intensive outreach will still be required in some cases and will be reliant on skilled professionals with sufficient and protected time and resource. The increased demand and funding pressures on mental health services over recent years will undoubtedly make it more difficult for trusts to effectively deliver this.

94. More generally, Mind commends the guidance issued by NHS England and considers that the principles and approaches it sets out remain a long way from being universally embedded in secondary mental health services.

95. Mind also commends the interventions proposed by the Ethnicity and Mental Health Improvement Project ("**EMHIP**"), which includes a bespoke, community-based service for those with a history of repeated hospital admissions under the Mental Health Act, poor treatment adherence and who are, traditionally, seen as "*hard to engage*" or "*refractory*" to treatment [WITN0433015]. In EMHIP's locality, the proposed intervention is for intensive support, care and treatment for young Black men with a diagnosis of SMI who have had multiple admissions and a history of coercive care. This represents an assertive outreach approach that is culturally informed and developed with the Black community.

Discharge

96. NHS England's guidance is clear that non-engagement should not be a basis for discharge if there are significant concerns or risks, and sets out what sort of assertive outreach is required [DHSC0000101]. Mind considers that the same applies to unwillingness to engage with treatment. Mind points to EMHIP's approach as an example of this principle in practice: "*engagement*

will not be conditional on treatment adherence – central to it will be a policy of 'no case closure'."

97. Once a patient is discharged from detention under section 3, a further and distinct legal obligation arises: the duty to provide aftercare under section 117 MHA. That duty is not contingent on a CTO being made. A CTO is one mechanism by which a person may be discharged from detention, but the section 117 duty arises independently of whether a CTO is used. Mind is concerned that this distinction is not always well understood at local authority level, and that misunderstanding of the legal framework may contribute to failures in aftercare provision for people discharged from detention without a CTO.

Role of primary care

98. Primary care plays an essential part in the care of people with SMI. GPs and other primary health care professionals may be the first point of contact when mental health problems develop or worsen, and can refer people into secondary services. They hold responsibility for treating a range of health needs a person has, and they may take back responsibility for a person's care when they are discharged from hospital. For example, they may monitor the effects of treatment, including any harmful side effects. Section 1.6 of NICE's 2016 guidance 'Transition between inpatient mental health settings and community or care home settings' sets out how the GPs should be involved and informed when a person is discharged from mental health hospital [NHSE0000540].

Depot medication

99. Mind does not hold views on clinical indications for depot medication, but would expect practice to follow NICE guidelines and other clinical guidance, as well as fully informed consent. Mind's online guide on depot injections and antipsychotic medication [WITN0133019] says the following about depot medication:

> *"A depot injection might be a good option for you if: you find it difficult to swallow medication; you find it difficult remembering to take medication regularly; you prefer not to have to think about taking medication every day. You may also be given a depot injection if the healthcare professionals involved in your care agree that you need the drug, but think you may struggle to take it regularly in a different form."*

100. Reasons some people may not want to have depot injections (as opposed to oral medication) could include side effects, pain or other problems at the injection site, or feeling coerced or controlled. Mind also notes that some psychiatric medications have changed little over many decades, and their side effect profiles can be serious, contributing to comorbidities such as obesity and cardiovascular disease. These factors may partly account for why people with SMI die on average 15–20 years earlier than the general population.

Community Treatment Orders (CTOs)

101. Mind's position, informed by research and its extensive engagement with people with lived experience of CTOs, is that CTOs are not equivalent to ongoing aftercare and should be abolished. In their place, there should be rights to assessment and treatment, and community-based mental health services that work proactively and provide intensive, tailored support to those who struggle most. That conclusion is grounded in three bodies of evidence: on effectiveness, on lived experience, and on the disproportionate impact of CTOs on Black patients.

102. On effectiveness: the research is clear that CTOs do not achieve one of their primary aims (reducing readmission) nor do they reduce the amount of time people spend in hospital. Mind's engagement with this evidence through its work on Mental Health Act reform drew on three key studies:

    102.1. Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, et al. 'Community treatment orders for patients with psychosis (OCTET)': a randomised controlled trial'. Lancet 2013; 381:1627–33 [WITN0320031];

102.2. Barkhuizen W, Cullen AE, Shetty H, et al. 'Community treatment orders and associations with readmission rates and duration of psychiatric hospital admission: a controlled electronic case register study'. BMJ Open 2020 [WITN0433016]; and

102.3. Weich S, Duncan C, Twigg L, et al. 'Use of community treatment orders and their outcomes: an observational study'. Health Services and Delivery Research, February 2020 [WITN0433017].

103. The OCTET randomised controlled trial (Burns et al., 2013), the largest RCT of CTOs conducted in England, found no statistically significant difference in readmission rates in the CTO and control groups (36% in each arm; hazard ratio 1.00) and no significant difference in total hospital stay (41.5 days vs 48 days) [WITN0320031]. No statistically significant benefit was identified in clinical or social outcomes. This was confirmed at 36-month follow-up. While the OCTET study has been criticised on its methodology, Mind notes that its authors have sought to address these criticisms in further publications.

104. The Barkhuizen et al. electronic case register study (BMJ Open 2020) found that patients on CTOs were associated with earlier readmission (HR 1.60) and an average of 17.3 additional inpatient days over two years compared with controls [WITN0433016]. Further, the mean CTO duration of 3.2 years was far in excess of the government's own original projection of 9 months at the time the legislation was introduced.

105. Weich et al.'s large-scale observational study (NIHR Health Services and Delivery Research, 2020), drawing on a nationally representative sample of almost 70,000 patients eligible for CTOs in England over a four-year period, found no statistically significant association between CTO use and shorter time to re-admission or reduced time in hospital [WITN0433017]. CTO patients spent on average 7.5 days longer in admission than non-CTO patients, with a daily rate of admission rate ratio of 1.20 (95% CI 1.10–1.30). The study also found no evidence of variation in effectiveness between NHS provider trusts, and no association between CTO use and reduced mental health treatment

costs, with CTO patients incurring average annual inpatient costs of £10,942 compared with £8,273 for non-CTO patients.

106. On lived experience: people with experience of being on a CTO have consistently described them to Mind as coercive and intrusive. In a workshop undertaken by Mind in 2018, people with lived experience of being on a CTO described them as *"a tag that nobody can see but you know it's around your mind*" and "*unsupportive*" (Workshop report titled 'The Mental Health Act – what needs to change for Black and minority ethnic people?' (2018)) [WITN0433018]. In the same workshop, Black African and Caribbean people shared with Mind anger at the disparities in the use of CTOs, with some characterising the powers as "*race surveillance*" [WITN0433018].

107. On racial disparity: the disproportionate impact of CTOs on Black patients is among the most serious injustices in the mental health system. CTO use in 2024–25 was highest for Black or Black British people – over eight times the rate for the White group [WITN0433019]. CTOs were supposed to provide a route out of disproportionate sectioning but, in Mind's view, have perpetuated and exacerbated Black people's subjection to compulsion under the Mental Health Act.

108. More generally, people report that they do not know how to end the restrictions placed on them by CTOs. A CQC report [WITN0433020] into CTO use in some London boroughs states that none of the people who they spoke with knew what needed to happen for them to come off their CTO. The report says it is "*almost impossible for patients or their legal representatives to show that their CTO should be discharged*" [WITN0433020(page 39)].

109. Service users told the Joint Committee on the Draft Mental Health Bill that they felt CTOs were an easier way for clinicians to manage discharge, but that this was just a way to pass on responsibility. One person said that he knew someone who felt so restricted under a CTO that he tried to take his own life, and another said that CTOs had caused "*untold damage to person-centred, collaborative care*" [DHSC0000151(page 27)]. In Mind's view, it is unacceptable that people should be subject to the powers of a CTO simply

because services have not been resourced sufficiently to deliver an appropriate level of care.

110. Further, being on a CTO is no assurance of community services. The CQC report heard from Independent Mental Health Advocates ("**IMHAs**") that some patients who contacted the IMHA service reported difficulty in accessing community services, such as housing support and day services [WITN0433020].

111. The OCTET study authors concluded that, "*In well-coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty*" [WITN0320031(page 1)].

112. It is noteworthy that in Mind's 2018 workshop for Black people with experience of the Mental Health Act, what people wanted to see in place of CTOs was: wider community programmes, respite care, adult education, talking therapies, and stress and mental health awareness [WITN0433018].

Mental Health Act reform publicity

113. The Inquiry will be alive to the risk that claims suggesting publicity about Mental Health Act reform has changed clinical practice in the detention of patients of African or Caribbean heritage is divisive. In Mind's view, these claims require further clarification.

114. Mind believes that the Inquiry's potential endorsement of the publicity claims would represent a serious step backwards in the collective understanding of racial inequality in mental health, and would risk causing further harm to a population that has already been significantly harmed by the mental health system. The Independent Review of the Mental Health Act was, in part, intended to address longstanding concerns about racial inequality in the use of the Act and to encourage greater clinical awareness of these issues. In Mind's view, this includes supporting a shift away from approaches that may

give rise to racial disproportionality, and towards more person-centred care. Mind therefore recommends that any response by the Inquiry to this perspective ought to be situated within the broader evidential context.

115. Mind is aware of no specific published evidence that directly demonstrates a causal link between publicity about Mental Health Act reform and a change in clinical practice in respect of the detention of patients of African or Caribbean heritage. Nor is this reflected in Mind's engagement with people with lived experience, from whom there has been no indication of a reduction in the use of detention. Rather, rates of detention among racialised groups have increased in recent years.

116. NHS annual Mental Health Act statistics [WITN0433021], covering the period from 2017/18 (the year before the Independent Review of the Mental Health Act was announced), show no reliable evidence of a significant reduction in detention numbers, rates, or use of CTOs for Black people. The number of Black people detained has in fact grown, from 4,804 in 2017/18 to 6,113 in 2024/25 [WITN0433022]. Standardised detention rates for Black people now are broadly similar to what they were in 2017/18. In 2017/18, the standardised rate for Black people was 288.7 per 100,000 people; in 2024/25 it was 262.4 per 100,000 people (Mind's data on racial disparities over time, taken from NHS annual Mental Health Act statistics) [WITN0433022].

117. There was some variation in the years in between. However, data reliability issues due to an NHS cyber incident in 2022/23 make it difficult to draw conclusions from that data (NHS Mental Health Act Statistics, Annual Figures, 2022-23) [WITN0433023]. The rate of use of CTOs for Black people has increased in the same period (56 per 100,000 in 2017/18 to 61.3 per 100,000 in 2024/25), with similar fluctuations in the interim period and similar problems interpreting data due to the cyber incident.

118. In addition, as mentioned above, the CQC's 'Monitoring the Mental Health Act' report notes that during 103 monitoring visits between January and March 2025, staff in more than three-quarters (77%) of those services said they had not heard of PCREF [CQCM0029115]. Similarly, in half (51%) of the services,

staff said they had not received any other training, support or information on racial inequalities and how to implement solutions to tackle them since November 2023. This is indicative of a broader pattern of limited awareness and training on racial inequalities in mental health services.

119. The disproportionate detention of Black people in the mental health system is well-evidenced. The rate of detention under the Mental Health Act for Black people is currently nearly four times that of White people [WITN0433022]. Mind has consistently highlighted this disparity and campaigned for reform aimed at addressing it.

120. For these reasons, Mind urges the Inquiry to ensure that any conclusions drawn from these claims are presented in a way that makes clear the overwhelming direction of the evidence: that Black patients are detained disproportionately often, in more restrictive conditions, and with less support.

RECOMMENDATIONS

121. Mind invites the Inquiry to make the following recommendations:

Access and early intervention

121.1. That the UK Government develop a national strategy for improving support for people with SMI whom existing services have been unable to engage, backed by dedicated resource. The strategy should address the full range of approaches available, including but not limited to assertive outreach, and should set out clear expectations for commissioners and providers.

121.2. That NHS England and ICBs take steps to improve access to early and culturally appropriate support in the community, so that people are able to access the right support at the right time, before their mental health deteriorates to crisis point.

121.3. That the UK Government introduces measures to ensure that people who seek help in the context of an impending mental health crisis are not turned away, consistent with the 'no wrong door' principle and in the context of wider inter-agency working arrangements.

Inter-agency working

121.4. That the Secretary of State commission an independent review of the effectiveness of the Right Care Right Person policy, with particular attention to whether local agencies have established clear, consistent and well-resourced pathways for people in mental health crisis, and that the findings of that review inform any recommendations this Inquiry makes in respect of inter-agency working.

121.5. That the UK Government establish a mechanism to ensure that Approved Mental Health Professionals are able to feed observations about service gaps systematically back into commissioning decisions at local and national level.

Race equality

121.6. That the UK Government take urgent steps to ensure that the Patient and Carer Race Equality Framework is implemented as intended, with clear expectations, transparent oversight, and accountability mechanisms that ensure providers act on evidence of racialised disparities in access, experience and outcomes.

121.7. That the UK Government invest at the scale required to deliver PCREF training across all mental health pathways (clinical, operational and managerial) so that staff are equipped to understand racial inequalities, respond to racial trauma, and work in genuine partnership with patients, carers and communities.

121.8. That the UK Government take steps to recruit and retain staff, including healthcare professionals, who speak community languages and have lived experience of poor mental health, and to actively address racism in the workplace.

121.9. That NHS England and ICBs promote greater understanding of the impact of trauma on people from racialised communities, including refugees and asylum seekers, and integrate trauma-informed approaches across community mental health provision.

Carers and families

121.10. That NHS England and ICBs strengthen the involvement of carers in assessment, care planning and review processes, ensuring that carers are brought in earlier and that their contextual, cultural and relational knowledge is treated as integral to safe and effective care.

Reducing risk of serious harm

121.11. That the UK Government and NHS England invest in research and service development to better understand and mitigate risks of serious violence associated with SMI, including evaluation of medication protocols, care pathways, and the role of psychiatric pharmacology in supporting safe outcomes.

Stigma, discrimination and public understanding

121.12. That the UK Government, in partnership with NHS England, local authorities, and community organisations, develop a national public awareness programme to reduce stigma and discrimination associated with SMI, promote understanding of mental health conditions, and encourage early help-seeking.

122. Each of these recommendations addresses a different part of the system, but they share a common foundation: that preventing serious harm by mental health patients requires the mental health system to reach people earlier, to treat them more equitably, and to invest in the relationships between services, patients, families and communities that make safe and effective care possible. In Mind's view, adjustments to crisis response alone will not be sufficient.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed GRO-B

Dated: 02/04/2026

Index to First Witness Statement of SARAH HUGHES

No.	URN	Document Description
1.	WITN0433003	CQC (2024/25) State of Care report
2.	WITN0433004	CQC (2024) Community Mental Health Survey 2024
3.	WITN0433005	Mind (2011) Listening to experience: an independent inquiry into acute and crisis mental health care
4.	NHSE0000002	NHS (2016) Five Year Forward View for Mental Health
5.	WITN0433006	NHS England (2026) CQC Community Mental Health Survey 2024: National qualitative report
6.	WITN0433007	Mind (2019) Mental Health Act Review: Mind's engagement and influence
7.	WITN0390143	Centre for Mental Health (2024) Pursuing Racial Justice in Mental Health Report
8.	DHSC0000105	NHS (2023) Patient and Carer Race Equality Framework
9.	CQCM0029115	CQC Monitoring the Mental Health Act in 2024/25
10.	WITN0433008	Centre for Mental Health (2026) Trauma-Informed Care and Racialised Communities
11.	DHSC0000092	NHS England (2019) Community Mental Health Service Framework
12.	WITN0409068	Health and Social Care Committee Report (2025)
13.	DHSC0000024	Modernising the Mental Health Act: Final Report of the Independent Review (2018)
14.	WITN0433009	Ahmed et al. (2024) Barriers and enablers to shared decision making in assessment and management of risk: A qualitative interview study with people using mental health services.

15.	NHSE0000515	NHS England (2023) Acute inpatient mental health care for adults and older adults
16.	PHSO0000010	DHSC Statutory Guidance (2024) Discharge from mental health inpatient settings
17.	NHNB0019524	DHSC (2025) Fit for the Future: 10 Year Health Plan for England
18.	HOMF0000017	National Partnership Agreement: Right Care, Right Person (2024)
19.	WITN0433010	HSSIB (2024) Interim Report
20.	WITN0433011	NICE guidance (2022) Self-harm: assessment, management and preventing recurrence
21.	WITN0433012	O'Rourke M, Wrigley C, Hammond S. Violence within mental health services: how to enhance risk management. Risk Manag Healthc Policy. 2018 Sep
22.	WITN0433013	Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews 1998, Issue 2
23.	NHFT0017605	Lord Darzi's Independent Investigation into the NHS in England (2024)
24.	WITN0433014	Mind Briefing on Mental Health Bill (Nov 2024)
25.	DHSC0000101	NHS England (2024) guidance to ICBs on assertive community treatment
26.	WITN0433015	Ethnicity and Mental Health Improvement Project Report (2020)
27.	NHSE0000540	NICE (2016) Transition between inpatient mental health settings and community or care home settings
28.	WITN0133019	Mind webpage (2020) Depot injections and antipsychotics
29.	WITN0320031	Burns et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. Lancet 2013

30.	WITN0433016	Barkhuizen W, Cullen AE, Shetty H, et al. Community treatment orders and associations with readmission rates and duration of psychiatric hospital admission: a controlled electronic case register study. BMJ Open 2020
31.	WITN0433017	Weich S, Duncan C, Twigg L, et al Use of community treatment orders and their outcomes: an observational study. Health Services and Delivery Research February 2020
32.	WITN0433018	Workshop report titled the Mental Health Act – what needs to change for Black and minority ethnic people? (2018)
33.	WITN0433019	NHS Digital Mental Health Act Statistics, Annual Figures, 2024-25
34.	WITN0433020	Mental Health Act community treatments orders (CTO) – focused visits report. Care Quality Commission, November 2022.
35.	DHSC0000151	Joint Committee on the Draft Mental Health Bill – Report of Session 2022-23
36.	WITN0433021	NHS Mental Health Act Statistics, Annual Figures, 2017-18
37.	WITN0433022	Mind MHA data on racial disparities over time
38.	WITN0433023	NHS Mental Health Act Statistics, Annual Figures, 2022-23

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