

# Mental Health Act reform (evidence to Joint Committee)

---

**September 2022**

## **About us**

The [NHS Confederation](#) is the membership organisation that brings together, supports, and speaks for the whole healthcare system in England, Wales, and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care, and reducing health inequalities. As such, we will predominantly focus on the health workforce rather than social care in this submission.

Our [Mental Health Network](#) represents providers from across the statutory, independent and third sectors. We work with government, regulators, opinion formers, media and the wider NHS to promote excellence in mental health service and the importance of good mental health.

## **Executive summary**

- This is a once in a generation opportunity to get this right. The rising demand for mental health support exacerbated by the pandemic means it is critical to reform the Mental Health Act.
- We welcome the place of reducing racial and other inequalities as a major part of the reforms, this must be included in the legislation, Code of Practice, and guidance.
- Reducing detentions under the Mental Health Act will save money in the medium to long term, not just for the NHS, but also for the justice system and other public services.
- These are long-term reforms that will need resourcing – in terms of both revenue and capital - for the NHS, local authorities, and the Ministry of Justice.
- Increasing workforce capacity and the introduction of robust workforce plans supported with funding are key to successful implementation.
- Successful implementation of the reforms requires a cultural change. Legislation is just the start of change, and the Code of Practice and guidance will be as important.
- Community mental health transformation is going well but Government needs to be more ambitious to make reforms realistic and more funding is needed.

- Reforms for people with learning disabilities and people with autism are positive, but there are significant issues that need to be addressed both in the legislation and the Code of Practice.
  - Working with the mental health, learning disability sector and ICSs to plan the implementation is key. This needs to include the independent and voluntary sector.
1. We welcome the Mental Health Act reforms and have been pleased to contribute to thinking around the reforms since the independent review was published. Our Mental Health Network has engaged with both our members who provide mental health services and service-users to inform our positions on the Draft Mental Health Bill. During the engagement we heard a wide variety of views on the proposals, and we have tried to reflect the range of views within our response.
  2. Many of the recommendations rely on additional resources and staffing capacity and without significant additional resources for the NHS, social care and the Tribunal Service, the proposals will not be successfully implemented.

**How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act? Might there be unintended consequences and, if so, how should those risks be mitigated?**

3. The opinion from some clinicians was that the review has missed an opportunity to fuse the Mental Health Act and the Mental Capacity Act into one Act, as this would provide a less complex legislative landscape for both clinicians and service-users. There was acknowledgement that the implementation of the Liberty Protection Safeguards (LPS) should improve the current system, but this will have significant resource implications for trusts.

**To what extent is the approach of amending the existing Mental Health Act the right one? What are the advantages and disadvantages of approaches taken elsewhere in the UK?**

4. We believe that the new legislation will help, but only if implementation is appropriately supported by adequate resource and the workforce.
5. It is essential to increase capacity in community service provision first if the system is to be less reliant on inpatient beds. This will require additional funding, especially in the short to medium term, as whilst effective community provision and mixed sector delivery models will provide better value for money in the long term more investment will be needed to ensure the level of need for community provision can be met.
6. Northern Ireland has a single piece of legislation – the Mental Capacity Act (NI) 2016 - which covers both mental capacity and mental health. Whilst the legislation has been on statute since 2016, only the first phase of the Act has been put into operation. So currently they are using both the Mental Capacity Act (NI) 2016 and the NI Mental Health Order 1986.

**Does the draft Bill strike the right balance between increasing patient autonomy and ensuring the safety of patients and others? How is that balance likely to be applied in practice?**

7. There are a number of proposals in the Draft Bill that should increase patient autonomy. The proposed nominated person rather than the nearest relative will give people more autonomy. It would also be useful if service-users could identify more than one person who they would choose as their nominated person (NP), in case of any difficulty in appointing the NP.
8. Care and Treatment Plans (CTPs) should be prepared in direct collaboration with the patient, or where they are not well enough to engage, those close to them, so that the

plan is built around the patient's wishes, preferences, and individual needs, as far as possible.

9. The proposed list of items that could be included in a CTP looks comprehensive, and we agree that CTPs have the potential to strengthen patient voice and re-calibrate the relationship between service-users and clinicians. Additional staff and smaller caseloads would help clinicians have the time to create high-quality and co-produced CTPs. Again, this requires investment in funding and the workforce.
10. Advance Choice Documents (ACD) are not specifically mentioned in the draft legislation, but they are in the draft impact statement. We believe that ACDs would give people more autonomy and set-out their wishes ahead of being seriously ill and should be included in the Bill, and definitely in the Code of Practice as best practice.
11. Tribunals are a useful safeguard for service-users and increasing access to them will allow service-users more opportunities to challenge decisions about their care and treatment, which the Mental Health Network welcomes.
12. However, increased access to tribunals must be balanced with the capacity of the Tribunal System and mental health providers to ensure that hearings can be timely, and that staff have capacity to sufficiently prepare for the hearings. We heard that preparing for tribunals can already take up a significant proportion of some clinician's time, and given the current high vacancy rates, our Medical Directors' Forum are very concerned about the impact it will have on the workforce.
13. Additional resources for the NHS and the Tribunal Service will be required to successfully implement additional tribunal hearing, and better use of technology and digitalisation may help to make the process more efficient.

**To what extent will the draft Bill reduce inequalities in people's experiences of the Mental Health Act, especially those experienced by ethnic minority communities and in particular of black African and Caribbean heritage? What more could it do?**

14. A key issue considered in the Independent Review of the Mental Health Act was around the over representation of ethnic minority communities, particularly Black young men, admitted to mental health facilities and coming under section arrangements. There are also issues where equal access, experience and outcomes are not experienced uniformly by people using Mental Health services, whether as in patients or in community settings, particularly those with protected characteristics and/or from communities with high levels of deprivation.
15. There does not appear to be much attention in the draft legislation on addressing inequalities, and so there needs to be a strong focus in the Code of Practice and any guidance on EDI. A focus on EDI will require a culture change and ongoing organisational development. It also needs to be a key feature of ongoing service transformation. The implementation of the Patient and Carers Race Equalities Framework (PCRED) is essential.
16. The Department for Health and Social Care funded a number of culturally appropriate advocacy projects. Learning from [these pilots](#) needs to be shared and referenced in the Code of Practice and in any guidance.
17. There is a risk that patients from some BAME backgrounds will still be regarded as high risk and that detention is necessary, and the disproportional use of the Act on some groups will remain or be exacerbated.

18. Training and development will be required for staff to establish understanding of inequality, being actively anti-racist, understanding unconscious bias and how to provide more personalised, tailored access, experience, and care to address the disadvantage that many users have when coming into MH services.
19. Co-production of models of care/services with the communities served and third sector, to develop support tailored to meet their needs is essential. All of this requires investment (local and national) as organisations will need to release staff from frontline duties to engage in developing shared solutions and more personalised care. In the longer term this will be cost-effective.
20. Business cases show that investment up front saves the costs of double running, multiple admissions and crisis care further down the line, as well as improving health and well-being for individuals and their carers/families, with all the benefits that brings e.g., continuing in employment.

**What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?**

21. The Mental Health Network agrees that having a learning disability and/or autism should not be grounds for detention alone. Learning disabilities and autism are not conditions that can be treated and detention for these groups, especially for people with autism, is often not therapeutic and can be detrimental to their mental health, causing unnecessarily long inpatient stays and distress for the individuals and their families.
22. However, people with learning disabilities and autism have a high incidence of mental health issues, other health conditions and often social issues as well. Assessing people with a learning disability or autism is complex and takes time. There are concerns about what will happen to those people if clinicians can't establish whether a person has co-occurring mental illness within 28 days. They may have undiagnosed mental illness, and if they are not on a section 3, they may lose out financially because they will not receive Section 117 aftercare packages. If a person has challenging behaviors, but does not have an underlying mental illness, there needs to be further consideration for how they will be supported in the community.
23. This change will only be beneficial to people with a learning disability and/or autism and their families if they have access to high quality community support. Otherwise, there is a risk that people from these groups will end up in the criminal justice system.
24. Clinicians raised concerns that this proposal may be "putting the cart before the horse" and that a significant expansion of community services is needed, particularly for those with autism, before this legislative change is made.
25. There is a wider issue that inpatient mental health care does not always meet the needs of people with a learning disability and people with autism who do have a co-occurring mental health condition. Improved training for staff around learning disabilities and autism and working towards making mental health environments autism friendly will help improve the care these individuals receive.
26. There is risk that if people with a learning disability and/or autism do not receive support they need from services that their carers, who already often face difficulties in supporting their family members, will need to do more to ensure that their loved one is able to lead their life as independently as possible. This could impact on carers' mental health, their ability to care for other members of their families, their employment, and finances. Increased and improved respite care for families would help mitigate this risk but is reliant on adequate resources.

27. People with a learning disability face some of the starkest health inequalities, with life expectancy around 15-20 years shorter than average. If people with a learning disability are not able to access the care they need, then there is a risk that physical health issues are less likely to be identified, and the unacceptable inequalities will be exacerbated.
28. The proposed reforms will only provide adequate safeguards for people with a learning disability and/or autism if there is the funding, workforce, and capacity of organisations to expand community learning disability and autism services.

**Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to people with a learning disability and to autistic people?**

29. People with a learning disability and/or autism are already significantly over-represented in the criminal justice system. If people are not able to access support in the community their behaviour may become more challenging, and this could be interpreted by the police as criminal behaviour. There is also a higher risk for individuals from some Black ethnic groups, as they are already more likely to come into contact with the criminal justice system.
30. Improved liaison and diversion services within the criminal justice could help mitigate this risk. Improved custodial environments for people with a learning disability and/or autism would also help reduce the negative impact of people in these groups who do come into contact with the criminal justice system.

**We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?**

31. Learning disability and autism services have been historically underfunded, and too many people do not get the care they need. The commitment to ensuring that there are adequate learning disability and autism services for all is welcome and will help reverse the historic inequalities in accessing care.
32. However, clarification about what adequate actually means and who determines that threshold is important. Significant additional resources will be needed to achieve this, and they will need time to be developed and delivered nationwide. We are concerned about changes to the diagnostic criteria happening before there is sufficient capacity in high-quality community provision.
33. The number of learning disability nurses has reduced by around 40 percent between 2010 and 2020. While there are some financial incentives to encourage people to train as learning disability nurses, and the introduction of nursing associates will help booster the workforce, it will still take some time before we have an adequate number of nurses to support people in the community.
34. Now that Integrated Care Systems (ICS) have control over funding allocations, it will be vital that there is an acceptance and understanding at ICS level of the need to increase funding for learning disability and autism services. This is challenging when they have a limited financial envelop and many other priorities. Whilst there is a duty on commissioners in the Health and Care Act 2022, it is unclear how it will be enforced.
35. It is essential that ICSs retain specialist knowledge, skills, and capacity in relation to those who commission learning disabilities and autism services as this is not always given the profile and attention that it requires, and this would need to be rectified for services to be successfully expanded and improved.

36. Spending on learning disability services is not currently included in the Mental Health Investment Standard (MHIS), which has been effective in increasing funding for mental health services. This means that it is more difficult for commissioners to target investment into these services. Serious consideration needs to be given to how these community services will be funded.

**To what extent will the draft Bill achieve its aims of reducing detention, avoiding detention in inappropriate settings and reducing the number of Community Treatment Orders?**

37. The implementation of the legislation will need to be accompanied by a culture change, and an increase in the availability of community services. If clinicians do not feel the services in the community are available or appropriate, they will continue to default to admitting service-users at risk to inpatient services.

**What do you think the impact of the proposals will be on the workforce within community mental health services and multidisciplinary working practices both in inpatient and community services?**

38. Our members are very concerned about the impact the reforms will have on the mental health workforce.

39. Our members have stressed that the additional number of tribunal hearings that would be created would require an additional 33% expansion of the inpatient responsible clinician (RC) workforce. Given the 10-15% national consultant psychiatrist vacancy rate, this will be very challenging. Expansion of the workforce will require quite significant funding on top of other funding imperatives for mental health. The legal aid budget would also need to increase.

40. Whilst not in the draft legislation, we would need staff to have the capacity to work with service-users to develop high-quality, Approved Choice Documents. These staff would need smaller caseloads to ensure that advanced care planning is effective.

41. We have mentioned above the training that will be required for staff in relation to EDI and the culture change that would be needed.

**How far will the draft Bill allow patients to have a greater say in their care, with access to appropriate support and avenues for appeal?**

42. Increased access to tribunals must be balanced with the capacity of the Tribunal System and mental health providers to ensure that hearings can be timely, and that staff have capacity to sufficiently prepare for the hearings.

**Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?**

43. We agree with this proposal, as it is correct that an individual with capacity should have as much right to determine their own lives as possible.

**What do you think of the proposed replacement of “nearest relative” with “nominated persons”? Do the proposals provide appropriate support for patients, families and nominated people?**

44. We agree that giving the nominated person (NP) more power will be a positive change to the legislation, as those who know the needs of the service-user will be more involved in decisions made about their care.

45. Giving the service-user the right to choose their NP is also welcome, as the current system is outdated and does not reflect modern family and support network structures.
46. Other considerations we heard were around who will be deemed as an appropriate person to identify as a NP, and the importance of a process to manage these situations within the code of practice, potentially involving the Approved Mental Health Professional (AMHP). For example, if a healthcare professional or a peer support worker could be chosen as a NP or if another service-user is chosen and they become too unwell and cannot effectively act as a NP.
47. While it is right that the service-user can decide who their NP will be, we heard concerns from both clinicians and service-users around how families may feel if they are not chosen as an NP. They may feel frustrated at not being involved in their loved-one's care, or that the chosen NP is inappropriate. This may put service providers and clinicians in a difficult position mediating between the family and the service user.
48. We agree that the process for an AMHP to identify a NP if a service-user does not have capacity should be set out in the code of practice. The knowledge of a service-user's care coordinator would be useful to help determine the most appropriate person.
49. The proposal to allow the AMHP to overrule the NP's objection to admission, as opposed to the NP being removed or displaced, is a positive shift, as current rules mean that someone who is best placed to promote the patient's interests may be prevented from doing so.
50. However, concerns were raised by service-users that this change may mean that the AMHP is more likely to overrule the NP, as the process is less burdensome. If an AMHP does want to overrule the NP temporarily, it is important that they are required to explain in detail why they believe overruling the NP is in the best interests of the service-user.

**What impact will the draft Bill have on children, young people and their families?  
Does it take sufficient account of the existing legal framework covering children and young people?**

51. With regards to children and young people (CYP), the experience of people who are under 16 who are detained is too often negative and allowing young people to have more say will help them feel more ownership and agency over the care.
52. However, clinicians are concerned that there are potential safeguarding issues in allowing someone under the age of 16 to choose their nominated person, even if they are Gillick competent, and there may be strong push-back from families if they are not chosen as the NP. This needs to be balanced with the wishes of a Gillick competent young person, as they may not engage with services and treatment if their family are involved. It is often left to clinicians to manage these relationships.
53. The existing legal framework (Children and Families Act 2014) is going to look very different if the SEND Review proposals are implemented and it will need to be clear which body holds accountability for the experience and outcomes of CYP with autism or learning disabilities. There is a danger that the system that CYP and their families currently have to navigate in order to get adequate healthcare (physical and mental), education and/or social care becomes even less coherent than it already is.
54. It needs to be clear how these reforms will align with other reforms being proposed, including wider reforms around levelling up, the Independent Review of Children's Social Care, the SEND Review and Schools White Paper. In the SEND Review alone there are a number of bodies mentioned as bearing responsibility for delivery: the local authority, a new national SEND delivery board, ICBs, local SEND partnerships.

**To what extent are the proposals to allow for conditional discharge that amounts to a deprivation of liberty workable and lawful?**

55. We understand that this new “supervised discharge” has been proposed in response to a Supreme Court judgement, and that it could be the least restrictive option for this small numbers of people to which it would apply.
56. However, clinicians have concerns that this would be a less regulated but more coercive structure and there are risks that this power would become similar to Community Treatment Orders, which are difficult to be discharged from and not always seen as effective.
57. Some of our members have raised concerns about the Supreme Court Judgement, and this Joint Committee would be a good opportunity to discuss this issue, which is complex and whilst it only applicable to a small group of people, it has a big impact on them, their families and on services. If this proposal stays in the Draft Mental Health Act, it should be closely monitored and reviewed if appropriate.

**What are your views on the proposed changes in the draft Bill concerning those who encounter the Mental Health Act through the criminal justice system? Will they see a change in the number of people being treated in those settings?**

58. Significant additional resources would be needed in order for trusts to be able to meet the 28-day target, and there are risks that clinician would be more hesitant to recommend hospitalisation if they were not confident that this target would be met.