

Modernising the Mental Health Act

A summary of the final report of the Independent Review of the Mental Health Act

Key points

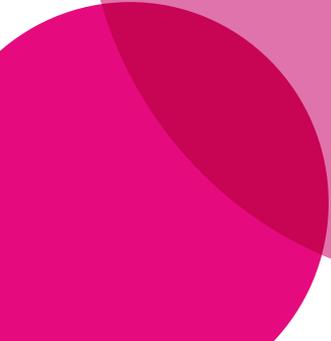
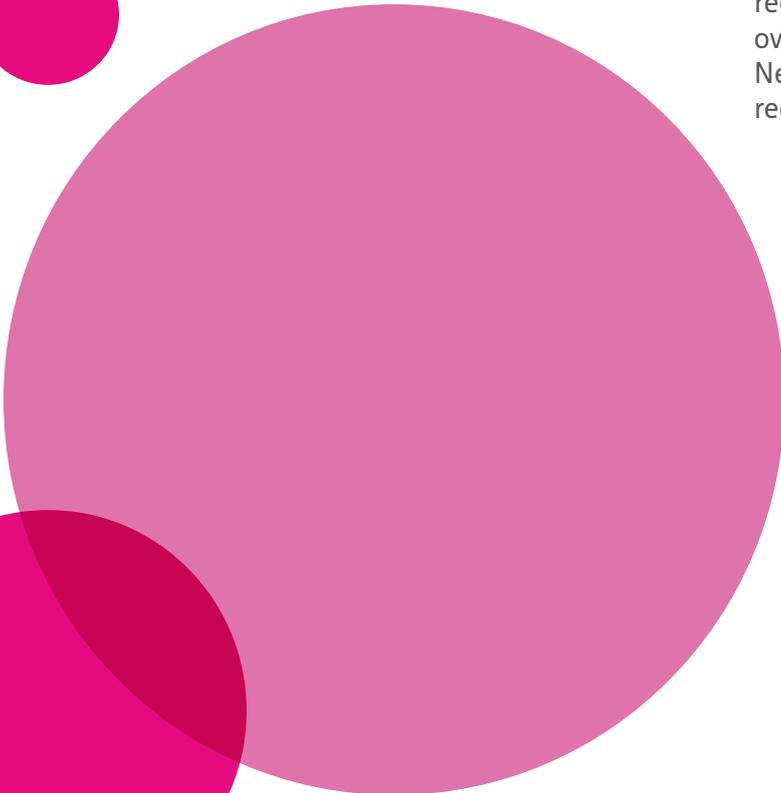
- In October 2017, the government announced an independent review of the Mental Health Act would take place.
- An interim report from the review team was published in May 2018.
- It highlighted a range of issues relating to before and during detention, as well as issues relating to specific groups of people including BAME communities.
- The final report was published in December 2018.
- This briefing summarises key points from the final report for Mental Health Network members.

Introduction

In October 2017, the Prime Minister, The Rt Hon Theresa May MP, announced an independent review of the 1983 Mental Health Act (MHA). Chaired by Professor Sir Simon Wessely, the review was tasked with making recommendations for improvements “in relation to rising detention rates, racial disparities in detention, and concerns that the act is out of step with a modern mental health system”.¹ The review team were asked to look at both legislation and practice.

On 1 May 2018 the review team published an interim report, which summarised their work to date and outlined emerging priority areas. The second stage of the review probed further into 18 separate topic areas which were highlighted in the interim report.

The review’s final report was published on 6 December 2018 and makes a total of 154 recommendations.² This briefing sets out an overview of the final report for Mental Health Network members, with a particular focus on those recommendations relevant to service providers.



Review activity

Supporting Professor Sir Wessely as vice chairs to the review were Steven Gilbert (a service user and lived experience consultant), Sir Mark Hedley (a retired high court judge), and Rabbi Baroness Julia Neuberger (former chief executive of The King's Fund and chair of the Liverpool Care Pathway Review). In turn, the review was supported by four governance groups (a working group, a service user and carer group, an African and Caribbean group, plus an advisory panel). Eighteen topics groups were also established to explore the priority areas identified in the review's interim report.

The Mental Health Network's chief executive, Sean Duggan, chaired the review's topic group on reducing detention rates. Over the course of the review, the Mental Health Network hosted two private roundtables for members to meet with Professor Sir Wessely and members of the review team.

The review team undertook extensive engagement. This included holding over 50 focus groups and examining over 1,500 survey responses from service users and carers. The review also held seven public workshops with over 550 attendees, as well as a series of bespoke roundtables on priority areas. This included a roundtable at 10 Downing Street to discuss priorities for African and Caribbean communities.

Lastly, a short note on scope. The MHA applies to England and Wales. However, the health policy aspect of the act is the responsibility of the Welsh Government, while the justice side of the act is the responsibility of the UK Government. Therefore, the recommendations in the review cover England for health, but both Wales and England for justice.

The case for change

The review sets out a clear case for change. Rates of detentions in psychiatric hospitals have more than doubled since 1983, with the steepest rises seen over the last decade and during the late 80s and early 90s. From 2005/06 to 2015/16, the reported number of uses of the MHA to detain people in hospital increased by 40 per cent. The review states that emerging data from the last three years suggest that this trend may be changing. A considered analysis of the data relating to these trends is set out in the report, including consideration of which societal and legal factors, as well as issues relating to patterns of service provision, could be contributing to rising rates of detentions.

The review also provides a thoughtful consideration of the experience of service users. Overall, the review finds, they "have been disturbed and saddened by what we have heard from patients". Too many people are described as being cared for in wards which are below standard, and the experience of care is too often found wanting. The review "heard repeatedly of the distressing and unacceptable experiences from people from ethnic minority communities and in particular black African Caribbean men. Fear of what may happen if you are detained, how long you may be in hospital and even if you will get out are all widespread in ethnic minority communities".

The review found that "there is unacceptable overrepresentation of people from black and minority ethnic groups amongst people detained; and people with learning disabilities and or autism are at a particular disadvantage". There is a need, says the review, to achieve a greater focus on rights-based approaches.

New Mental Health Act principles

The review recommends that a statement of fundamental purpose and principles should be articulated in the MHA's opening section. They would provide the basis for all actions taken under the act, setting the standards against which decisions can be held to account and providing service users with clear expectations for their care and treatment.

The review proposes this should enshrine the concepts of:

- **Choice and autonomy:** Ensuring service users' views and choices are respected.
- **Least restriction:** Ensuring the act's powers are used in the least restrictive way.
- **Therapeutic benefit:** Ensuring patients are supported to get better, so they can be discharged from the act.
- **The person as an individual:** Ensuring patients are viewed and treated as rounded individuals.

These four principles form the basis for the 154 recommendations set out by the review. The following section summarises those proposed actions. Later in this briefing, the government's initial response to those recommendations is outlined as well as a consideration of next steps.

“If there is one theme that runs through this review, it is to ensure that the voice of the patient is heard louder and more distinctly, and that it carries more weight, than has been the case in the past.”

PRINCIPLE ONE:

CHOICE AND AUTONOMY

Making decisions about care and treatment

The review makes approximately 30 recommendations relating to strengthening the principle of choice and autonomy. As the review states:

“If there is one theme that runs through this review, it is to ensure that the voice of the patient is heard louder and more distinctly, and that it carries more weight, than has been the case in the past. It is our intention that even when deprived of their liberty, patients will have a greater say in decisions, including decisions about how they are treated. We also want to make it harder to have those decisions overruled.”

In relation to making decisions about care and treatment, the review seeks to increase service user involvement by ensuring shared decision-making is the basis, as far as possible, for care planning and treatment decisions made under the act. It also seeks to establish a new basis for making treatment decisions which respects both the service user's expertise and knowledge and that of the clinician. Further, it recommends making it harder for clinicians to administer treatment which a service user has refused and strengthening challenges to treatment. The review also recommends providing in statute the right for people to express their choices in advance, and better recording of service users views.

Recommendations of particular interest here include proposing the introduction of statutory advance choices documents (ACDs) that enable adults to make a range of choices and statements about their care and treatment. Service users should also be able to request a second opinion appointed doctor (SOAD) review from once their care and treatment plan has been finalised or 14 days after their admission, whichever is the sooner; and again, following any significant changes to treatment. Service users should be able to appeal treatment decisions at the Mental Health Tribunal following a SOAD review. The review also recommends that mental healthcare providers should be required to demonstrate that they are co-

producing mental health services, including those used by service users under the MHA.

Family and carer involvement

The review recommends that service users should be able to choose a new nominated person to replace the current nearest relative role under section 26 of the MHA. A new interim nominated person selection mechanism should be created for those who have not nominated anyone and do not have capacity to do so. Nominated persons should have the right to be consulted on care plans, and to challenge treatment decisions before the Mental Health Tribunal where the service user does not have the capacity to do it themselves.

Advocacy

The review recommends enhancing and extending advocacy provision. Specifically, it recommends that the statutory right to an independent mental health advocate (IMHA) should be extended so that it includes all mental health inpatients, including informal patients. In addition, it should also include patients awaiting transfer from a prison or an immigration detention centre, as well as people preparing their advance choice documents that refer to detention under the MHA. IMHA services should be 'opt out' for all who have a statutory right to it, and the Care Quality Commission (CQC) should monitor access. Commissioning by local authorities should also be strengthened so that the requirement for IMHAs to be available to meet the needs of different groups, particularly ethnic minority communities, is made clear, in light of the public sector equality duty.

Complaints

The review makes a number of recommendations relating to complaints. Among them, it recommends that section 132 of the MHA should be amended to require managers of hospitals to provide clearer information on making complaints to patients and their nominated person. Information going to hospital boards should be separated between complaints made by patients detained under the MHA and complaints made by informal patients.

Deaths in detention

Lastly in this section, the review makes a number of important recommendations relating to responding

to deaths in detention. It recommends that a formalised family liaison role should be developed to offer support to families of individuals who die unexpectedly in detention. Further, it recommends that guidance should make clear that a death under deprivation of liberty safeguards (DoLS) or liberty protection safeguards (LPS) in a psychiatric setting should be considered to be a death in state detention, as this would trigger the duty for an investigation by a coroner. An inquest with a jury should also be held.

PRINCIPLE TWO:

LEAST RESTRICTION

Tackling rising rates of detention

In relation to tackling the rising rates of detention, the review states that there is "no clear single driver for the rising rates of detention" and that "similarly there is no simple solution to addressing them". Bringing rates of detention down will require government and other agencies to work together to develop a long-term approach, supported by better partnership working on the ground. The review calls for the government and national bodies to fund and undertake a major programme of research into service models, as well as clinical and social interventions, and their relationships to rates of detention.

The review heard of many examples of services providing alternatives to detention, as well as interventions to prevent a crisis or the escalation of crisis. These included a case study of a mental health crisis house run by Look Ahead Care and Support that was visited by Professor Sir Wessely. The service provides a non-clinical alternative to an acute hospital admission. The review recommends that there should be more accessible and responsive mental health crisis services and community-based mental health services that respond to people's needs and keep them well. The government should resource policy development looking into alternatives to detention, and prevention of crisis.

Criteria for detention

Considering criteria for detention, the review states that there is "great value in patients being able to be treated as an inpatient voluntarily with their own

consent wherever possible, in line with the principles of least restriction and patient choice". It recommends that people should be treated as an inpatient with consent wherever possible. A service user's capacity to consent to their admission must always be assessed and recorded, including on the application form. In order to be detained under the MHA, the review states that a service user must be objecting to admission or treatment. Otherwise they should be admitted informally or be made subject to an authorisation under the framework provided under the Mental Capacity Act (MCA). Detention criteria concerning treatment and risk should also be strengthened.

A statutory care and treatment plan

The review recommends that a statutory care and treatment plan (CTP) is developed soon after the point of detention, which should evolve at each state of the process. This should be the responsibility of the responsible clinician (RC). The CTP should be in place within seven days and reviewed at 14 days. During the assessment period, the plan should be developed, so that by the time of a long-term order being imposed under section 3, there is a clear account of why detention is needed and what it seeks to achieve. The plan "will continue to develop during detention and should be updated before renewals of detention periods, and appeals to the tribunal. Increasingly it will focus on how to support the ending of detention and the aftercare that should be in place on discharge". The review sets out a number of components that should be covered within the plan. The new CTP is described as "a cornerstone" of the review, which will enable the delivery of all four key principles.

Length of detention

A further area of consideration for the review was how periods of detention could be shortened. The review recommends a number of changes to the code of practice. That includes amending the guidance so that, where a person has been subject to detention under section 3 within the last 12 months, an application for detention under section 2 can only be made where there has been a material change in the person's circumstances.

Further, the review states that the detention stages and timelines should be reformed so that they are less restrictive through a number of changes. This

includes introducing a requirement for a second clinical opinion at 14 days of a section 2 admission for assessment, as well as extending the right of appeal for section 2 beyond the first 14 days. In addition, the review recommends introducing a new time limit by which a bed must be found following an order for detention, as well as requiring the RC and the approved mental health professional (AMHP) to certify ten days in advance of a tribunal hearing for section 3 that the person continues to meet the criteria for detention.

Challenging detention

During the review, the team heard from service users and carers that they would appreciate having greater access to the tribunal, and for the tribunal to have greater powers afforded to it. Careful consideration is paid to these questions in the review and a number of recommendations made. In doing so, the review makes clear that they have worked closely with the judiciary to develop their recommendations and are mindful of the need to undertake a full impact analysis for any future consultation.

The review recommends that the tribunal should have the power, during an application for discharge, to grant leave from hospital and direct transfer to a different hospital, as well as a limited power to direct the provision of services in the community. Among a range of other recommendations, it states that where the tribunal believes that the conditions of a patient's detention breaches the Human Rights Act 1998, they should bring this to the attention of the CQC. A statutory power should be introduced for IMHAs and nominated persons to apply for discharge to the tribunal on behalf of the service user. There should be an automatic referral to the tribunal four months after the detention started, then after 12 months and then annually after that. For part III patients, automatic referrals should take place once every 12 months.

The Mental Health Act or the Mental Capacity Act?

As the review points out, both the MHA and the MCA provide different legal frameworks to treat someone without consent, and to deprive them of their liberty by detaining, or confining, them in hospital. The MCA can only be used where the person lacks capacity

to consent to their confinement. Where the MCA is enacted, professionals must use the DoLS process to authorise detention and protect the patient's rights. The review states that "we have been particularly concerned to hear that the MHA has been used, at least in some cases, because it is easier to use than DoLS". Further it states that "we want to take use of the MHA back to the position that it can only be used for people who are obviously objecting to treatment".

The review makes a number of relevant recommendations here, including that only the MCA framework (DoLS, in future the LPS) should be used "where a person lacks capacity to consent to their admission or treatment for mental disorder but it is clear that they are not objecting". They further suggest that "a patient could be held in hospital for a statutory period of up to 72 hours under MCA LPS amendments whilst it is determined whether the person is objecting".

Community treatment orders

Introduced in 2007, community treatment orders (CTOs) are a form of supervised community treatment for people who had previously been detained in hospital under section 3. The review finds that, overall, "the academic literature currently does not give much support to the theory that CTOs reduce re-admission". Further, the review raises some concerns relating to the fact that a 'Black or Black British' person is over eight times more likely to be given a CTO than a white person.³ On the other hand, the review states, they heard from service users, carers and professionals that there are a small number of people for whom CTOs represent the least restrictive option.

A large number of recommendations are made that are relevant to this issue, a number of which are highlighted below.

The review recommends that the criteria for CTOs should be revised in line with detention criteria. It further recommends that the onus should be on the RC to demonstrate that a CTO is a reasonable and necessary requirement to maintain engagement with services and protect the safety of the service user and others. The evidence threshold should be raised for demonstrating that contact with

services has previously reduced, and that this led to significant decline in mental health. Applications for a CTO should be made by the inpatient RC, with the community supervising clinician who will be responsible following discharge, and an AMHP. The nominated person/interim nominated person will have the power to object to both applications and renewals of CTOs.

CTOs should have an initial period of six months, renewed at the end of the first period, and then at 12 months. Each renewal must involve two approved clinicians and an AMHP, unless the tribunal has recently reviewed the order. CTOs should end after 24 months, though provision should be made for the RC to make a new application.

Coercion and restrictive practices

The review recommends that wards should not use coercive behavioural systems and restrictions to achieve compliance from patients, but should develop, implement and monitor alternatives. Further, providers should take urgent action to end unjustified use of 'blanket' restrictions applied to all service users.

PRINCIPLE THREE:

THERAPEUTIC BENEFIT

The third principle underpinning the review is to achieve better and more therapeutic experiences for those who are detained under the MHA, as well as preventing crisis and the requirement for detention.

Care planning and aftercare

The review acknowledges significant issues with the complexity of the system and different sets of entitlements service users may have. The team heard of a number of issues relating to the provision of section 117, and say that they would have liked to have recommended the extension of aftercare to more categories of service users who may benefit from it. Within the current financial envelope they have concluded this is not possible in the short or medium term without the risk of creating further inequalities.

In the short to medium term they make a number of recommendations including the creation of a new high-quality care plan with a statutory footing. There should be a statutory care plan (SCP) for people in contact with community health teams, inpatient care and/or social care services. The SCP will encompass existing rights under the Care Act, NHS continuing healthcare and personalised budgets (and section 117 entitlements if someone has been detained on an eligible section). The new SCP should follow service users through the system, and incorporate the new statutory care and treatment plan when someone is detained, as well as discharge planning and aftercare provision.

The review recognises the value of better discharge planning. The period after discharge carries with it an increased risk of suicide. Being admitted as an involuntary patient can have major impacts in all aspects of someone's life, including housing, employment, welfare benefits and childcare. The review recommends that discharge planning should be improved, as part of the care and treatment plan during detention, to ensure it is being considered from day one, and should be recorded and updated in the SCP post detention.

Hospital visitors

Associate hospital managers (AHMs) are local, lay people appointed by the hospital or trust who have the power, on the behalf of hospital managers, to discharge service users. The review heard that there is no national job description or framework for the role of AHMs. There is no formal or ongoing training, nor a requirement for updated knowledge on National Institute for Health and Care Excellence (NICE) treatment standards. Some areas face challenges in recruiting AHMs that have experience of the ethnicity, culture, age and gender of the service users they are dealing with.

AHMs are described as a scarce resource, "hard-working, and committed to the task of participating in improving the way those with the severest illnesses are looked after". The review suggests that "if their discharge hearing function is removed, we think that they would have capacity to take on a new role which would enable them to make the most of these qualities". The review goes further to say that there

would be value in replacing the current AHM role with a new hospital visitors role, the main purpose of which would be to monitor day-to-day life in the hospital and ensure that service users are treated with dignity and respect, that they receive the treatment they need, and that their rights are protected.

The review recommends that the managers of the hospital should continue to have the duty to scrutinise applications for detention and a duty to scrutinise renewal documents. The power of AHMs to order discharge following a hearing should be removed.

Inpatient social environments

The review is clear that commissioners and providers must do more to improve the social environments of wards. In doing so, they should learn from co-produced and service-user led initiatives such as Starwards and the Dragon Café.

The review recommends that the CQC should develop new criteria for monitoring the social environments of wards. These criteria should be the yardstick against which wards are registered and inspected, plus this should be reflected in ratings and enforcement decisions. It further recommends that service users should have a daily one-to-one session with permanent staff in line with NICE guidelines.

Inpatient physical environments

The review states that "detained patients... are often placed in some of the worst estate that the NHS has, just when they need the best". They further observe that "the physical environment of wards has become affected by an increasingly risk- and infection-averse approach which can create the kind of institutional atmosphere that psychiatry has been trying to move away from for the last half century, because of its negative impact on patient experience. For example, rimless toilets, heavy wipe clean armchairs, hard flooring and bare walls that are easier to clean, but absorb little sound make buildings oppressively noisy".

The review recommends that the physical environment of wards needs to be improved, through co-design and co-production with people of relevant lived experience, to maximise homeliness and

therapeutic benefit and minimise institutionalisation. Risk assessments of issues such as infection control should be designed specifically for mental health inpatient care, and not lifted from other health settings. The unintended psychosocial effects must also be considered. Further, it is recommended that a review should be undertaken of the physical requirements for ward design for mental health units (e.g. the building notes, regulatory standards). The design of this review should be co-produced with people with lived experience.

The backlog of maintenance and repairs needs to be addressed so that mental health facilities are brought up to standard, and all dormitory accommodation should be updated without delay to allow service users to have their own room. Definitions of single sex accommodation should be tightened up. Lastly, and critically, the review recommends that “the government and the NHS should commit in the forthcoming spending review to a major multi-year capital investment programme to modernise the NHS mental health estate”.

PRINCIPLE FOUR:

THE PERSON AS AN INDIVIDUAL

Person-centred care

The review is clear about the need to recognise individual and cultural needs, as well as strengths. Care must also be trauma informed, and the review notes the work of the Women’s Mental Health Taskforce in this area. Maintaining contact with family and the outside world is also seen as vitally important.

The review recommends that the CQC should review and update their inspection and monitoring of individual treatment and care to provide assurance that it meets the needs of different minority groups. Reasonable adjustments should be made to enable people to participate fully in their care, including in relation to communication abilities.

Further to the above, the physical health of service users should be monitored, so that physical illness and conditions (for example diabetes and asthma)

can be identified and treated. The CQC should pay particular regard to obtaining service user (and carer) input from those who might find it difficult to articulate their views, including those in secure and out-of-area placements, those with learning disabilities or autism and children and young people.

Recognition of patient individuality at the tribunal

The review recommends that training should be developed for panel members in specialisms including children and young people, forensic, learning disability, autism, and older people. Further to this, statistics should be collected on the protected characteristics of those applying for a tribunal hearing, and their discharge rates.

The experiences of people from Black, Asian and minority ethnic (BAME) communities

The review highlights the unacceptable inequalities experienced by people from BAME communities in terms of access, experience and outcomes from mental health treatment and care. Adults of black African and Caribbean heritage are more likely than any other ethnic group to be detained under the MHA.⁴

The review describes its recommendations here as representing “a shift in tackling racial inequalities by accepting that the structure of existing systems needs to change gradually to improve overall quality of services. The input of service users, carers and communities is crucial in achieving this change”.

The review’s primary recommendation relating to this issue is for an organisational competence framework (OCF) and a patient and carer experience tool to be developed and implemented first by the NHS, but ultimately for rollout to wider public services. This follows the recommendation of the Crisp Commission to identify a clear and measurable set of race equality standards for acute mental health services, which it was suggested should be developed to test whether the Workforce Race Equality Standard (WRES) is improving services.

The review endorses ongoing work by NHS England to develop an OCF for mental health – the Patient and Carer Race Equality Framework (PCREF). The review states that it believes that goals should focus

on several core areas of competence: awareness, staff capability, behavioural change, data and monitoring, and service development.

The review further recommends that regulatory bodies such as the CQC should use their powers to support improvement in equality of access and outcomes. The Equality and Human Rights Commission should make use of their existing legal powers to ensure that organisations are fulfilling their public sector equality duty. In addition, culturally-appropriate advocacy should be provided consistently for people of all ethnic backgrounds and communities, in particular for individuals of black African and Caribbean descent and heritage. Behavioural interventions to combat implicit bias in decision-making should be piloted and evaluated.

The review makes some very specific recommendations relating to the workforce and ensuring this is more representative of the communities served. In line with the NHS Workforce Race Equality Standard programme, the review calls for greater representation of people of black African and Caribbean heritage in all professions, in particular psychology and occupational therapy. Further, people of black African and Caribbean heritage should be supported to rise to senior levels of all mental health professions, especially psychiatry and psychiatric research, psychiatric nursing and management.

Children and young people

While many of the recommendations made in other areas of this report also apply to children and young people, the review focuses on two areas in making some recommendations relating specifically to the needs of children and young people. Those are the legal basis for admission and treatment and proper safeguards and procedures.

The review recommends that legislation and guidance should make clear that the only test that applies to those aged 16/17 to determine their ability to make decisions in relation to admission and treatment is contained in the MCA. In young people under 16, competence should be understood in this context as the functional test under the MCA, although without the presumption of capacity that

applies in relation to those over 16. Young people aged 16 or 17 should not be admitted or treated on the basis of parental consent. The MCA (DoLs or LPS) or MHA should be used as appropriate if they are unable to consent to their treatment.

Further, government should consult on the ability of parents to consent to admission and treatment for those under 16. Every inpatient child or young person should have access to an IMHA who is trained to work with young people and their families. In addition, every inpatient child or young person should have a personalised care and treatment plan which records the views and wishes of the child or young person on each issue. Initial reviews should take place within five days of emergency admission (or three days if it is to adult facility) and at a minimum of four-to-six weekly intervals after that.

Amongst a range of other recommendations, it is suggested that for children and young people placed in an adult unit, or out-of-area, the CQC should be notified within 24 hours. The CQC should record both the reasons for placement and its proposed length.

People with learning disabilities and autism

The review highlights a range of concerns about the way the MHA works for people with learning disabilities, autism or both. In brief, those recommendations are that health and social care commissioners should have a duty to collaborate to ensure provision of community-based support and treatment for people with a learning disability, autism, or both to avoid admission into hospital and support a timely discharge back into the community. The review also recommends that the MHA code of practice is amended to clarify best practice when the MHA is used for people with autism, learning disabilities or both.

Further, the mental health services dataset should include specific data to monitor the number of detentions and circumstances surrounding that detention of people with autism, learning disabilities or both.

Policing and the Mental Health Act

The review notes that the use of police cells as places of safety has reduced by 95 per cent over the period

System-wide enablers

from 2011/12 to 2017/18. This is positive progress. We must build on this and strive to ensure that people experiencing a mental health crisis are treated with dignity and respect.

The review recommends that by 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety in the act and ensure that the majority of people detained under police powers should be conveyed to places of safety by ambulance. This is subject to satisfactory and safe alternative health-based places of safety being available.

Further to this, ambulance services should establish formal standards for responses to section 136 conveyances and all other mental health crisis calls. Ambulance commissioners and ambulance trusts should improve the ambulance fleet, including commissioning bespoke mental health vehicles. Equality issues, particularly police interactions with people from ethnic minority communities under the MHA, should be monitored and addressed. This should be under the proposed Organisational Competence Framework where possible.

Criminal justice system

A large number of recommendations are made by the review relevant to the provision of care of service users in the criminal justice system. These can be read in full in the report, but in part relate to the powers of magistrates' courts and tribunals. Further, it is recommended that prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the MHA. In addition, it is recommended that a new statutory, independent role should be created to manage transfers from prisons and immigration removal centres. The time from referral for a first assessment to transfer should have a statutory time limit of 28 days.

In addition to the recommendations outlined above, the review also highlights a number of additional points where it calls for better use of data and leveraging digital technology to support efficiency and effectiveness. Specifically, the review recommends that an agreed, accurate national baseline of the use of mental health services should be established, following a pilot programme to develop robust methodology. Amongst other recommendations, it suggests that a national MHA data hub should be established to pull together and routinely analyse MHA data across NHS services, exploring possibilities for developing linkages across the various datasets, local authorities and policing.

In addition, NHS Improvement and NHS England should fund the establishment of a national quality improvement (QI) programme relating specifically to the MHA.

The review also makes a thoughtful consideration about the workforce and how this can be best supported. The review recommends the factors that affect the timely availability of section 12-approved doctors and AMHPs should be reviewed and addressed. The government should consider introducing a minimum waiting time standard for the commencement of an MHA assessment.

NHS England and NHS Improvement should consider the implications of the evidence linking staff morale and patient experience in the context of detained patients, and take action accordingly.

“The review recommends that by 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety”

The government's response

Responding to the publication of the report, Prime Minister Theresa May said:

"The disparity in our mental health services is one of the burning injustices this country faces that we must put right. For decades it has somehow been accepted that if you have a mental illness, you will not receive the same access to treatment as if you have a physical ailment. Well, that is not acceptable.

"I commissioned this review because I am determined to make sure those suffering from mental health issues are treated with dignity and respect, with their liberty and autonomy respected.

"By bringing forward this historic legislation – the new Mental Health Bill – we can ensure people are in control of their care, and are receiving the right treatment and support they need.

"I'm grateful to Prof Sir Simon Wessely and his team for their tireless work on this vitally important review".⁵

The government has stated it will issue a formal response to the review's recommendations in the new year before preparing to bring forward legislation.

On publication, the government said it accepts two of the review's recommendations to modernise the MHA. Those detained under the act will be allowed to nominate a person of their choice to be involved in decisions about their care. Currently, they have no say on which relative is contacted. This can lead to distant or unknown relatives being called upon to make important decisions about their care when they are at their most vulnerable. People will also be able to express their preferences for care and treatment and have these listed in statutory 'advance choice' documents.⁶

Mental Health Network viewpoint

On behalf of Mental Health Network members, we have previously shared our deep concerns relating to rising numbers of people being detained under the MHA and of the over-representation of people from BAME communities. We very much welcomed the announcement of this review in October 2017.

During the second phase of the review we were impressed by the strong focus on improving the patient experience and the level of engagement that was undertaken with a wide variety of stakeholders.

We welcome the recommendations that, if implemented, would allow patients a greater say in the care they receive while detained, and will provide alternatives to detention following years of rises in detention rates. Taken as a whole, the recommendations will also start to address the unacceptable disparity of rates of detention between different BAME groups.

The successful implementation of the review's recommendations is reliant on extra revenue and capital funding for mental health services, and we hope to see this reflected in the upcoming NHS long-term plan funding settlement and spending review. We welcome the government's initial response and look forward to working with them on plans to take these important recommendations forward.

References

1. HM Government (May 2018), ***The independent review of the Mental Health Act: Interim report***, [online pdf], accessed November 2018.
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3. NHS Digital (October 2018), ***Mental Health Act Statistics: Annual Figures 2017–18***, [online pdf], accessed November 2018.
4. Ibid.
5. HM Government (December 2018), ***Government commits to reform the Mental Health Act***, [online], accessed December 2018.
6. Ibid.

The Mental Health Network is the voice of mental health and learning disability service providers for the NHS in England. We represent providers from the not-for-profit, commercial and statutory sectors – including more than 90 per cent of NHS trusts and foundation trusts providing secondary mental health services. We work with government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of our members and to influence policy on their behalf.

For more about our work, visit www.nhsconfed.org/mhn or email mentalhealthnetwork@nhsconfed.org

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