SUMMARY OF INFORMATION FROM MENTAL HEALTH CHARITIES

1. As part of its work, the Inquiry has sought evidence and information from various Mental Health Charities. The following is a summary of the evidence that has been provided to the Inquiry so far by the mental health charities Mind and Rethink Mental Illness.

2. It should be noted that this summary will not cover the totality of the information provided.

MIND

Background

3. The evidence submitted on behalf of Mind was provided in a statement signed by Alice Livermore, Head of Legal, and dated 24 March 2025 **[Core Bundle Index item 66, page 1370]**. The statement provides information on behalf of **national** Mind. National Mind undertakes its work under four headings: Campaigns and Policy, Advocacy and Engagement, Research and Observations, and Collaboration with Local Organisations.

4. National Mind is a mental health charity operating in England and Wales. The senior management team is made up of six individuals who are responsible for Mind's overall strategy and for ensuring that its activities are effectively carried out. The board of trustees consists of 15 individuals. The board is responsible for Mind's governance and

strategic direction, which includes scrutiny of Mind's performance and support of the executive team of directors.

5. As well as national Mind, there are approximately 100 local Minds which act as independent charities with their own CEOs, boards of trustees and strategies. Some local Minds work in inpatient settings in roles such as Independent Mental Health Advocates. Local Mind branches may campaign for better local services or join national campaigns.

Involvement with inpatient care

6. One of the pillars of Mind's strategy to 2030 is titled 'changing minds', which details the charity's intentions to tackle injustice and inequity in the delivery of mental health services and to demand services that support people's rights, keeps them safe and offers them hope regardless of background. Work on inpatient care sits under this pillar.

7. One of the ways in which Mind has contributed to the safety of inpatient care was with the start of its work relating to physical restraint in crisis care in 2010, followed by the launch of a national campaign in 2013. The report 'Mental health crisis care: physical restraint in crisis: a report on physical restraint in hospital settings in England' made several recommendations, one of which was for NHS England to introduce standardised data capture methods to ensure that every mental health trust is collecting the same data on the use of restraints. Ms Livermore explains that the report, in connection with the BBC Panorama documentary on the Winterbourne scandal, led to new national guidance, and subsequent restriction on the use of restraint.

8. Prior to 2018, Mind worked to influence the Mental Health Units (Use of Force) Act 2018, liaising with Steve Reed MP to generate support for the Bill and strengthen its content. Mind was involved in briefings to MPs and encouraged supporters to write to their MPs asking them to attend to debate the Bill. Mind was also involved in the drafting of statutory guidance to accompany the Bill. The Bill was given Royal Assent in 2018. Mind's work significantly contributed to the Act's commencement.

9. Mind was involved with the Independent Review of the Mental Health Act from the beginning. Director of External Relations, Sophie Corlett, was on the working group supporting the Chairs in completion of the Review. Mind also ran influencing and participation workshops, seeking the views of those with mental health problems to establish what they wanted to campaign for. This input helped shape Mind's submissions to the Review. Strong themes that arose out of the discussions were the presence of racial bias and discrimination and a lack of access and confidence or trust in services.

10. Mind has continued to engage with reform in a number of ways, including the running of a week long parliamentary exhibition on people's experiences of inpatient admissions. Mind also submitted a response to the Government's White Paper, 'Reforming the Mental Health Act'. The research highlighted the need for the right to a statutory care plan and safe and therapeutic service environments, amongst other things.

11. Prior to 2018, Mind focused primarily on the rights and needs of adults. In 2022, Mind conducted research into children and young people's

experiences of inpatient services. The findings were published in 2023. The report noted serious failings including young people being placed in adult wards far from home and being unnecessarily medicated and restrained. It found that 45% of children and young people were sectioned five times or more, and many were provided with inadequate care in the community with some leaving hospital without a care plan.

12. In 2023, Mind launched its 'Raise the Standard' campaign, a campaign specifically concerned with inpatient care. The campaign sought several changes including the reshaping of mental health hospitals as places of hope, dignity and recovery; reforming of the Mental Health Act with changes to give everyone more choice, dignity and control in hospital; and a full statutory inquiry into failings in inpatient mental health services.

13. In the lead up to the campaign, the charity conducted a survey to better understand experiences of inpatient care. In addition, a YouGov poll conducted on behalf of Mind showed that more than a third of respondents said they would not have confidence that a loved one would be safe if they needed inpatient care, or that they would be treated with respect or compassion. One respondent, citing her experience of being sectioned for bipolar disorder six times, recalled seeing people 'manhandled by staff'.

14. Visitors to Mind's website for information and support relating to being sectioned in mental health inpatient hospitals has significantly increased, reaching nearly one million views in 2022/23.

Involvement with Essex-based Trusts

15. The statement details that national Mind does not partner with any local healthcare providers, in Essex or otherwise. They have held online briefings with providers to give their views on policy matters, such as the NHS Long Term Plan, and have met Integrated Care Boards (ICBs) to discuss mental health plans. The organisation has not met with any Essex-based ICB chairs.

16. Mind did not provide any exhibits with their evidence.

17. Since this summary was prepared, Mind has provided further evidence to the Inquiry by way of a more detailed statement and associated exhibits. This evidence is currently being reviewed.

RETHINK MENTAL ILLNESS

Background

18. The evidence on behalf of Rethink Mental Illness was provided by Mark Winstanley, Chief Executive, in a statement dated 26 March 2025 **[Core Bundle Index item 67, page 1377]**.

19. Rethink Mental Illness is a leading charity provider of mental health services. Its mission is to improve the lives of people severely affected by mental illness; to provide expert advice, information and training in mental health; and to advance awareness and understanding of the causes, consequences and management of mental illness.

20. The organisation is governed by a board of trustees responsible for the overall direction and control of the charity's activities. There are four committees to assist the board with its work: Honorary Officers Committee performing the function of an Executive Committee; the Audit and Assurance Committee; Finance and Investment Committee; and the Council of Rethink which exists to improve the work and governance of the charity.

21. There are also several Governance Link Groups (Lived Experience Advisory Board, Carer's Advisory Board, and Clinical Advisory Group) which involve a wider range of people interested in contributing to the organisation's work. The statement sets out that Rethink Mental Illness also holds Regional Forums designed to enable community feedback and local intelligence.

Involvement with inpatient care

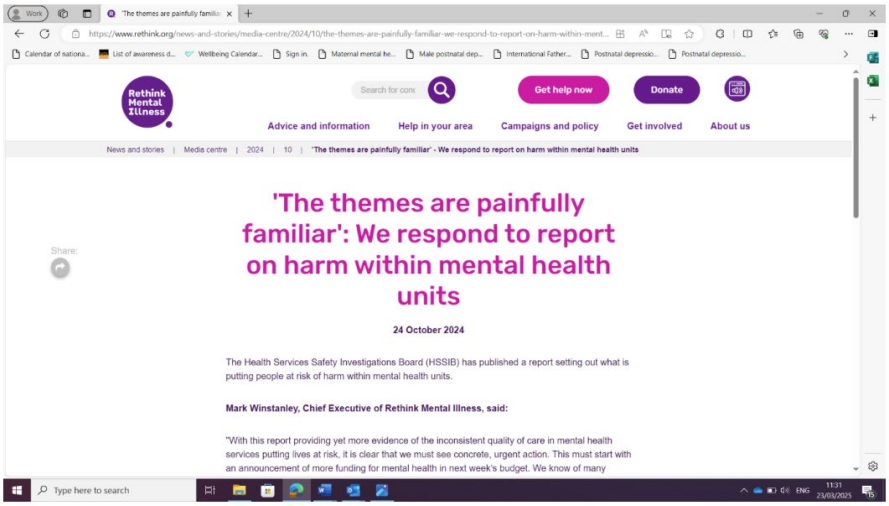
22. One of the ways that Rethink Mental Illness has been involved in inpatient care, is through representation on boards and groups. For example, Mr Winstanley currently sits on the Mental Health, Learning Disabilities and Autism Quality Transformation Oversight Group and previously co-chaired the Steering Group of the Rapid Review into data on Mental Health Inpatient Settings, and Ian Callaghan, Lived Experience Programme Manager, currently sits on the Culture of Care Lived Experience Group and previously worked with the Care Quality Commission (CQC) on the development of new methodology for their inspections.

23. Influencing activity is key to Rethink Mental Illness' work for inpatient care. Under that umbrella, it has several policy priorities relating to

inpatient safety, focused on improving the culture and workforce of inpatient settings, increasing accountability and oversight and reforming the Mental Health Act. As part of this work, the charity engages with NHS England (NHSE), the CQC and the Department of Health and Social Care (DHSC).

24. Rethink Mental Illness fed into the Health Services Safety Investigations Body's (HSSIB) investigation **[His Exhibit 8, Exhibits Bundle page 14210]** regarding safe care in the transition from children and young people's mental health services to adult services. The report was dated December 2024. Earlier on in the year, Rethink Mental Illness published a response to the HSSIB report concerning the risks of harm in inpatient units. The report cited that 'the themes are painfully similar' **[His Exhibit 19, Exhibits Bundle page 14269]**.

'The themes are painfully familiar': We respond to report on harm within mental health units – 24 October 2024



25. Rethink Mental Illness is part of the Mental Health Policy Group, of which Mind is also a member. The Group works together to improve mental health. It collaborates by sharing information about policy

developments, engaging with Government officials and, on occasion, submitting joint pieces of work such as consultation responses. The Inquiry has already engaged with other members of that group.

26. Rethink Mental Illness' campaigning efforts in relation to mental health inpatient services have primarily concentrated on influencing national policy. Rethink Mental Illness founded the Schizophrenia Commission in 2011 and has continued to campaign for reform of the Mental Health Act. This led to the publishing of a report in 2018 titled 'No Voice, No Choice; Making the Mental Health Act Person-Centred'. In 2021, Rethink Mental Illness commissioned two papers on the experience of those under section in response to the Government's White Paper, and in 2022 they submitted evidence to the Joint Committee on the draft Mental Health Bill.

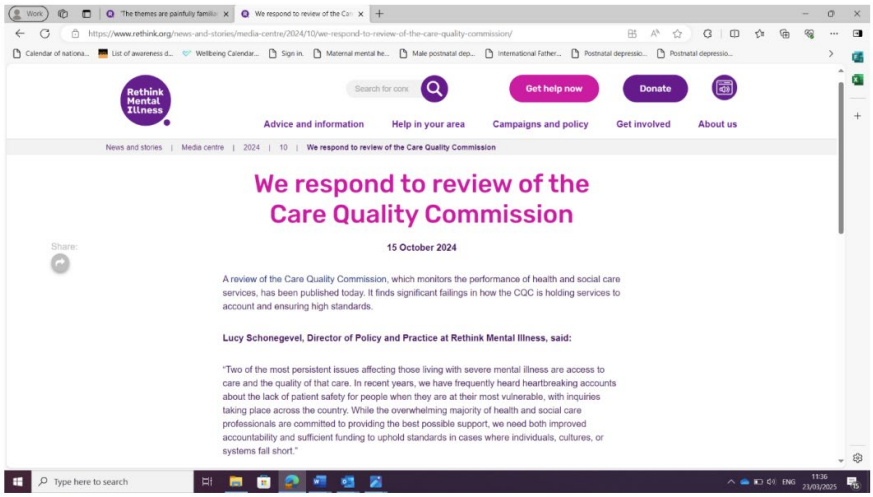
27. In 2023, Rethink Mental Illness launched a campaign called 'Wrap It Up' to persuade the Government to reform the Mental Health Act. Following Dispatches and Panorama documentaries, the charity published five recommendations to improve inpatient safety. The recommendations were:

    i. improve the mental health work force;
    ii. prioritise reform of the Mental Health Act;
    iii. address the continuing rise in out of area placements;
    iv. work collaboratively with experts by experience; and
    v. change the attitude from policy makers.

28. Rethink Mental Illness has conducted a range of research and surveys into the standard of care provided by inpatient wards. For instance, the CQC funded an engagement project on patient safety and care in specialist inpatient mental health services in 2023. The project

involved hearing views from a diverse range of people as to what made them feel safe or at risk as a patient, the report is also within the evidence disclosed for this hearing **[Exhibit 2, page 14183]**. There were several recommendations made. More recently, Rethink Mental Illness issued a response to the review of the CQC in October 2024, citing 'significant failings' in how they were holding services to account **[Exhibit 22, page 14272]**.

We respond to review of the Care Quality Commission – 15 October 2024



29. Between July and September 2023, the DHSC funded Rethink Mental Illness to conduct a project on mental health crisis, preventions, response and discharge. Several key themes were identified, including a need for greater accessibility to healthcare professionals in inpatient settings and improvements to the discharge process. The organisation was involved in a 'Health and Mental Health Inequalities with an Adult Secure Care Provider Collaborative' between April and July 2023. The themes raised on that occasion included issues with diagnosis and care pathways, and restrictive practices. The recommendations called for further engagement and data collection

and a better understanding of inequalities, amongst other things. One issue previously identified by Rethink Mental Illness was the 'staggering' use of restrictive interventions against Black people **[Exhibit 16, page 14214]**.

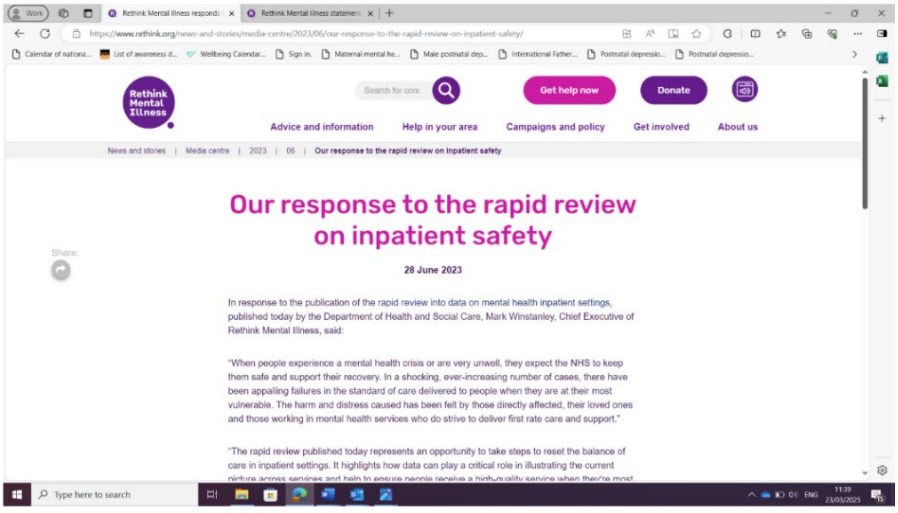
30. Rethink Mental Illness has undertaken projects with NHSE, including assisting NHSE in conducting a survey into the views and experiences of people in adult secure services, as well as their families and carers, to ascertain the impact of Covid-19. Rethink Mental Illness also supported the development of the 'Carer support and involvement in secure mental health services toolkit' **[Exhibit 17, page 14216]**.

31. Rethink Mental Illness also participated in the consultation on the new service specifications for adult medium and low secure mental health services. The themes identified included the importance of good communication and adequate staffing levels. As part of this, the charity conducted consultations with 80 people living in secure services.

32. In addition to the projects already set out, Rethink Mental Illness worked with NHSE and specifically the National Specialised Commissioning (Adult Secure) Team and Mental Health Secure Care Programme to develop 'A Guide to Involvement and Co-Production for Provider Collaboratives'.

33. Mr Winstanley notes that although there have been specific examples of policy changes, there is limited evidence as to how practice has evolved following those policy changes, and the effects that the changes may have had on patient outcomes. One example of a policy change detailed by Mr Winstanley, however, is the 2023 Rapid Review, which made several recommendations that were accepted by Government. Rethink Mental Illness published a response, firstly, to the announcement that a review would take place **[Exhibit 20, page 14270]** and, secondly, to the data itself **[Exhibit 13, page 14212 (below)]**.

Our response to the rapid review on inpatient safety - 28 June 2023



Involvement with Essex-based Trusts

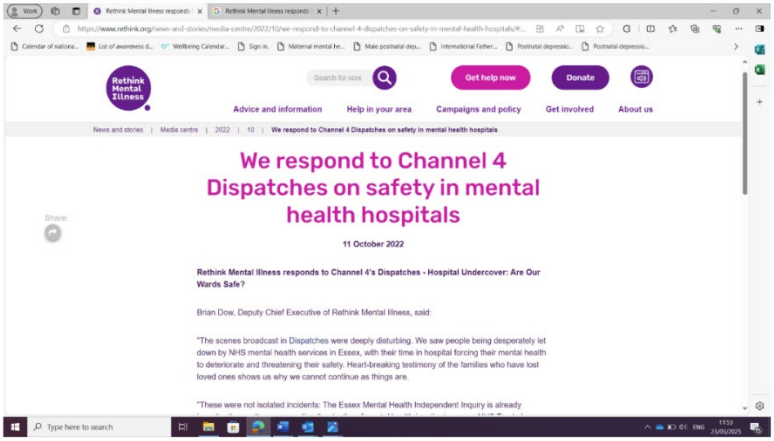
34. The primary focus of the campaigns conducted by Rethink Mental Illness is on national policy rather than local issues. The charity does not currently deliver any services in Essex, since transferring the Improving Access to Psychological Therapies in Northeast Essex over 10 years ago, nor has it conducted any research specifically into inpatient services in Essex.

35. There is, however, a volunteer-run peer support group called Braintree Rethink Carers Support Group which meets monthly to offer support and raise awareness of the impact of mental illness on carers. Between 2012 and 2019, Rethink Mental Illness also ran a regional group in the east of England and in some Essex secure units as part of the National Recovery and Outcomes Network commissioned by NHSE. The programme was introduced to influence the design, delivery and monitoring of secure services.

36. Rethink Mental Illness provided advocacy services in Essex between 2018 and 2024. During this time, they raised 109 safeguarding concerns with the local authority, and it is said that the concerns would have related to issues such as falls, care plans not being reviewed, and allegations about staff. It is estimated that around 20 of these related to the local authority or the NHS trust and their action or inaction.

37. The Communications and Campaigns team have previously highlighted patient safety issues on inpatient wards, which included responding to the Panorama and Dispatches documentaries **[Exhibit 15, page 14213** and **Exhibit 21, page 14271 (below)]**.

We respond to Channel 4 Dispatches on safety in mental health hospitals - 11 October 2022



38. In response to Dispatches, Rethink Mental Illness conducted an internal review to establish the extent of the charity's knowledge of events in Essex, whether their data reflected the findings, and to review their processes for reporting incidents. The report found that none of the individuals in the programme were known to the charity and the advocates were unaware of the issues. Rethink Mental Illness had reported one concern to the local authority regarding Rochford Hospital and one relating to the Linden Centre. The charity considered appropriate actions had been taken.

39. In 2019, Rethink Mental Illness was contacted by a bereaved mother of a patient treated at an inpatient facility in Essex who asked for support in campaigning for a public inquiry. At the time, the charity had a policy against getting involved with individual cases. In 2021, Rethink Mental Illness declined a request by INQUEST for support to call for a statutory inquiry into the deaths and systemic failures in Essex. However, in January 2023, they supported the transition to a statutory inquiry, submitting evidence to support the change in the Terms of Reference. In addition, the charity revised its policy against advocating

for individual cases following the events in Essex. In a response to the BBC investigation into the Priory Group in 2023, Rethink Mental Illness published a statement regarding the deaths of specific patients **[Exhibit 12, page 14211]**.

40. Rethink Mental Illness has identified several areas for improvements in inpatient care. The charity emphasises the barriers it has encountered, which include lack of funding and inconsistent approaches to engaging with charities and people with lived experience. The statement cites changes within DHSC and the CQC as contributing to the problem and creating difficulties in maintaining meaningful engagement. Mr Winstanley states that implementation of a reformed Mental Health Act and associated Code of Practice is a key opportunity to improve inpatient care and safety.

41. Rethink Mental Illness collects feedback in several ways, particularly through surveys of those with lived experience, and others. It uses this data to inform its campaigning, policy and influencing, service improvement and strategic recommendations.

42. Finally, in relation to Oxevision, Rethink Mental Illness has highlighted several studies on the topic. Mr Winstanley notes that there is currently insufficient evidence to suggest that surveillance in inpatient mental health settings is achieving its intended outcomes of improving safety and reducing costs. He also states that several studies on the use of Oxevision have been conducted by Oxehealth, the company making Oxevision, which presents a conflict of interest. Ian Callaghan attended a conference in 2024 at which NHSE set out the principles for Oxevision. Rethink Mental Illness is of the view that

the opportunities and risks of new technology need to be openly discussed to balance safety with the needs and views of patients.

43. As outlined at the start of this summary, the Inquiry has sought evidence from and/or is engaging with a number of Mental Health charities[1]. The Inquiry continues to consider carefully whether and when it should approach other similar organisations to assist in its work.

13 May 2025

Counsel to the Inquiry

[1] See also - Disclosure update - March 2025 - The Lampard Inquiry - investigating mental health deaths in Essex.

APPENDIX 1 – List of Documents

The documents considered for the purposes of this summary are set out below.

Name of document	***Date***	***Ref.***
Witness statement of Alice Livermore re: MIND's structure, campaigns, policy work and research	24.03.25	April Hearing Core Bundle p1370
Witness statement of Mark Winstanley re insights and activities regarding mental health inpatient care, and interaction with care providers in Essex	26.03.25	April Hearing Core Bundle p1377
Exhibit 2 – Rethink Mental Illness Report – Safety in specialist inpatient mental health services with CQC	2023	April Hearing Exhibits Bundle p14183
Exhibit 8 - Rethink Mental Illness response to HSSIB report on transition from child to adult mental health services	12.12.24	April Hearing Exhibits Bundle p14210
Exhibit 12 - Rethink Mental Illness response to the BBC investigation into the Priory Group	26.04.23	April Hearing Exhibits Bundle p14211
Exhibit 13 - Rethink Mental Illness response to the rapid review on inpatient safety	28.06.23	April Hearing Exhibits Bundle p14212
Exhibit 14 - Rethink Mental Illness statement on the first day of the Lampard Inquiry	09.09.24	April Hearing Exhibits Bundle p14215
Exhibit 15 - Rethink Mental Illness response to BBC Panorama investigation	29.09.22	April Hearing Exhibits Bundle p14213
Exhibit 16 - Rethink Mental Illness response to 'staggering' number of Black people subject to restrictive interventions	24.11.22	April Hearing Exhibits Bundle p14214
Exhibit 17 - Rethink Mental Illness Secure carer's toolkit	June 2018	April Hearing Exhibits Bundle p14216
Exhibit 19 - Rethink Mental Illness Media Statement: 'the themes are painfully familiar' – response to report on harm within mental health units	24.10.24	April Hearing Exhibits Bundle p14269
Exhibit 20 - Rethink Mental Illness response to announcement of rapid review into mental health inpatient safety	23.01.23	April Hearing Exhibits Bundle p14270

Exhibit 21 - Rethink Mental Illness response to Channel 4 Dispatches on safety in mental health hospitals	11.10.22	April Hearing Exhibits Bundle p14271
Exhibit 22 - Rethink Mental Illness response to review of the Care Quality Commission	15.10.24	April Hearing Exhibits Bundle p14272