

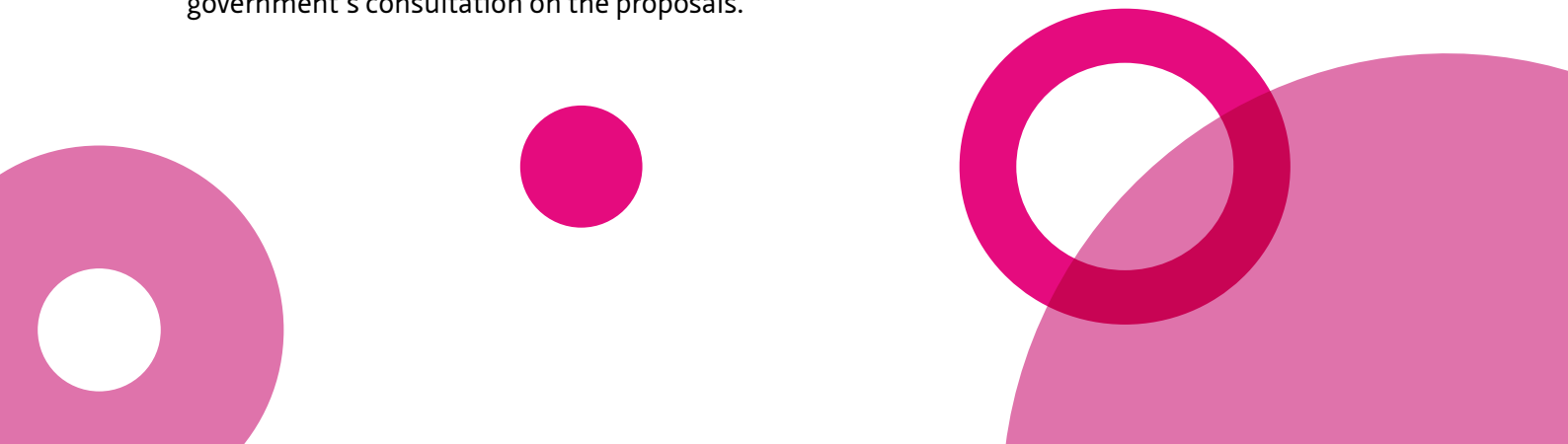


Reforming the Mental Health Act

A summary of the government's white paper

Key points

- Reforming the Mental Health Act – the government's white paper on legislation that covers the assessment, treatment and rights of people with a mental health disorder – proposes a raft of changes to improve mental health services and people's experiences under the Mental Health Act. As detailed in the white paper, the government has accepted the large majority of recommendations made by the Independent Review of the Mental Health Act in 2018.
- Among the white paper's proposals are measures to raise the bar for detention; remove having a learning disability or autism as grounds for detention; and a new duty on health and care commissioners to ensure adequate supply of community services for people with a learning disability and autistic people; and an expectation that community treatment orders should not last more than two years. There will also be new statutory requirements for care and treatment plans and advance choice documents.
- The government plans to publish a draft Bill by the end of 2021 and we expect the Act to come into force in 2023 at the latest.
- By updating the legislation, the government aims to address rising rates of detention and tackle the unacceptable disparities in the use of the Act on people from black and minority ethnic (BME) backgrounds, particularly people of black African and Caribbean descent.
- The proposals will have significant funding implications for the NHS, local authorities and the tribunal service. This is a once in a lifetime opportunity to drastically improve the care that is provided to some of the most vulnerable people in society and reduce unacceptable inequalities in how the Act is used.
- Successful implementation will rely heavily on improvements and expansion of mental health services as part of the NHS Long Term Plan. As the voice of mental health and learning disability service providers and commissioners in England, we will continue to argue for appropriate resources to allow our members to successfully implement the legislation and wider commitments. We will work with our members to formulate a response to government's consultation on the proposals.



Introduction

In January 2021 the government published [Reforming the Mental Health Act](#), a white paper issued in response to the Independent Review of the Mental Health Act's [final report](#), published in 2018. The white paper sets out the government's proposals to update the Mental Health Act and wider reforms of policy and practice around it. It also includes a full response to the independent review.

Key proposals include:

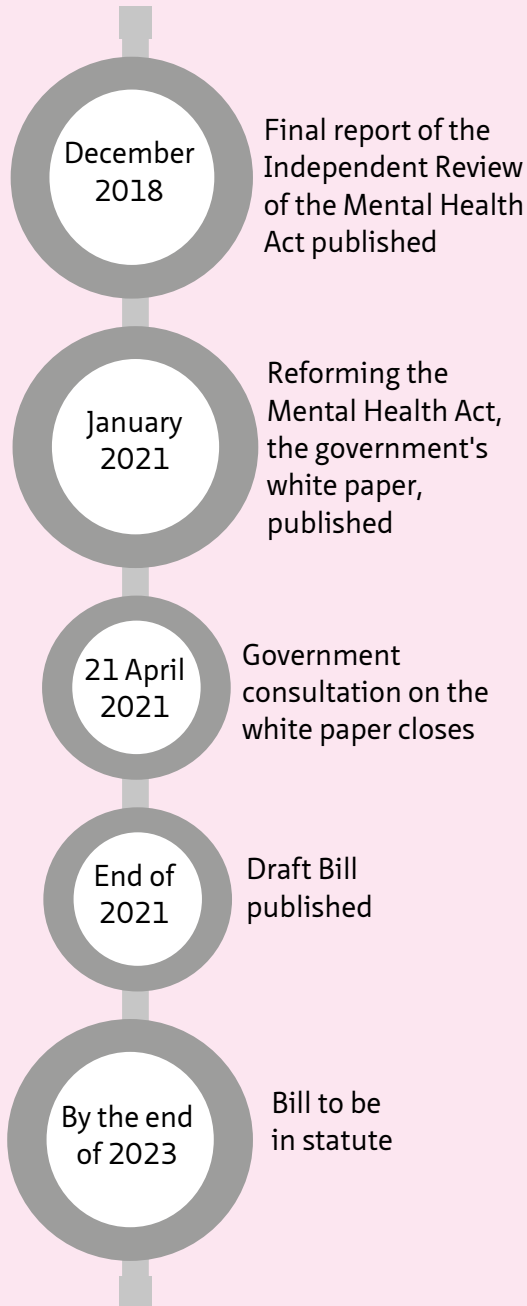
- raising the bar for detention
- removing having a learning disability or autism as grounds for detention
- a new duty on health and care commissioners to ensure adequate supply of community services for people with a learning disability and autistic people
- expanding the role of the mental health tribunal
- introducing statutory requirements for care and treatment plans and advance choice documents.
- an expectation that community treatment orders (CTOs) should not last more than two years
- updating the nearest relative provisions.

We are pleased that the government has accepted the vast majority of the independent review's recommendations. This briefing, produced in partnership with [Mills & Reeve](#), summarises the government's legislative and policy proposals.

The government expects to publish a draft Bill by the end of the 2021, which will be followed by pre-legislative scrutiny before making its way through parliament. We currently expect the Bill to be in statute by 2023. It is important to note that reforming the Act has cross-party support.

By updating the legislation, the government aims to address rising rates of detention and tackle the unacceptable disparities in the use of the Act on people from black and minority ethnic (BME) backgrounds, particularly people of black African and Caribbean descent. Implementing the legislation and wider reforms will have significant funding implications for mental health services, local authorities and the tribunal service. It also relies on improved and expanded community mental health services, as committed to in the NHS Long Term Plan.

Timeline for reform



The white paper is being consulted on until 21 April 2021. As the voice of mental health and learning disability service providers and commissioners in England, we will be engaging with members to develop a response.

Although the proposals apply to England part 3 of the Act (patients under the criminal justice system) is the most relevant for Wales. However, as all the reforms are likely to impact on Wales, consultation responses from Wales are also encouraged.

Legislative proposals

1. Guiding principles

In 2018, the independent review recommended that the Mental Health Act be underpinned by guiding principles to provide a foundation for all actions taken under the legislation. The government has accepted the principles in full, which will be embedded into the Act and its code of practice. The government is considering how the principles will impact on practical application and where else they can be applied.

New guiding principles

- 1. Choice and autonomy** – ensuring service users' views and choices are respected.
- 2. Least restrictive** – ensuring the Act's powers are used in the least restrictive way.
- 3. Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged as quickly as possible.
- 4. The person as an individual** – ensuring patients are viewed and treated as individuals.

2. Clearer, stronger detention criteria

The government plans to implement a number of measures that will address rising detention rates and ensure that detention is only used when absolutely appropriate. Revised criteria will be based on the core principles of therapeutic care and least restriction.

The government is proposing that for someone to be detained, it must be demonstrated that:

- the purpose of care and treatment is to bring about a therapeutic benefit
- care and treatment cannot be delivered to the individual without their detention
- appropriate care and treatment is available.

Raising the bar for detentions

The government agrees with the independent review that the current wording in the Act which justifies detaining an individual sets the bar for detention too low. The amended detention criteria will mean that for someone to be detained, it must be shown that:

“There is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person.”

This will apply to sections 2 and 3 of the Act and when using CTOs, but will not apply to those in the criminal justice system (part 3 of the Act).

3. More rights for patients to challenge detention

The government wants to introduce more opportunities for patients to challenge detentions, to ensure that they are as short as possible and continue to provide therapeutic benefit.

- Section 3 reviews will rise from two to three times in the first year. At each review, the patient's case for detention will be subject to scrutiny by the responsible clinician (RC) and other decision makers, such as hospital managers.
- Patients will have three opportunities to appeal to the tribunal in first the 12 months, up from two.
- Independent mental health advocates (IMHAs) will be given a new power to apply to the tribunal on the patient's behalf.
- Patients under section 2 will be able to make an application for discharge to the tribunal up to 21 days after detention, up from 14 days.

Automatic referrals to tribunals are also an important safeguard for patients and the government is considering increasing the frequency. However, it understands that this will have implications on the capacity of the tribunal system. The government plans to implement the necessary legal framework to allow for changes to the frequency and to assess capacity and phase in changes over time.

Tribunal powers

The government proposes several changes to the powers of the tribunal, including:

- removing the automatic referral to the tribunal when a CTO is revoked, as the independent review found this was not an effective safeguard
- giving the tribunal a legal power to grant leave, transfer patients, and to direct services in the community, with a legal duty on health and local authorities to take reasonable steps to follow the tribunal's decision and respond within five weeks if they are unable to.

Hospital manager hearings

The review felt that the role of hospital manager hearings in discharging patients is not an effective safeguard. The government acknowledges that tribunals are better placed to assess if the criteria for detention are still met, but understand that some trusts value hospital manager hearings. As such, the government is consulting on whether to remove hospital manager hearings in relation to discharge.

4. Strengthening the patient's right to choose and refuse treatment

The government wants to legislate so that people under the Act have more say over the care and treatment they receive. They want to 'radically change the Act's provisions around the administration of treatment once someone has been detained' and will do this in a number of ways:

Advance choice documents

Advance choice documents (ACDs) will allow people to record choices about their care and treatment, and there will be a legal requirement for decision makers to consider these. ACDs will be held in a secure database that can be easily accessed by health and care professionals. They must be made in partnership with the individual when they have relevant capacity, to

be used when an individual loses capacity. They will be available to all but it will be a legal requirement to proactively offer them to those who have been previously detained. The review recommended that ACDs be authenticated by a health professional, but the government does not feel this is necessary and is consulting on this point, and on other preferences that should be included in an ACD.

ACDs should include preferences around:

- treatment and how treatments are administered
- chosen nominated person and others who should be informed of the detention
- communication preferences
- behaviours that indicate early signs of relapse and signs that relevant capacity has been lost
- religious or cultural requirements
- crisis planning
- other reasonable adjustments.

Statutory care and treatment plans

There will be a legal requirement for all patients subject to detention to have a care and treatment plan, completed and maintained by the RC. For section 2 and 3 detentions, the plans should be completed within seven days, approved after 14 days by the medical or clinical director or equivalent, and are expected to be iterative documents.

The plans must be detailed, consider patient preferences and plan the route for discharge. The government is consulting on what else could be included in the care and treatment plan.

If patient preferences are overruled, the justification must be recorded and explained to patients.

For patients with a learning disability and/or autism, there will be a legal requirement for the RC to consider the findings and recommendations made as part of the [care and treatment review \(CTR\)](#) or [care, \(education\) and treatment review \(CETR\)](#). Any deviations must be justified.

Care and treatment plans have been a legal requirement in Wales since 2012, and there are opportunities to learn from their experience, including how to ensure systematic co-production with patients.

Consent and refusal of treatment

Another part of strengthening the patient voice is to strengthen patients' rights to refuse certain treatments. The government has proposed three categories of treatment:

- category 1: the most invasive treatments (for example neurosurgery)
- category 2: invasive treatments (for example electro-convulsive treatment)
- category 3: all other medical treatment for mental disorder.

The proposed changes include requiring RC to obtain court approval when the patient has capacity and refuses treatment from category 2 (invasive) treatments, which includes

electroconvulsive therapy (ECT), and when the treatment is considered urgent. When a patient lacks capacity but has not refused treatment, greater weight should be given to the views of the patient, and nominated persons should, where appropriate, be consulted. Justification for overruling any patient's wishes must always be given.

For the vast majority of treatments – category 3 (all other medication) – the government wants to bring forward the date on which a second opinion approved doctor (SOAD) certifies treatment against a patient's wishes, from three months to 14 days. If a patient does not have capacity, this will take place at two months, rather than three as it is currently.

When the treatment is immediately necessary to save the patient's life but against a patient's wishes, the RC should still be able to override patient's refusal without SOAD certification. However, the government proposes removing one current justification for this 'to alleviate serious suffering' if the patient has capacity to refuse, as they believe patients should be able to 'make their own judgments on the degree of suffering they are willing to accept'.

The government is also looking to introduce the ability for patients to challenge their treatment at tribunal, rather than by judicial review which is the only current mechanism. If a patient lacks capacity, their IMHA or nominated person could also challenge on their behalf. A preliminary review, to assess whether full review of the treatment is appropriate, would be carried out by a judge sitting alone. The judge cannot make a clinical decision about treatment but could find that the treatment must be reconsidered by the RC; they will review whether the correct processes have been followed.

The government is consulting on whether the tribunal should have the power to order that a treatment is not given.

5. Improving support for people who are detained

Updating nearest relative provisions

The independent review recommended a new statutory role to replace the current [nearest relative \(NR\)](#) role. The government agrees that the current system is outdated, as patients currently have no choice over who their NR is.

Patients with capacity will be given a new power to identify their nominated person (NP).

The NP will have the same rights as the NR but with some additional rights:

- to be consulted on the care and treatment plans
- to be consulted, not just notified, of hospital transfers, renewals and extensions of detentions or CTOs
- to appeal treatment decisions at the tribunal if patient lacks capacity
- to object to a CTO.

Patients in the criminal justice system have, until now, not been able to have a NR. They will be given a new right to an NP.

16–17-year-olds will have the same rights as adults to choose their NP. For patients under 16, clinicians must establish if the child is '[Gillick competent](#)' for them to choose their NP.

The government will legislate so that an approved mental health professional (AMHP) can overrule an NP's objection to detention, without having to remove the person as an NP. The government is also exploring whether the power to overrule or remove an NP could sit with the tribunal, rather than the county court, which is the current process. However, it acknowledges the additional burden this would put on the tribunal service.

Advocacy

The [role of independent mental health advocates \(IMHAs\)](#) will be expanded to help ensure patients understand their rights and that their opinions are heard. The additional powers are:

- supporting patients to take part in care planning
- supporting individuals in preparing advance choice documents
- the power to challenge a particular treatment
- the power to appeal to the tribunal on the patient's behalf to challenge detention.

Currently, IMHAs are only available to support patients detained under the Act, but the government wants to expand their role to also support informal patients. The government acknowledges this will create additional burdens on local authorities and advocacy providers, and therefore is subject to future funding decisions.

The review highlighted the lack of culturally appropriate advocacy, particularly for people of black African and Caribbean descent. The government has committed to a pilot programme of culturally sensitive advocates, to identify the best ways to meet the needs of people from BME backgrounds. Subject to appropriate funding, it plans to legislate to ensure culturally appropriate advocacy is available for detained patients.

The government is also working with NHS England and NHS Improvement on a review of current advocacy provision for people with a learning disability and autistic people, to help improve advocacy support for these groups.

6. Community treatment orders

The independent review heard a wide variety of strong opinions on CTOs, with some advocating for repealing them and others who valued them as a least restrictive option.

The government wants to make CTOs more difficult to use, shorter when they are used, and with more safeguards for patients. It also wants to work towards addressing the unacceptable disparity in their use, as black people are over ten times more likely to be given a CTO than white people.

The government plans to achieve this through the following:

- The revised criteria for detention will also apply to CTOs. There must be a 'substantial likelihood of significant harm' and they must provide a therapeutic benefit.
- The community RC will now be required to work with the patient when they are on the CTO, to improve continuity of care and will also be involved when a CTO is renewed.

- There will be an expectation that CTOs should not last more than two years. This will be in the code of practice, rather than legislated for. However, the government reserves the right to legislate on this issue if CTOs continue to be used for extensive periods.
- Clinicians will need to provide evidence that CTOs are proportionate, the least restrictive option, tailored to the needs of patients and deliver therapeutic benefit. These conditions must be regularly reviewed.
- A nominated person must be consulted and they will have a new power to object to a CTO, without being displaced from their role.
- The government is looking at bringing forward the automatic referrals to the tribunal and removing the automatic referral when a CTO is revoked.

The strong views both for and against CTOs means the government response to the future of CTOs will not be welcomed by all parties. The government is acknowledging this by monitoring the use of CTOs over the next five years.

7. The interface between the Mental Health Act and the Mental Capacity Act

The independent review found there is a lack of clarity on when the Mental Health Act (MHA) or the Mental Capacity Act (MCA) should be used if a patient lacks capacity and is not objecting.

The government agrees with the review's findings that a clearer dividing line would help reduce inappropriate uses of the MHA when the MCA would be more appropriate. It is consulting on how to implement this.

This is a very complex area and the implementation of the [new liberty protection safeguards \(LPS\)](#) framework around the MCA, which will replace the [deprivation of liberty safeguards \(DOLS\)](#) framework from April 2022, will also impact on this area.

The proposal is that the choice between MCA and MHA would be removed and decision makers would use the DoLS or LPS and not the Mental Health Act, if a patient:

- lacks the relevant mental capacity to consent to detention and treatment
- and is not objecting to detention or treatment.

Prior consent to be admitted as an informal patient

The government is seeking views on a recommendation by the review to allow patients to give prior consent to informal admission if they later become unwell and lose relevant capacity.

However, the government acknowledges this would mean an informal patient would not have access to the same safeguards as a formal patient. There are also concerns around whether the patient would be aware of the gravity of their choice and that they may not feel comfortable objecting when they are admitted.

The government thinks that embedding a 'get out' clause into the code of practice that allows consent to be withdrawn in certain circumstances may help mitigate the risks. Again, the government is consulting on this.

Extending section 5 to cover A&E

The government wants to reduce the reliance on the police to hold individuals who are in crisis, have capacity and are attempting to leave A&E.

This is partly addressed by changes to the MCA due to come into force in April 2022. But these do not apply when a referral for a MHA assessment is made, or when a person has relevant capacity.

Currently, section 5 of the MHA provides powers to hold a person while an MHA assessment is completed, but only if they are already an inpatient. The government wants to extend this to individuals attending A&E. The power would only be available to senior clinicians and used when absolutely necessary. However, the government acknowledges that the independent review was against extending section 5, as it was felt improving the environment and resourcing of A&E for people experiencing a mental health crisis would be a better and less restrictive approach.

8. Patients in the criminal justice system

The government wants to ensure that patients under the criminal justice system (part 3 of the Act) have timely access to appropriate care, while protecting the public from those who have committed a serious offence. Because of that, some of the proposed reforms will not apply to those under part 3 of the Act, namely:

- raising the bar for detention
- full powers for the nominated person
- changes to tribunal powers and automatic referrals
- changes to detention criteria for people with a learning disability and autistic people.

Court powers

Currently county courts and magistrates courts have different powers to divert a person into mental health treatment and the government wants greater alignment of the powers.

Secure patients

The government wants to ensure that people who meet the criteria for detention are not held in prisons or immigration removal centres inappropriately. It will do this in a number of ways:

- **Introduce a 28-day statutory time limit for transfers from prisons or immigration removal centres to mental health inpatient settings.** However, the government acknowledges the risk that the time limit may mean patients are not placed in the most appropriate setting and that clinicians may avoid recommending hospitalisation if they risk not meeting the deadline. The new limit will not come in until new NHS England and NHS Improvement guidance is embedded.
- **Introduce a new power of 'supervised discharge' for restricted patients,** which can include patients with capacity whose discharge conditions will deprive them of their liberty. This would provide a new legal mechanism to allow these patients who no longer therapeutically benefit from hospital detention to be discharged with conditions that amount to a deprivation of liberty, similar to a CTO. This would be reviewed annually by the tribunal and closely monitored.

- **Create a new designated role for a person independent of the health or criminal justice system to oversee the transfer of people from prison to hospital.** This could be an expansion of the role of AMHPs, or an entirely new role and they are consulting on this.
- **Remove prisons as place of safety,** but acknowledging that this is reliant on new investment to ensure alternatives to prison are available so guidance for courts and adaptations and investment need to be in place before legislative changes are commenced.
- **Strengthen and clarify the role of the [social supervisor](#),** who is responsible for supervising conditionally discharged patients in the community.
- **Reduce the amount of time between the tribunal and the parole board** when considering transferred prisoners for parole.

Victims

There are concerns that there is 'inconsistent provision of information' to victims of unrestricted patients. A working group led by the Ministry of Justice's victim policy team has explored various ways to address the concerns of victims and improve access to timely and accurate information.

9. People with a learning disability and autistic people

Too many people with a learning disability and/or autism are admitted inappropriately to mental health wards and, once admitted, stay too long. Instead of helping the patient, detention can lead to a deterioration in their condition, particularly for people with autism. The government proposes several ways to reduce inappropriate admissions and ensure the quality of care these groups receive is improved.

Co-occurrence of mental health conditions

The proposal is to make clearer in the legislation that having autism or a learning disability are not grounds for detention under section 3. If a person's 'behaviour is so distressed that there is a substantial risk of significant harm to self or others,' and a mental health condition is the probable cause, then they can be detained for up to 28 days, for assessment under section 2. The assessment will allow clinicians to determine the driver of the behaviour, and if it is not due to a mental health condition, the detention must end. This would not apply to patients under part 3 of the Act.

The government is also proposing a statutory requirement for RC to consider findings of care, (education) and treatment reviews and justify any deviance from them.

Improving and expanding community services for people with a learning disability and people with autism will help reduce the risk of detention and speed up discharges. The government is proposing a new duty on local authority and NHS commissioners to ensure there is an adequate supply of services in the community. The government acknowledges that this will have funding implications and will undertake a new burdens assessment to establish the implications for local government.

It is also consulting on a new duty on commissioners to monitor the risk of crisis for people with a learning disability and autistic people, to enable better planning to avoid admissions. Also, on how the pooling of NHS and local authority budgets can improve services for these groups.

10. Children and young people

Children and young people will benefit from advance choice documents, the right to choose a nominated person, more rights to refuse treatment, increased access to the tribunal and faster second opinions on treatment. Care, (education) and treatment plans will also be statutory requirements for children and young people who are both formal and informal patients.

Autonomy and decision-making

The independent review recommended reform and clarification in legislation and the code of practice around assessing competence and capacity of children and young people. The government states it will maintain existing legislation but will look at improvements to guidance, including the MCA code of practice and how it applies, or could apply, to both 16–17 year-olds and those under 16.

11. Experiences of people from BME backgrounds

Reducing the disparities in the use of the Act on people from BME backgrounds was one of the main drivers of the review. Enhancing the patient voice, improving advocacy, increasing scrutiny of decisions and more opportunities to challenge decisions are all expected to address the disparities that exist, along with changes to CTOs.

There are a number of approaches outside the legislative changes that the government state will help reduce the unacceptable disparities in access, experience and outcomes for those from BME backgrounds, which are outlined below.

- [A Patient and Carer Race Equality Framework \(PCREF\)](#) will be implemented, to allow organisations to better understand the steps they need to take to improve. PCREF will support organisations to identify areas for improvement, work with communities to improve interventions and monitor progress.
- Up to £4 million will be made available for research which focuses on identifying and explaining the challenges that people from BME backgrounds face around mental health, with a particular focus on people of black African and Caribbean descent.
- There will be a concerted effort through various approaches to increase the diversity of the workforce, which the review was clear would help improve the experiences of BME individuals.
- New mental health ambulances will be introduced to transfer people experiencing a mental health crisis, reducing the reliance on the police.

Reforming policy and practice around the Act

The proposed legislative changes will modernise the Act and, taken together, should help reduce the amount and length of detentions and improve the care people receive while detained. However, many of the changes are reliant on wider improvements of mental health services.

Part 2 of the white paper outlines how the government is working with, and plans to work with, partners to improve mental health services which will help support the implementation of the reformed Mental Health Act:

- Improvements and expansion of mental health services through the [NHS Long Term Plan](#).
- Quality improvement programme.
- Increasing [patient safety](#) and reducing risk.
- Increased patient protection against sexual and physical assault.
- Reducing restrictive practice.
- Suicide reduction.
- Improving the physical ward environment.
- Increasing the effectiveness of the CQC.
- Improving support and care planning for people in the community.
- Updating section 117 guidance.
- Improved crisis support.
- Reduction of the use of police custody and police vehicles for conveyance.
- Expanding and diversifying the mental health workforce.
- Improving staff morale.
- Use of data and digital technology to improve data collection and service delivery.

Viewpoint

We welcome the government's acceptance of the large majority of the independent review's recommendations and our members look forward to implementing the much-needed changes. This is a once in a lifetime opportunity to drastically improve the care that is provided to some of the most vulnerable people in our society and reduce unacceptable inequalities in how the Act is used.

However, successful implementation will be heavily reliant on additional funding and workforce for mental health services and local authorities. Throughout the process, we will raise the necessity of additional resources to support members to implement the new legislation.

We will be surveying members and will hold a number of dedicated meetings to inform our response to the white paper. Details will be communicated with members. If you have any questions or issues you would like to raise with us directly, please contact Emma Paveley, senior policy manager, at emma.paveley@nhsconfed.org

The Mental Health Network is the voice of mental health and learning disability service providers and commissioners in England. We represent organisations from across the statutory, independent and third sectors and promote excellence in mental health services and good mental health for all. 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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