



Reforming the Mental Health Act

January 2021



Reforming the Mental Health Act

Presented to Parliament
by the Secretary of State for Health and Social Care and the
Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty

January 2021



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Joint foreword from the Secretary of State for Health and Social Care and the Secretary of State for Justice and Lord Chancellor

It is two years since Professor Sir Simon Wessely delivered his landmark Independent Review of the Mental Health Act. This set out what needs to change in both law and practice in order to deliver a modern mental health service that respects the patient's voice and empowers individuals to shape their own care and treatment. It also made recommendations on how to address the disparities in how the Act affects people from black, Asian and minority ethnic backgrounds.

We are grateful to Sir Simon, and to his Vice Chairs, Sir Mark Hedley, Baroness Julia Neuberger and Steve Gilbert OBE for their report and for their continued advice and support.

We welcome the considered work and in-depth engagement undertaken by Sir Simon Wessely's Independent Review. **We accept, and we will take forward, the vast majority of its recommendations for change.**

The Government has not been able to bring forward this White Paper as early as originally planned – because of the unprecedented battle we are waging with the COVID-19 pandemic. We have all made it our priority to fight this virus, which has already claimed so many lives and is affecting the mental health and wellbeing of the nation.

This is a challenging time. But we are confident that people who are or who have been users of inpatient mental health services, their families and carers, and those who work for these services will all recognise the critical importance of taking the next steps in this process of reform.

The Review is already influencing the major decisions and actions the Government is making to improve mental health care. We have already taken steps to introduce significant new investment to transform the mental health estate so that inpatients can have the privacy and dignity of their own bedrooms with en suite bathrooms. We are investing over £400 million to rid the mental health estate of dormitory provision, just as the Review recommended. We will build new mental health hospitals – with two schemes already approved and with more to come – and will tackle the maintenance work needed in the mental health facilities where patients are treated.

Fortunately, NHS mental health services did not need to use the emergency provisions contained in the Coronavirus Act 2020 designed to be deployed if severe staff shortages due to the pandemic disrupted vital care and assessment under the Act. Instead, steps have successfully been taken to innovate in order to adapt and manage the pandemic within wards. As a result, the emergency provisions within the Coronavirus Act have been expired.

Some of these approaches point to new ways of doing things – such as remote video consultations, when appropriate, as part of the Care Quality Commission's Second Opinion Appointed Doctors service. The Department of Health and Social Care has also followed suit - removing regulatory barriers to the electronic transmission of the Act's statutory forms. This has allowed more flexible and remote working to take place and represents a crucial first step in our work towards digitising the clinical pathways under the Act.

This Government believes firmly in increasing the liberty of its citizens. And so we will seek to implement reforms which see people not just as patients, but as individuals, with rights, preferences, and expertise, who are able to rely on a system which supports them and only intervenes proportionately, and which has their health and wellbeing as its central organising principle.

Mental health services must be improved for people of black, Asian and minority ethnic backgrounds. The Government asked the Independent Review to take a close look at the disparities that exist and to make proposals to address them.

This White Paper reflects on the progress that has been made in response to the Review to enable organisations to take the steps they need to make improvements in access, experience and outcomes for individuals from different ethnic backgrounds. It also sets out future plans, including work to develop and support a more diverse and representative workforce and to launch a programme of culturally appropriate advocates, in order to better help patients from all ethnic backgrounds voice their individual needs.

We have seen high profile cases of quality failings in the care of people with a learning disability and autistic people in inpatient settings such as the abuse uncovered at Whorlton Hall in May 2019. Too often people have been detained without sufficient therapeutic input and without their rights being upheld. We propose changes to reduce reliance on inpatient services for people with a learning disability and autistic people and to further ensure the availability of community alternatives. We will also deliver on our commitment to improve how people with a learning disability and autistic people are treated in law, with a separate legal approach more suited to their needs. This acts on our manifesto pledge and on our commitment earlier last year to the Joint Committee on Human Rights (JCHR) that individuals within this group should only be in inpatient care for as short a time, as close to home and in the least restrictive setting possible, with a clear, therapeutic benefit, not as a last resort due to lack of appropriate community support.

This White Paper marks the next step on this journey. We urge you to take part in the consultation that will take place over the next three months to help shape future legislation, service approaches, and modernise the Act's principles and values.

Executive summary

Unprecedented transformation - making mental health services fit for the future

The Government and NHS England and Improvement (NHSEI) are delivering the most ambitious programme for the transformation of mental health care England has ever known. This expansion of support, central to our NHS Long Term Plan and backed with record levels of investment, will see two million more people receive high quality mental health services by 2023/24 – from primary care and specialist community teams, in some schools and colleges, in accident and emergency departments, when in crisis, and in inpatient settings. This work builds on the successes of the Five-Year Forward View for Mental Health which will deliver services to one million more people by April 2021.

Putting these transformation plans in place gives us a vital opportunity to modernise mental health legislation. We have a unique chance to ensure enhanced services are matched by enhanced rights for patients who should have a greater say about what happens to them when they are made subject to the Mental Health Act (“the Act”). Taken together, the NHS Long Term Plan and this White Paper share common aims – that people affected by serious mental health conditions and their families do not get left behind and that inequalities experienced by people from black, Asian and minority ethnic backgrounds in access, experience and outcomes of mental healthcare are addressed.

The NHS Long Term Plan is delivering a clear and concerted shift towards providing more people with high quality, accessible care closer to home. However, sometimes people with serious mental illnesses will still need to be detained in hospital so that they can be treated and supported in their recovery.

We echo Professor Sir Simon Wessely’s view that living in a country that protects and cares for people when they are at their most vulnerable is far preferable to the alternative. It is our strong view that such protection should always be in the least restrictive setting, and where possible support people to live independently at home. Therefore, assessment and detention under the Act should only happen when detention is truly the best option to support someone to get out of crisis and get better as quickly as possible. We recognise difficult tensions will always exist between individuals’ autonomy and protection under the Act, detention should not be without regard to human dignity, respect or the right to have a say in your own care. Supporting this is at the heart of our reforms.

The current Mental Health Act has a Code of Practice that promotes considerations of a person’s dignity and independence, as well as a requirement not to restrict people more than is absolutely necessary. It is true, however, that the Act has not kept pace with

developments in public attitudes, how we understand and treat mental health, or how we should support people with a learning disability or autistic people. We have heard consistently that the Act, which is still arranged around a system that essentially was established in 1959, does not fit with our modern sense of how health and care services should provide for people in the 21st century.

People should expect parity of esteem between mental health and physical health services. People who need to be detained under the Act should have every right to expect that their voice and views will be central to decisions made about their care, as with any other NHS service.

People must be able to express their views and to collaborate with professionals to agree care and treatment plans that work for them, that have a clear therapeutic benefit and are focused from the outset on discharge and recovery. Today, while there are many examples of good practice across the country, we simply cannot say this is everyone's experience.

The Government has serious concerns about the rising rates of the use of the Act. Between 2006 and 2016 the number of detentions rose by 40% and we are now detaining tens of thousands of people each year. Not only this, there are significant disparities between different groups in terms of who becomes subject to the Act, particularly for black people, who are both more likely to be detained and more likely to be discharged from hospital with the further restrictions of a Community Treatment Order (CTO).

There is a clear case for modernisation and change. This White Paper sets out our proposals for a substantive programme of legislative reform, taking forward the Government's commitment to legislate to give people greater control over their treatment, and ensure they are treated with dignity and respect. It also takes forward our commitment to improve how people with a learning disability and autistic people are treated in law and reduce the reliance on specialist inpatient services for this group. We want everyone to have the opportunity to live a full and rewarding life in their communities and see an end to perpetuated detentions without appropriate therapeutic inputs. The White Paper also provides the Government's full response to each recommendation made within the final report of the Independent Review of the Mental Health Act.

Responding to the Independent Review of the Mental Health Act.

In 2017, the Government asked Professor Sir Simon Wessely to lead the Independent Review of the Mental Health Act 1983, to examine issues around the use of the Act and to propose recommendations for modernisation and reform.

The final report of the Independent Review, published in December 2018, concluded that the Act does not always work as well as it should for patients, nor for their families and carers. When the Act fails people, they become disempowered, are excluded from decisions about their care and treatment, and are treated with neither dignity nor respect. The current legislation goes too far in removing people's autonomy and does not do enough to protect and support the ability of people to influence or make decisions about their own care.

We welcome the considered work and in-depth engagement undertaken by the Review. **We accept, and we will take forward, the vast majority of its recommendations for change.**

Informed by the Review's recommendations, we are proposing a wide range of changes to rebalance the Act, to put patients at the centre of decisions about their own care. Four principles, developed by the Review and in partnership with people with lived experience, will guide and shape our approach to reforming legislation, policy and practice. These are:

- **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 individuals

The Government agrees that these principles are the right ones, has put them at the centre of the reforms that we propose to make, and will continue to do so as we seek to embed them into practice.

We are improving access to community-based mental health support, including crisis care, to avoid the need for detention and admission.

Through the transformation programme set out in the Long Term Plan, we want to ensure that more people are able to get the care and treatment they need, at an earlier stage and in their local community, in order to prevent people reaching crisis and needing detention under the Act.

The NHS Long Term Plan, backed by £2.3 billion of new investment for mental health services a year by 2023/24, will improve mental health care for people of all ages and all types of mental illness, particularly severe mental illnesses. We are developing new and integrated models of primary and community mental health care to support adults and older adults with severe mental illnesses, as well as new comprehensive crisis services for

people of all ages, including children and young people, ensuring greater focus on prevention and early intervention.

With these services in place, we will be able to provide better and earlier support to reduce the risk of people reaching crisis point, better alternative options to detention under the Act, and arrangements for quicker discharge, with appropriate mental health care services available in the community.

The NHS Long Term Plan also makes provisions for better crisis care and once these enhanced services are fully in place, and local areas are ready, legislation will end the use of police cells to hold someone experiencing a mental health crisis, once and for all.

We will seek to revise and clarify the detention criteria for civil sections of the Act, so that patients are only detained when it is appropriate and where there is demonstrable therapeutic benefit to the patient.

We propose to reform the criteria so that the purpose of detention is always about helping patients to recover and supporting them towards discharge. This is what we mean by therapeutic benefit. We also want to revise the criteria around the risk of harm posed by the individual to themselves or others. We want to make this clearer so that detention is only used when the risk of harm is substantial. Detentions under the Act must always provide the least restrictive option for the individual.

We will seek to align the criteria for using CTOs with the planned reforms to the detention criteria - so that they are only used where there is strong justification, and a clear therapeutic benefit to the individual.

The proposed changes will make the criteria for detention and subjecting an individual to a CTO more stringent, better reflecting the gravity of placing restrictions on a person's liberty.

We acknowledge significant concerns relating to admissions of people with a learning disability and autistic people to mental health hospitals under the Act, where such an admission could become protracted or may not result in someone receiving an appropriate therapeutic intervention. We propose to make reforms which would ensure that mental illness is the reason for detention and that neither autism nor a learning disability are grounds for detention under the Act in and of themselves.

We will increase the frequency with which patients are reviewed against these new criteria, making longer term detentions more difficult to justify after the point where the patient is no longer considered to pose a significant risk and where treatment or detention ceases to have therapeutic value.

We will also improve the rights of patients around challenging their detention, where they feel their detention is unjustified.

We will give everyone a voice and the power to express their views about the care and treatment they want to have.

Giving someone a greater say in their care can lead to greater engagement in treatment and potentially longer-term therapeutic benefit.

We will introduce statutory Advance Choice Documents to enable people to express their view on the care and treatment that works best for them as inpatients, before the need arises for them to go into hospital.

For the first time, we will put care and treatment plans on a statutory footing and require them to be developed in good time and in partnership with patients. The plan will be regularly updated to reflect the patient's progress and to ensure that care and treatment continues to be carried out in the way they would like. For each patient, the plan will also set out the steps to be put in place to make sure discharge to home or community settings can happen as quickly and safely as possible.

We want to see a culture change, so that a patient's views and preferences, whether given at the time or in advance, are taken fully into consideration, and that the very process of developing the plan makes decision-making transparent and collaborative.

Patients will have greater rights to choose their preferred evidence-based treatment, and to refuse a particular treatment, where there is a clinically appropriate alternative available. There will be more stringent rules about the circumstances and process to be followed in overruling a patient's choice, including an expanded role for the Mental Health Tribunal.

We will provide high quality, tailored support to everyone detained under the Act.

A new right to choose a Nominated Person will mean patients will be able to choose the person who is best placed to look after their interests under the Act. We think it is important that people are able to choose the specific individual who, under the Act, is able to exercise certain rights on their behalf, for example by applying to the Tribunal. Currently, people cannot choose this person, rather it is dictated by legislation.

To ensure people have awareness of their rights, and are supported to exercise them, we will expand the role of Independent Mental Health Advocates to offer a greater level of support and representation to every patient detained under the Act.

We will take steps to improve how the Mental Health Act works for people with a learning disability and autistic people.

The Government has committed to improving the way that people with a learning disability and autistic people are treated in law. We will take steps to address the inappropriate use of detention of people with a learning disability and autistic people, recognising that the mental health inpatient environment can fail to meet the specific needs of this group.

We propose that neither learning disability nor autism would be considered a mental disorder for which someone can be detained for treatment under Section 3 of the Act. People with a learning disability or autistic people could only be detained for treatment if a co-occurring mental health condition is identified by clinicians. This would allow for detention for assessment of a person with a learning disability or autism behaving in a way that was inherently risky, but would end the use of the Act for people with a learning disability or autism longer than 28 days where there is no evidence of a co-occurring mental health condition.

When people with a learning disability and autistic people are detained, we propose to give Care and Treatment Reviews (CTRs) statutory force to help address the issue of inappropriately long stays in inpatient units. This will also apply to Care, Education and Treatment Reviews (CETRs) for children and young people. Clinical teams leading on the patient's care and treatment will be required to justify why they have not acted on the recommendations made by a CTR or CETR. Improvements made to specialist services and community crisis care set out in the NHS Long Term Plan will help reduce avoidable inpatient admissions of people with a learning disability and autistic people. This is important in supporting the proposals we are making on detention, by helping ensure there is adequate provision in the community as an alternative to inpatient hospital care.

We propose to introduce a new duty on the NHS and Local Authorities to ensure an adequate supply of community services for people with a learning disability and autistic people.

We will take action to tackle the disproportionate number of Mental Health Act detentions of people from black, Asian and minority ethnic backgrounds.

The Independent Review was commissioned by the Government because of the profound inequalities that exist for people from ethnic minority groups in terms of access to treatment, experience of care and quality of outcomes. Black people are over four times more likely to be detained under the Act and over ten times more likely to be subject to a CTO.

We are committed to taking action on the issues, which the Review shone a spotlight on, and addressing the underlying causes of these disparities. The reforms to the Act proposed in the White Paper follow key recommendations made by the Review. We aim to improve the transparency of decision making, provide greater choice and autonomy, and increase the ability for patients to challenge decisions. These changes will benefit all

people subject to, or at risk of detention, but are designed to have a particularly positive impact for people from black, Asian and minority ethnic groups.

In June 2019, the Government pledged to introduce a new Patient and Carer Race Equality Framework (PCREF), as recommended by the Review. This will support NHS mental healthcare providers to work with their local communities to improve the ways in which patients access and experience treatment. Monitoring data on equality at board level, and taking appropriate action, will be a fundamental component of this.

Momentum on developing this framework is building. Patients, carers and front-line staff are currently instrumental in shaping the PCREF to ensure it can be applied across a number of mental healthcare settings, and supports measurable improvements in black, Asian and minority ethnic patient and carer experience.

While advocates can help patients under the Act voice their needs, poor cultural understanding can worsen outcomes for patients from black, Asian and minority ethnic backgrounds and compound other inequalities. We have committed to launching a pilot programme of culturally appropriate advocates so that patients from all ethnic backgrounds can be supported to voice their individual needs.

A diverse and representative workforce at all levels is critical to making progress to address disparities. The Review found that parts of the mental health workforce don't reflect the populations they serve, meaning there are gaps in the delivery of meaningful support.

We are undertaking several programmes to improve the diversity of the workforce. The NHS People Plan for 2020/21, along with the [NHS COVID-19 phase three recovery guidance](#)^[1] urgently prioritises further action for the NHS to advance equality and diversity and to develop leaders who have the knowledge, skills and behaviours to create and sustain cultures of compassion and inclusion.

NHSEI's Advancing Mental Health Equalities Taskforce and Health Education England (HEE) are working to address the workforce priorities outlined in the NHS Long Term Plan and to implement strategies to enable a more diverse and inclusive mental health workforce that is reflective of the population it serves. This includes workstreams to increase fairness of access to and inclusion in mental health training programmes.

We will ensure the benefits of reform are extended to people with serious mental illness who come into contact with the criminal justice system, with a focus on public protection, rehabilitation and reduced re-offending

We think it is important that people with serious mental illness, who come into contact with the criminal justice system, benefit from many of the reforms set out above. We will continue work which has been under way in recent years to support rapid diversion to

mental health care and treatment from court or from custody as appropriate. We will ensure that where people in prison require treatment in a mental health hospital, they are transferred within an appropriate timeframe to support necessary care and recovery.

The Ministry of Justice and NHSEI are working together to ensure prompt decisions in relation to 'restricted patients', for whom the Justice Secretary is responsible for approving clinicians' recommendations. We want to ensure the reformed Act upholds its function to protect the public, and that appropriate support is available to victims of mentally disordered offenders.

We will drive a renewed focus on improving quality of care, through improvements to the patient environment, training for the existing and new workforce, and through a dedicated Quality Improvement Programme to promote practical and cultural change across the system.

Through the NHS Long Term Plan, the Government and the NHS are taking steps to drive up the quality of inpatient mental health care, to improve patient experience and ensure everyone is treated with dignity and respect.

Providing a modern, positive environment is particularly important for people with mental illness in terms of promoting a strong focus on recovery and return to independence. We are investing over £400m to rid the estate of dormitory provision, as the Review recommended. We will build new mental health hospitals – with two schemes already approved and with more to come – and will tackle the maintenance work that the estate needs.

The Government and the NHS will work with wider partners to bring about an overall culture change that places individuals at the heart of care and promotes partnership working between patients and professionals. We will support our dedicated frontline staff to create the best ward cultures, that are focused on high quality patient experience, outcomes and safety. This will require strong clinical leadership at all levels and co-production with services users at every stage. This work will be underpinned by NHSEI and HEE through comprehensive training for staff and a full implementation plan including a National Quality Improvement (QI) programme, which will look specifically at care under the Act to enable and support this system-wide drive for change.

Next steps

This White Paper represents a significant milestone on the journey towards reform, but changing the legislation is only part of the story. Long-term sustainable change will require everyone to play their part, including national health and social care organisations, NHS mental health services, Local Authorities, the courts and the police, and the third sector. Continuing the collaborative approach taken by the Review, we are committed to

continuing to work with people with lived experience, their families and carers and frontline staff to help people plan for change and ensure all aspects of care place the patient's needs and preferences front and centre.

The in-depth work undertaken by the Review provides a strong platform for change based on the four new guiding principles.

During the Review, people also underlined the importance of taking the necessary time to get this reform right, given the complexity of the legal framework and the important implications it has on people's lives.

As a next step, and in the spirit of co-production established by the Review, we will consult widely to gather the views of everyone who may be impacted by the planned reforms, including service users, their families and carers, mental health clinicians and professionals, and experts in mental health and mental capacity legislation, to ensure the reforms work for everyone. We will use the evidence and views from this consultation to make final policy decisions and to draft a revised Mental Health Bill, which we will introduce when Parliamentary time allows.

The proposals set out in this White Paper are also subject to future funding decisions, including at Spending Review 2021. The Government will continue to work closely with national and local health and care organisations, including NHSEI, the CQC and HEE, to understand the impact of legislative reform on the current system and to develop a robust and achievable plan for implementation. This will need to take into account other demands placed on the system by wider transformation plans and the capacity of the health and care workforce to deliver what is required.

Introduction

The Government and NHS England and Improvement (NHSEI) are delivering the most ambitious programme to transform mental health care that England has ever known. As part of this, we have committed to legislate so that patients suffering from mental health conditions, who may require care under the Mental Health Act, have greater control over their treatment and receive the dignity and respect they deserve. We have also committed to improve the treatment of people with a learning disability and autistic people in law.

This White Paper sets out the Government's proposals to reform mental health legislation. Our proposals take forward the recommendations made by the Independent Review of the Mental Health Act, and the full Government response to all 154 recommendations is set out at part 3 of this White Paper. The Review engaged widely and heard from a range of views to inform its findings, including those of service users and carers and people with lived experience of treatment under the Act. We are committed to continuing this collaborative approach and will consult on our proposals before bringing forward a Bill to amend the Act.

Throughout this White Paper we are seeking views on the implementation and impact of the reforms, which will inform the final drafting of the Bill. We will supplement the responses we get back on these questions with further engagement during the formal consultation period with service users, carers and professionals to ensure legislation, policy and implementation are all informed by the experience and expertise of people who have lived experience of being treated under the Act. Given the continued constraints of the pandemic, this engagement will take place in a COVID secure manner, whilst ensuring that it is broad and inclusive.

This White Paper represents a significant milestone in the journey towards reform. This consultation period will last for fourteen weeks. Following this, we will consider and report on what people have told us and bring forward a draft Bill when parliamentary time allows. To guide professional practice the Code of Practice will later also be revised to align with the reformed legislation.

We are clear that these reforms will require additional funding over and above commitments made in the NHS Long Term Plan. Analysis to support this view is outlined in the accompanying Impact Assessment. The delivery of the transformational proposals set out in this white paper will therefore be subject to future funding decisions, including at Spending Review 2021.

The White Paper, which comprises the Government's response to the Independent Review, is arranged around three discrete parts:

Part 1: Our proposals for reform of the Mental Health Act. This brings together our plans for legislative change.

Part 2: Our proposals and ongoing work to reform policy and practice to support implementation of the new Mental Health Act to improve patient experience.

Part 3: The Government's response to the recommendations made by the Independent Review of the Mental Health Act. This section considers each numbered recommendation in turn.

Scope of the White Paper

The current Mental Health Act applies in both England and Wales. The majority of the White Paper concerns health policy which is devolved to Wales.

Although health policy is devolved to Wales, justice matters remain reserved to the UK Government. There is also a separate devolved system for Tribunals* in Wales.

This White Paper represents the position of the UK Government, which commissioned the Independent Review of the Mental Health Act.

Improving mental health outcomes is a cross-cutting priority in Wales, and the Welsh Government has set out a clear policy commitment to deliver excellent mental health services. Given that the Act has application in both England and Wales, the findings of the Review and the proposals set out in this White Paper will also be carefully considered in the context of how the Act currently operates alongside legislation, mental health services and systems in Wales. In particular, the Mental Health (Wales) Measure 2010 has already put some similar proposals, such as care plans for people subject to detention, on a statutory footing in Wales.

The Welsh Government will continue to engage with the UK Government on the proposals set out in the White Paper as it considers appropriate next steps for Wales and develops its own response to the Review.

Reserved matters where the UK Government could apply changes in both England and Wales are highlighted in this White Paper (in particular in relation to the criminal justice system). However, even in reserved areas, the UK and Welsh Governments are working closely to understand any distinct impacts and issues for Wales, and there may be cases where a different approach to reform is appropriate between nations.

It is not uncommon that Welsh patients are cared for in England and English patients cared for in Wales. Both Governments are therefore committed to ensuring there is a

joined up, person-centred mental health system that works for all patients and staff in these circumstances.

We will ensure that voices from Wales are heard during the consultation period and we will work with the Welsh Government, sharing consultation responses to help inform policy decisions for Wales.

* Explanatory text 1: Explanation of the jurisdiction mental health tribunal

The functions which in England are performed by the Mental Health jurisdiction of the First-tier Tribunal (usually referred to as the Mental Health Tribunal or MHT), are dealt with by a separate tribunal in Wales, the Mental Health Review Tribunal for Wales, or MHRTW. This is a devolved Welsh Tribunal under the President of Welsh Tribunals and is administered by the Welsh Government. It is important to note that the response to the recommendations in this White Paper only refer to the MHT in England and not the MHRTW.

PART 1: Proposals for reform of the Mental Health Act

1. New guiding principles

We will introduce new guiding principles to drive a more person-centred system, in which the choices made by patients have weight and influence, where care must have a therapeutic benefit for the patient, and where the powers of the Act are only used when absolutely necessary.

These principles have informed every aspect of the Government's approach to this White Paper and as we move forward to legislation and implementation, they will continue to inform our ambition to shape a modern Mental Health Act. We want the principles to have impact beyond legislative reform; changing day to day practice and providing a guide for anyone working with or supporting someone who is detained under the Act.

Together with the other legislative reforms set out in this White Paper, these principles will help to redress the balance of power between patient and professionals with a view to improve patient experience. The new principles are:

- **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 as quickly as possible
- **The person as an individual** – ensuring patients are viewed and treated as individuals

These reflect the principles put forward by the Independent Review and were developed in close collaboration with service users and carers.

Embedding the principles in the Mental Health Act.

We will seek to include these four principles up front in the Act, as well as in the **Code of Practice**. The Care Quality Commission's evaluation of how the [Code of Practice](#)^[2] is applied found that - although the principles introduced to the Act in 2007 do influence practice for the better, they are applied inconsistently and are not widely understood. By putting these principles on the face of the Act itself, we are hoping to support better understanding and awareness.

We also want to embed the principles within our planned reforms to the Act, including in the following ways:

- **Choice and autonomy:** Service users' views and choices will be represented in Advance Choice Documents and through their involvement in Care and Treatment Plans, and through enhanced opportunities to challenge treatment decisions.
- **Least restriction:** We will ensure the Act's powers are used in the least restrictive way, by strengthening and clarifying the criteria that must be satisfied before a person is detained and treated. We will make discharge planning a key part of care planning so that people are detained for the shortest possible time according to their needs.
- **Therapeutic benefit:** We want to ensure patients are supported to get better, so they can be discharged from the Act, and that therapeutic benefit is a requirement of detention.
- **The person as an individual:** We will ensure that patients are viewed and treated as rounded individuals in accordance with the NHS Constitution's statement that staff should "value each person as an individual, respect their aspirations and commitments in life and seek to understand their priorities, needs, abilities and limits". This will be supported by enhanced rights to Independent Mental Health Advocates, and through NHSEI's commitment to a Patient and Carer Race Equality Framework (PCREF) with the goal of improving access, experience and outcomes for people from black, Asian and minority ethnic backgrounds.

Before seeking to put the principles on the face of the Act, we will consider how the principles will impact on the practical application of the Act and address any issues of compatibility – so that the new principles can be embedded into the Act with real meaning and without causing confusion for practitioners. Compatibility with the principles is a particular consideration for Part III of the Act, where public safety concerns necessitate a higher degree of restriction and compulsion.

Wider application of the new principles

These principles will apply to all professionals involved in the care of people under the Act. Once the reforms are enacted, we will work with service users and practitioners to ensure the new principles are effectively embedded in future revisions of the Act's Code of Practice and are used to guide broader policy and practice surrounding the Act. This will ensure that the principles govern every element of someone's care.

Consultation Question 1: We propose embedding the principles in the MHA and the MHA Code of Practice. Where else would you like to see the Principles applied to ensure that they have an impact and are embedded in everyday practice?

2. Clearer, stronger detention criteria

Context: the rising and disproportionate rates of detention

The detention criteria set out in the Act are the fundamental justifications that allow decision makers to remove a person's liberty and give them treatment without consent. The criteria which must be met are that a person must be suffering from a mental illness with symptoms severe enough to present a risk to themselves or to other people. As a society, we accept that these are circumstances that necessitate the use of these powers, but practitioners should not use them lightly - these are strong state powers to detain people and remove both their liberty and their right to make choices about their care.

The Government commissioned the Independent Review in response to concerns around the growing number of people being detained, inequalities among the detained population, and the length of time people spend detained under the Act. The rate of compulsory detention in mental health hospitals has more than doubled since 1983 and it is disproportionately higher amongst certain ethnic minority groups, with Black people four times more likely than white people to be detained under the Act and ten times more likely to be put on a CTO. In parallel, as highlighted by the Review, there are concerning cases of people being subject to unsuitably long stays in wards, which may exacerbate and not ease their problems. This is most common among autistic people, people with a learning disability and people living with schizophrenia.

To help address growing detention numbers, we need to ensure patients are provided with the appropriate care and support they need in the community. The NHS Long Term Plan's commitments for mental health – to improve community provision, to provide earlier support for people with serious mental illness, and to ensure that alternatives to detention are available for those in crisis – are all critical improvements we need to make to tackle detention rates. Our plans to improve services for people with a learning disability and autistic people will also have an impact on detention rates. The NHS Long Term Plan and the NHS Mental Health Implementation Plan 2019/20 – 2023/24 both provide detail on how the NHS will take this work forward.

Detention criteria: our proposal

To complement this significant expansion of community provision, we need to ensure the Act is used in a fair and just way and works to increase trust amongst those groups which are more likely to be detained. To be effective, this must take a multi-pronged approach, and must include better and more transparent decision making, when assessing whether someone meets the criteria for detention under the Act.

We propose to revise, strengthen and clarify the detention criteria to ensure that, in the future, detention only takes place when it is absolutely appropriate. We will also introduce requirements around how and when the new detention criteria should be applied, to ensure that people are only detained when there is a clear justification for doing so and that they are discharged as soon as that justification ceases to be relevant.

We will seek to revise the criteria to deliver two of our core principles:

- i. Therapeutic benefit** - greater consideration must be given to whether, and if so how, detention and interventions provided under the Act are or would be beneficial to a person's health and recovery
- ii. Least restriction** - ensuring a person is only detained where it is absolutely necessary, where not detaining poses a substantial risk of significant harm being caused to themselves or others

i. Therapeutic benefit

Currently, the Act states that detention should be "necessary for the health or safety of the patient" and that "appropriate medical treatment is available", neither of which expressly provides for a requirement that the patient should benefit from the treatment allowed for by the detention.

We therefore propose to amend the detention criteria in section 3 of the Act, and elsewhere, to more clearly stipulate that in order 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.

Applying the principle of therapeutic benefit to the detention criteria is designed to ensure care and treatment provided under the Act will promote recovery and facilitate patients to get better, so that they can be discharged as soon as possible. This could mean through improved mental health, or the therapeutic management of an ongoing condition. This should prevent the 'warehousing' of patients, where they are detained within inpatient settings without treatment which provides therapeutic benefit, something that the Review identified as more likely to happen for people with a learning disability and autistic people. Care and treatment that constitutes therapeutic benefit should include consideration of the patient's wishes and preferences. Decisions about when and whether to discharge a patient should also include an assessment about whether the hospital or an alternative community setting provides the most therapeutic package of care. The presumption should

always be that care is delivered in the least restrictive setting possible. Patients and service users have consistently said that delivering therapeutic benefit is about more than just medication. The ward culture and environment in which someone is being cared for is also very important.

Our proposed reforms to reduce reliance on inpatient services for people with a learning disability and autistic people, further embed this principle, to ensure that neither autism nor a learning disability are grounds for detention in and of themselves.

ii. Substantial likelihood of significant harm

The presence of a risk to self or others will remain a fundamental justification for detention under the Act. However, we agree with the Review that the current wording within the Act, that detention is lawful for the interests of the patient's "own health or safety or with a view to the protection of other persons" is too ambiguous and may have contributed to growing risk aversion amongst some professionals, particularly with regard to patients with a learning disability and autistic people. We want to revise the Act to ensure it is more explicit about how serious harm must be, or how likely it is that the harm will occur, to justify detention and/or treatment.

We propose to amend the detention criteria for sections 2 and 3 of the Act, and elsewhere, to clearly stipulate that in order for someone to be detained, it must be demonstrated 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. We think that this will make it harder to detain people in a way that is more in keeping with the gravity of the removal of their liberty. Requiring that the potential harm is significant will mean detention will only be permitted in the most serious of cases. The risk of harm posed by the individual must be evidenced and recorded, encouraging professionals to focus on more than the individual's presenting behaviour and their perceived likelihood and severity of the harm.

Clearly, how risk to oneself or others is managed will remain a sensitive and critical issue at the heart of the Act - and there remains a reality that some people with mental illness can present a risk to other people. This must be dealt with by assessing risk on a case by case basis, taking a positive approach to clinical risk management, and by regularly reviewing if the individual continues to meet the detention criteria on the grounds that they pose a substantial risk to themselves or others.

Where that threshold is no longer met, detention under the Act should no longer be justified and would not be lawful under the proposed revised criteria. We think that this will protect patients from prolonged detention under the Act.

Applying the new detention criteria

Those taking the decision to detain someone will need to document the specific risk that justifies detention and how detention will deliver therapeutic benefit in the new statutory Care and Treatment Plan.

Our intention is that this will improve transparency and help tackle a culture of risk aversion which could impact on decisions, particularly in relation to people from a black, Asian and minority ethnic background or people with a learning disability or autistic people.

The new detention criteria will apply when detaining an individual under sections 2 and 3 of the Act, and when using a CTO. Following the initial decision to detain a patient, the new criteria will need to be applied every time a decision is made about a patient's continued detention under the Act. For example, the decision to transfer a patient from section 2 to 3 for treatment, as part of the routine detention renewal process and when a patient's case is brought before the Mental Health Tribunal.

Taken together, these changes will make longer term detentions more difficult to justify after the point where the patient is no longer considered to pose a significant risk and where treatment or detention ceases to have therapeutic value.

While we intend to tighten the detention criteria, we want to avoid making them so stringent that people who need the protection of the Act can no longer be legally detained. The legislation will still allow for the detention of people at risk of suicide, and for patients with conditions that may be harder to treat, so long as detention under the Act has a therapeutic benefit.

Consultation question 2: We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation question 2a: Please give reasons for your answer

Consultation question 3: We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation question 3a: Please give reasons for your answer

Part III patients and the new detention criteria

For clarity, we do not propose to change the criteria for detention under Part III of the Act (nor was this proposed by the Review). Patients in the criminal justice system have a unique risk profile which must be carefully managed. Changing the detention criteria for Part III patients would limit the scope for professional discretion or judgment with regard to risk, and therefore compromise our ability to adequately protect the public from risk of harm from sometimes serious or violent offenders. We are satisfied the current criteria for detention under Part III of the Act enables professionals to make the right decisions for people, including where this requires diversion from criminal justice settings into a hospital setting.

3. Giving patients more rights to challenge detention

We are concerned that too often patients are detained for longer than is needed, and beyond the point of therapeutic benefit to the individual. The previous chapter set out proposed reforms to detention criteria. We think it's important that all detentions are frequently reviewed against these criteria, to ensure detention is justified, that it lasts for as short a time possible and only so long as there is a therapeutic benefit.

We want to introduce more checks on whether a patient's detention continues to be appropriate, both internally and by the Tribunal, and increase the rights of patients and their representatives to challenge detention.

We also want to expand the powers of the Tribunal so that it plays a greater role in embedding the core principles of reform – in particular those of least restriction, therapeutic benefit and greater choice and autonomy.

More frequent review of the case for detention

For patients under section 3 of the Act, going forward we want their detention to be reviewed to assess whether it is still justified three times within the first year, as opposed to current policy and practice which states this needs to happen just two times.

The decision to detain an individual is one which has significant impact. We think that six months is too long to wait for detention to be reviewed for the first time. We want to bring this forward to month three by halving the initial detention period to three months. This will mean that in the first year of detention, reviews will occur at month three, month six and at month twelve. At each review, the patient's case for detention will be subject to scrutiny by the Responsible Clinician and other decision makers, such as the Hospital Managers who are required to provide additional oversight and to assess the Responsible Clinician's decision in certain circumstances.

Greater access to the Mental Health Tribunal so detention can be scrutinised

We also intend to increase people's access to The First Tier Tribunal (Mental Health) (MHT), which provides vital independent scrutiny of detention.

The Mental Health Tribunal is responsible for considering applications by patients and their nearest relative, and referrals by hospital authorities or the Secretary of State for Justice, for discharge from the Act.

For patients detained under section 2 of the Act, there is currently a 14-day time limit in which they (or their representative) can make an application for discharge to the Tribunal. We think that this is too short and therefore we will seek to extend the limit to 21 days, to give patients (or their representative) greater opportunity to appeal their detention. Whilst allowing enough time (seven days) for the hearing to take place before the section expires, after which the patient must be discharged or transferred to section 3 of the Act.

For patients detained under section 3 of the Act, the patient (or their representative) will have three opportunities to appeal to the Tribunal in the first 12 months of detention, up from the current two.

To ensure that the right to apply to the Tribunal can be fairly accessed by all, we will create a new statutory power for Independent Mental Health Advocates (IMHAs) to apply to the Tribunal to challenge the patient's detention on their behalf. This will be in addition to the Nominated Person who can also apply to the Tribunal in certain circumstances, in line with the current powers of the Nearest Relative.

The Tribunal will consider applications for discharge against the revised detention criteria, as set out above. As part of their assessment of whether the detention continues to be justified, the Tribunal will take into consideration the new statutory Care and Treatment Plan, which will set the Responsible Clinician's justification as to why the patient continues to meet the detention criteria. As the Tribunal is a judicial body, rather than a clinical body, the tribunal will not comment or rule on the specific details of the plan or the treatments being provided, as part of applications for discharge, but will be able to consider the strength of evidence set out that the patient continues to meet the detention criteria.

We will work with Her Majesty's Courts and Tribunals Service (HMCTS) to consider whether the statutory Care and Treatment Plan could replace some of the existing tribunal reports, to reduce paperwork and bureaucracy.

Automatic referral to the Tribunal

As set out above, patients under section 3 of the Act will have further opportunities to appeal their detention under the reformed Act. Their Nearest Relative, and going forward their IMHA, will also have the power to exercise this right on their behalf. Their Nearest Relative (NR), and going forward their IMHA, will also have the power to exercise this right on their behalf. Where a patient (or their NR or IMHA) does not request a Tribunal, we are also considering increasing how frequently patients are automatically referred to the Tribunal.

Automatic referrals to the Tribunal are an important safeguard, ensuring that all detentions are reviewed independently from the detaining authority on a regular basis, rather than relying on the patient or their representative to request one. This helps ensure that patients

who are intimidated by the process or lack the capacity to exercise their rights do not miss out on having their case for discharge considered by the tribunal.

Increasing the frequency of automatic referrals to the Tribunal, as recommended by the Review, would ensure that detentions under the Act are more regularly scrutinised. However, this creates an additional demand on the Tribunal that must be carefully balanced alongside other reforms that will also result in new pressures on the body. For example, the patient's increased right to appeal to the Tribunal, and the expansion of its function to considering treatment challenges. Making too many requirements on the system at once could lead to long waits before a patient's case is heard. Therefore, while we plan to put in place the necessary legal framework to allow the timeframes for automatic referrals to change, we wish to first ensure that the new timeframes proposed by the Review are appropriate and ensure there is sufficient capacity in the system to take them forward. We will then consider phasing in any changes over time so that we can carefully assess resource constraints and ensure sufficient capacity and funding to enable the Tribunal to deliver on the reforms to the Act.

We would welcome views on the proposed changes to the frequency of automatic referrals to the Tribunal, set out in detail below, to help inform our thinking:

Consultation question 4: Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal? (see Table 1 for details)

a) Patients on a section 3

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

b) Patients on a CTO

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

c) Patients subject to Part III

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

d) Patients on a Conditional Discharge

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Question 4a Please give reasons for your answer.

Table 1 – Frequency of automatic referrals - Current and future proposals

Type of patient	Current provisions	Proposed provisions
Patients subject to section 3	<p>Referral 6 months after the detention started, if the Tribunal has not considered the case in the first 6 months (e.g. if the patient had not made an appeal).</p> <p>Following that, referral takes place if more than 3 years have elapsed since the case was last considered by the Tribunal.</p> <p>Or, if the patient is under the age of 18, the case is referred to the Tribunal annually.</p>	<p>Referral would instead take place 4 months after the detention started, if the Tribunal has not considered the case in the first 4 months.</p> <p>Thereafter, referral would take place 12 months after the detention started, if the Tribunal has not considered the case in the intervening months.</p> <p>After the first 12 months of detention, referral would take place annually.</p>
Patients on a CTO	<p>During the CTO, referral takes place 6 months after their detention began, so long as the Tribunal has not considered the case in the first 6 months.</p> <p>Following that, referral takes place if more than 3 years (or 1 year in the case of a patient under 18) have elapsed since the case was last considered by the Tribunal.</p> <p>If the CTO is revoked, referral to the tribunal takes place as soon as possible after that point.</p>	<p>Referral would take place 6 months after the patient was put on the CTO, if the Tribunal has not considered the case in the first 6 months.</p> <p>However, thereafter, referral would take place 12 months after the patient was put on the CTO, if the Tribunal has not considered the case in the intervening months.</p> <p>After the first 12 months of detention, referral would take place annually.</p>
Patients subject to Part III	Referral takes place if the Tribunal has not considered the patient's case in the last 3 years.	Every 12 months.
Patients on a Conditional Discharge (restricted, part III patients only)	These patients have no right to an automatic referral.	<p>Referral would take place 24 months following receipt of the conditional discharge by the patient.</p> <p>Thereafter, referral would take place every 4 years.</p>

Removing the Tribunal's role when revoking CTOs

While overall we want to increase the scrutiny of detention, including by the Tribunal, we also want to ensure that the process for reviewing an individual's detention works effectively. Currently, there is an automatic referral to the Tribunal when someone's CTO is revoked. The Review made the case that this is an ineffective safeguard, as often by the time the Tribunal sits, the patient is back in the community, on another CTO, or where the CTO have been revoked, they have reverted to a section 3 patient. This makes the automatic Tribunal redundant, as the outcome of the Tribunal will not have a material impact on the patient. We therefore propose to remove the automatic referral to a Tribunal when a CTO is revoked. This will also help create capacity in the system, to take on other reforms.

Consultation question 5: We want to remove the automatic referral to a Tribunal received by service users when their Community Treatment Order is revoked. Do you agree or disagree with this proposal?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation question 5a: Please give reasons for your answer

Giving the Tribunal more power to grant leave, transfers and community services

Where the continuation of a patient's detention is justified, we want to give the Tribunal the power to determine if the current setting represents the least restrictive option or if other options are available that better support the recovery of the patient and their path to discharge.

We will extend the role of the Tribunal, when considering applications for discharge, to give it the power to grant leave, transfer patients, for example to a less secure hospital, and to direct services in the community.

Under section 72 of the Act, the Tribunal can already make recommendations relating to a patient's leave or transfer, but such recommendations are not binding. We intend to legislate so that the Tribunal is able to grant leave and transfer, and direct services in the community. We propose that there should be an obligation in legislation on health and Local Authorities to take all reasonable steps to follow the Tribunal's decision. If the authority is not able to give effect to the Tribunals' decision, it must provide an explanation to the Tribunal, setting out the steps it took and why it was not possible to follow the decision. This approach will align the Tribunal with that of the Special Educational Needs and Disability Tribunal (the SEND tribunal).

These powers would only apply for patients who are not subject to restriction orders (unrestricted patients) and would only be considered as part of an appeal for discharge. Patients will not be able to appeal directly to the tribunal to be granted leave or transfer.

We acknowledge that there are practical implications to implementing this recommendation. For example, if the Tribunal grants the transfer of a patient to a hospital in a different location or with a lower level of security, bed availability may mean it is not possible to give effect to the transfer immediately. We therefore propose that healthcare bodies and Local Authorities should be given a period of five weeks to take reasonable steps to deliver the Tribunal's direction and to respond to the Tribunal if they are unable to give effect to the direction.

Consultation question 6: We want to give the Mental Health Tribunal more power to grant leave, transfers and community services. We propose that Health and Local Authorities should be given five weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 6a: Please give reasons for your answer.

Hospital managers' hearings

Hospital managers* have various responsibilities under the Act, many of which are delegated to others who act on their behalf. Under section 23(4) of the Act, decisions to discharge a patient from detention and CTOs can be delegated to managers' panels. The panel is made up of people appointed specifically for this purpose who are not officers or employees of the organisation concerned and are therefore independent.

The Code of Practice establishes the right of the patient to appeal to the managers' panel to have their case for discharge heard. The managers' panel can also act on behalf of the Hospital Managers to exercise their power to discharge a patient if they disagree with the Responsible Clinician's decision to renew a patient's detention or extend their CTO.

The Review recommended removing the role of the managers' panel in discharging patients, based on concerns around the effectiveness of this safeguard and the lack of formality surrounding panel hearings.

We agree that the Tribunal is better placed to assess whether a patient continues to meet the criteria for detention under the Act. As set out above, we will be taking steps to increase access to this safeguard, both through increasing the patient's right to appeal to

the Tribunal and the frequency of automatic tribunals. However, we have heard mixed views from stakeholders on the effectiveness of managers' hearings, with some Trusts reporting to us that the managers' panel provides an effective means of identifying when a patient is ready for discharge. We therefore wish to consult on this issue prior to taking a final decision on whether or not to remove the hospital manager hearing.

Consultation question 7: Do you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a CTO?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 7a: Please give reasons for your answer.

* Explanatory text 2: Explanation of hospital manager

In England, NHS hospitals are managed by NHS Trusts and NHS foundation Trusts. For these hospitals (including acute/non-mental health hospitals), the Trusts themselves are defined as the 'hospital managers' for the purposes of the Act. In an independent hospital the person or persons in whose name the hospital is registered are the Hospital Managers.

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

We will take steps to legislate so that people with mental health conditions, when subject to the Act, have greater influence over decisions about their care and treatment.

Over recent years, the framework for user involvement in care under the Act has not kept pace with the increased expectations for patient-centred choice and care seen elsewhere in healthcare. In particular, it does not place enough emphasis on empowering patients and it too readily removes their freedom and ability to express choices and preferences.

We want to change radically the Act's provisions around the administration of treatment once someone has been detained. We want to ensure that patients can specify what they want. We expect that their voice will be heard and respected and that they will have the opportunity to challenge when it is not. We will seek to do this in the following ways:

- **Advance Choice Documents (ACDs):** These will enable people to set out in advance the care and treatment they would prefer, and any treatments they wish to refuse, in the event they are detained under the Act and lack the relevant capacity to express their views at the time. It will be a legal requirement that ACDs are considered when a patient's care and treatment plan is developed.
- **Care and Treatment Plans:** These will set out the patient's care and treatment, including how this takes into consideration the wishes and preferences of the patient, and critically the rationale when a person's wishes have not been followed. Care and Treatment Plans will be a legal requirement for all patients, and there will be a legal time limit within which plans will need to be in place.
- **A revised Part IV:** This will provide a new legal framework for consent to and refusal of medical treatment, setting out the process which must be followed to ensure wishes and preferences are taken into consideration, and limiting the circumstances where a patient's views, and treatment refusals, can be overruled.
- **Enhanced role of the Mental Health Tribunal (MHT):** This will give patients a new route to challenge their treatment, where their choices have not been followed, by introducing a new role for the Tribunal.

Advance Choice Documents

The introduction of Advance Choice Documents (ACDs) and the legislation underpinning them will mean that decision makers are legally required to consider the advance wishes

of the patient, meaning that the patient's voice will play a far greater role in informing treatment.

Existing statutory provision in the Mental Capacity Act (MCA) for advance decision making in England has been developed primarily in the context of physical healthcare and community mental healthcare. With limited exceptions, there is no legal requirement on the Responsible Clinician to consider advance decisions made by the patient when determining their medical treatment under Part IV of the Act. This means that if a patient has a valid and applicable advance statement which sets out their preference of one antipsychotic drug over another, while the Responsible Clinician is professionally obliged to act in the best interests of the patient, they are not legally obliged to take this into account.

How the Advance Choice Document will work in practice

Advance Choice Documents give individuals the opportunity to record a range of choices and statements about their care and treatment in preparation for a future situation in which they are too unwell to express these decisions themselves.

An Advance Choice Document must be made when the individual has the relevant capacity. The statements made within it will only be considered if the individual loses the relevant capacity to make decisions about their own care and treatment. There will be a legal requirement on clinicians to consider the contents of an individual's Advance Choice Document while they are detained under the Act.

While Advance Choice Documents will be available to all individuals who wish to make one, we think it is particularly important that people who have previously been detained are proactively offered the opportunity to develop one. This would aim to ensure that people with experience of detention, who have developed knowledge and expertise of the sorts of things they do or don't prefer, can inform their care and treatment to meet their needs. We will therefore make it a requirement in the legislation for Advance Choice Documents to be offered to all people who have previously been detained. We will also set out in guidance that anyone who is at risk of detention should be offered the opportunity to make an Advance Choice Document.

To ensure that service users' Advance Choice Documents can be readily accessed by health and social care professionals, where necessary, we will seek to ensure that these important documents are available via a secure digital database.

What will you be able to include in an Advance Choice Document?

Advance Choice Documents will follow a standard format and approach, and should include the following information about an individual's preferences, including on treatment

and non-medical therapeutic approaches, as well as any other information deemed relevant by the individual:

- Any treatments the person does not wish to consent to as well as their preferred clinically appropriate treatments
- Preferences and refusals on how treatments are administered (e.g. refusal of suppositories, and preference for care staff of a particular gender, to avoid retraumatising them, given the relationship between gender-based violence and trauma)
- Name of their chosen Nominated Person
- Names of anyone who should be informed of their detention, care and treatment (including specific instructions on which individual should get what information)
- Communication preferences
- Behaviours to be aware of which may indicate early signs of relapse
- Circumstances which may indicate that the person has lost the relevant capacity to make relevant decisions
- Religious or cultural requirements
- Crisis planning arrangements, including information about care of children/other dependents, pets, employment, housing etc.
- Other health needs and/or reasonable adjustments that might be required for individuals with a disability or learning disability and for autistic people

Consultation question 8: Do you have any other suggestions on what should be included in a person's Advance Choice Document?

Advance Choice Documents should draw on an individual's expertise of managing their own mental health. Where possible, they should be written with support and guidance from an individual's clinician and other trusted health professionals. The patient may also invite their Independent Mental Health Advocate (IMHA), their Nominated Person (NP) and family and friends to take part in the discussion of what statements they would like to make in their Advance Choice Document.

What legal weight will an Advance Choice Document have?

Under the reformed Act, decisions made by people when they have the relevant capacity to make them will have a real power and influence over decisions and appeals regarding care and treatment. Any statements of preference in an Advance Choice Document will, in most cases, be considered as equivalent to those made in real time by a patient with the relevant capacity.

To remove the potential for doubt later as to whether the person had capacity to make the choices contained in an Advance Choice Document, the Review recommended that service users should seek to have their documents authenticated by a health professional. As part of this, the health professional would ensure that the patient understands the foreseeable consequences of an Advance Choice Document, including the potential risks of refusing treatment; the circumstances in which treatment refusals can be overridden; and in what circumstance wishes and preferences may not be followed, for example if preferred treatments are not available or clinically appropriate.

While we agree an authentication process would be beneficial in ensuring that the patient is fully informed of the decisions they are making and in giving the Responsible Clinician confidence in the document's contents, we do not think that formal authentication should be necessary for the Advance Choice Document to be valid. Instead, we think that for an Advance Choice Document to be valid and have legal effect, it must have been made by someone who had the relevant capacity and apply to the treatment in question. This is the same approach as under the MCA. Authentication would be one way that an individual could seek to ensure that there is no doubt later about whether the statements were made with capacity. Otherwise, it would be for those concerned with the patient's care and treatment to consider whether the statements were made with capacity, at the point when decisions need to be made.

Consultation question 9: Do you agree or disagree that the validity of an Advance Choice Document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 9a: Please give reasons for your answer.

Statutory Care and Treatment Plans

For the first time, the Act will require that all patients subject to detention must have a Care and Treatment Plan, with clear expectations about how and when this should be

developed with the patient. In practice this will mean clinicians setting out in detail their assessment and plan for a patient's care and treatment, including how their wishes and preferences have been accounted for and what the intended route is towards discharge.

In recent years, personalised and dynamic care planning has become accepted as a mainstay of modern health and social care services, promoting choice, control and improved levels of service user engagement. However, with regards to the Act, the Care Quality Commission has consistently raised concerns that care plans are not always discussed with the patient and often fail to reflect a patient's views about their care and treatment, as set out in their Monitoring the Mental Health Act [2017/18](#)^[3] and [2018/19](#)^[4] reports.

We will introduce legislation to change this. Patients must receive clear and accessible information to help them understand the reasons for their detention and treatment. They should have a right to see the plan for the treatment they will receive within a reasonable timeframe, showing how it will help them and what the plan is for their discharge. It is also especially important that patients know how their wishes and preferences have been considered.

It will be for the patient's Responsible Clinician (RC), working with all others involved in the patient's care, to complete and maintain the Care and Treatment Plan. The Plan should reflect the patient's preferences, as far as possible, even when the patient lacks the relevant capacity to make decisions about their care and treatment. It should also recognise that capacity can fluctuate, and that an individual may lose capacity for some decisions but not others, and ensure that capacitous decisions are followed wherever possible. Where a patient lacks the relevant capacity, their Advance Choice Document – where one exists – should be used to inform the development of the Care and Treatment Plan. Where a patient lacks the relevant capacity and does not have an Advance Choice Document, clinicians must still support the individual to express wishes and preferences, through supported decision making and consultation with the patient's Nominated Person, family and carers.

If decisions depart from the patient's wishes and preferences, however they are expressed and ascertained, the justification must be explained to patients and recorded. Where treatment refusals have been overruled, the Care and Treatment Plan should document how the necessary procedures have been followed (see following section).

Where a patient has a learning disability or is an autistic person, or both, the Responsible Clinician will also be required to take into account the findings and recommendations made as part of a Care and Treatment Review (CTR) or Care Education and Treatment Review (C(E)TR) for children and young people), in the patient's statutory Care and Treatment Plan. C(E)TRs are part of the Government and NHSEI's commitment to transform services for people with a learning disability and autistic people, and are designed to overcome barriers to the patient's progress. They are jointly produced with the

local authority and education services. Where the Responsible Clinician has not followed all the findings and recommendations of the C(E)TR, they will again have to explain their rationale in the Care and Treatment Plan.

What will be included in a Care and Treatment Plan?

We think that a Care and Treatment Plan should include the following information:

- The full range of treatment and support available to the patient (which may be provided by a range of health and care organisations)
- For patients who have the relevant capacity and are able to consent, any care which could be delivered without compulsory treatment
- Why the compulsory elements of treatment are needed
- What is the least restrictive way in which the care could be delivered
- Any areas of unmet need (medical and social) e.g. where the patient's preferred treatment is unavailable at the hospital
- Planning for discharge and estimated discharge dates (with a link to s117 aftercare)
- How Advance Choice Documents and the current and past wishes of the patient (and family and/or carers, where appropriate) have informed the plan, including any reasons why these should not be followed
- For people with a learning disability, or autistic people, how Care (Education) and Treatment Reviews, where available, have informed the plan, including any reasons why these should not be followed
- An acknowledgement of any protected characteristics, e.g. any known cultural needs, and how the plan will take account of these
- A plan for readmittance after discharge e.g. informal admission, use of civil sections, or recall by the Justice Secretary

Consultation question 10: Do you have any other suggestions for what should be included in a person's Care and Treatment Plans?

When will Care and Treatment Plans be created and reviewed?

For both section 2 and 3 detentions, a patient's Care and Treatment Plan should be made within seven days of their detention. It should be subject to internal scrutiny and approval by the Medical or Clinical Director (or equivalent) within 14 days of detention, who will check that the Care and Treatment Plan is sufficiently comprehensive, in view of the content requirements listed above, and that the detention criteria continue to be met.

For patients detained for assessment under section 2 of the Act, the Care and Treatment Plan will understandably be less clearly developed at the 7 day and 14 day stages, however, we propose it will still need to be sufficiently developed to inform decisions on whether to continue to detain the person.

These requirements will be set out in legislation. This will help ensure that the patient's assessment, recovery and eventual discharge is the primary focus from the very start of their detention. This will also support increased scrutiny of detention.

After approval within 14 days, the Care and Treatment Plan should be a living document, subject to continued dialogue with the patient and amended or adapted as required. It should reflect any changes in the care and treatment being provided, patient consent and refusal of treatment, and continued documentation of how the detention criteria are being met. There should be an ongoing and increasing focus on preparation for discharge and the aftercare that should be in place directly after that discharge. This should bring mental health inpatient units in line with acute hospitals, where there is an established principle of planning for discharge from the point of admission and a 'home first' approach to guide care planning.

A new legal framework for patient consent and refusal of medical treatment

Medical treatment for mental disorders, as regulated by the Act, covers a wide range of interventions, from the extremely invasive (e.g. neurosurgery) to more routine medical treatment given under the direction of an Approved Clinician.

We will seek to reform the Act to give patients greater control over their care and treatment, and the right to refuse specific medical treatments at a much earlier point in detention. This is a fundamental issue at the heart of our plans for modernising the Act, and our commitment to give patients more choice and autonomy, and greater confidence that their voice will be heard. We will take steps to strengthen safeguards and introduce new rights for people with regards to most treatments, in most circumstances, ensuring that the principle of patient choice and autonomy is at the centre of decision making.

Part IV of the Act regulates decisions about a patient's care and treatment, including what happens when a patient consents to treatment being administered to them, and what happens when they don't. Currently Part IV of the Act allows for most medical treatments to be given to an individual without their consent (even where they have the relevant capacity) for a period of three months, at which point a second clinical opinion is required from the Care Quality Commission's Second Opinion Appointed Doctor (SOAD) service.

We propose different requirements and safeguards depending on the nature or invasiveness of the treatment. These can be broken down into three categories:

Category 1: The most invasive treatments (e.g. neurosurgery)

Category 2: Invasive treatments (e.g. electro-convulsive treatment)

Category 3. All other medical treatment for mental disorder

Below, we set out in more detail our proposed framework for each category of treatment, based on the recommendations made by the Review. Which treatments fall within each category will be set out in regulations and will be subject to further engagement and consideration. A summary of the revised framework is set out in Annex A, as well as a more detailed description of the new categories and how they would work in practice.

Category 1 Treatments: most invasive

The provisions within section 57 of the current Act, which relate to the administration of invasive treatments, such as neurosurgery, will apply in the case of Category 1 treatments. These are described in Annex A. The Review did not make any specific recommendations relating to these provisions.

Category 2: Invasive treatments (e.g. electro-convulsive treatment)

This Category will include electro-convulsive therapy (ECT) and other similarly invasive treatments. As is now the case with ECT, treatments in this category will not be able to be given if the patient has the relevant capacity and is refusing.

We think that people who lack the relevant capacity to express their wishes, but who have refused treatment in a valid Advance Choice Document, should also have access to this important safeguard.

In both cases, the Responsible Clinician will only be able to override the patient's refusal for treatment if it is considered urgent, meaning it is necessary to save the patient's life or prevent a serious deterioration of their condition (as currently described in section 62(1) (a) and (b) of the Act)*.

We want to go further to strengthen this safeguard. We think that, where the urgent criteria are met, then the Responsible Clinician should be required to seek approval from court before overriding the patient's refusal. The Responsible Clinician should also have to secure two medical opinions to support their application.

If the patient lacks the relevant capacity to consent but has not refused the treatment via a valid Advance Choice Document, the current requirement for ECT would stand, in that the treatment could only be administered once a SOAD has certified that it is clinically appropriate and that it should be given. However, we want to see a greater emphasis on ascertaining the patient's wishes and preferences as far as possible. The SOAD should consider any statements of preference previously made by the individual, particularly at a time when they had the relevant capacity, as well as the individual's beliefs and values. Where appropriate, the SOAD should also consult with the Nominated Person, family or others who are concerned with the person's welfare.

For these individuals, if the treatment is considered to meet the urgent criteria set out above, it can be administered without SOAD certification, but the Care Quality Commission should in future be informed of the decision and provided with the clinician's records for scrutiny.

* Explanatory text 3: Urgent criteria as set out in the Mental Health Act 1983

Mental Health Act 1983, section 62(1) ...

- (a) which is immediately necessary to save the patient's life;
- (b) which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- (c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- (d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

Category 3 Treatments: all other medication

The changes we want to make to the safeguards and requirements surrounding this category signify the most significant advance from the current legislation.

At the moment, the medical treatments in this category, which represent the vast majority, can be administered for a period of three months without the need for consent. This is

even the case for patients who have the relevant capacity to refuse treatment. We want to change this so that the administration of these treatments is subject to far greater control. We will also seek to rebalance the system to be more responsive to the wishes and preferences of the patient.

Most crucially, where a patient is refusing treatment, and the Responsible Clinician wishes to overrule their refusal, we will seek to bring forward the point at which a SOAD must certify a patient's treatment from 3 months to day 14 of detention, when their Care and Treatment Plan has been signed off by the Clinical or Medical Director.

This will apply both to people who have the relevant capacity, at the time, and are refusing treatment and to people without the relevant capacity who have refused treatment in a valid Advance Choice Document.

We will also seek to bring forward the point at which the SOAD has to certify treatment for patients who lack the relevant capacity to consent to treatment and who do not have an Advance Choice Document. Our intention is that this certification will take place at two months, rather than the current three.

Again, where a SOAD is required to certify treatment they should, as part of deciding whether the treatment should be given, ascertain as far as possible the wishes and preferences of the individual and consult with the appropriate people, ensuring the treatment is in the patient's best interests. Where the patient is refusing treatment, the SOAD will also be required to certify that there is no other clinically appropriate treatment available that is more acceptable to the patient.

Where treatment is considered urgent, we think the criteria for administering treatment against someone's wishes should differ depending on whether the individual has the relevant capacity to refuse treatment at the time, versus if they lack capacity but have refused treatment in a valid Advance Choice Document. In both cases, we think that the Responsible Clinician* should be able to overrule the patient's refusal and administer the treatment, without the certification of a SOAD, if it is considered immediately necessary to save the patient's life, to prevent a serious deterioration of their condition, or to prevent the patient from behaving violently or being a danger to themselves or others, as is currently described in section 62(1) (a), (b) and (d). However, we think that the fourth requirement, which is that the treatment is needed to alleviate serious suffering (as described in section 62(1) (c)), should only apply in the case of patients who lack the relevant capacity to refuse treatment at the time. We discuss the proposed changes to the urgent criteria and consult on this issue below.

* Explanatory text 4: Definition of responsible clinician

For brevity, (and because it is the term most commonly used), when discussing treatment decisions, this document refers broadly to Responsible Clinicians, a professional category that can include professionals other than doctors, who would therefore not be responsible for treatment decisions. The Act refers, more accurately, “to the approved clinician in charge of the treatment”.

The right to choose to suffer

The Review recommended that the criteria that must be met to administer urgent treatment to a patient with the relevant capacity should be amended to remove section 62(1)(c)*. This would mean that urgent treatment could no longer be given to patients with the relevant capacity, against their wishes, on the basis of the alleviation of serious suffering. This proposal is based on the rationale that patients with the relevant capacity should be able to make their own judgements on the degree of suffering they are willing to accept.

Exclusion of this criterion would mean that urgent treatment under category 3 could still be administered to patients with the relevant capacity if it was:

- Immediately necessary to save the patient's life;
- (Not being irreversible) immediately necessary to prevent a serious deterioration of their condition; or
- (Not being irreversible or hazardous) immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or to others.

* Explanatory text 5: Section 62(1)(c) as set out in the Mental Health Act 1983

Section 62(1)(c) requires that treatment (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient.

Consultation question 11: 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?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 11a: Please give reasons for your answer.

Absolute refusal of medical treatment

The new framework for patient consent and refusal will support our ambition of giving patients more choice and autonomy over their treatment. However, the framework will not allow someone to refuse treatment altogether. Creating a new legal framework which would allow for detention without any medical treatment risks contradicting the principle that detention should provide a therapeutic benefit to the patient.

The rights of patients without the relevant capacity

We are aware that the framework set out above introduces significant changes to the legal weight of decisions made with the relevant capacity, whether made at the time or in advance. We also want to ensure that the safeguards to promote choice and autonomy for patients who lack the relevant capacity are also sufficiently robust.

In all circumstances, the Responsible Clinician should take account of any wishes, preferences, beliefs and values previously shared by the patient. They should also consult with the patient's family, their Nominated Person, or others who are concerned with their welfare to establish what the patient's wishes might be. This approach should closely follow the best interest assessment checklist set out in the Mental Capacity Act. We intend to set out requirements for this in the revised Part IV of the Act.

In the case of most treatments (category 3), we will bring forward the current requirement for a SOAD to certify that a patient's medical treatment is appropriate and that it should be given at 2 months, as opposed to at 3 months. The most invasive treatments will never be given to someone who lacks the relevant capacity to consent and advance certification by a SOAD will continue to be required for certain other invasive treatments to be administered to individuals who lack the relevant capacity.

What happens if a patient is given treatment they don't want?

At any point where a treatment is administered against a patient's wishes, it should only be administered in the lowest possible dose to be effective and for the shortest period to achieve its purpose.

The Responsible Clinician should always provide the patient with their justification for not complying with the patient's choice and record this within the Care and Treatment Plan, including any additional processes which have been followed to allow this (e.g. SOAD certification or High Court Judge approval). Clinicians should also be required to record discussions with patients, Nominated Persons and advocates within the Care and Treatment Plan. Where the patient lacks the relevant capacity, the Responsible Clinician should record evidence of their efforts to ascertain the wishes and preferences of the patient and document their rationale if they have not been followed.

A new right to challenge a treatment decision at the Tribunal

While the reforms set out so far aim to strengthen the patient's say over their care and treatment and ensure that decisions that contradict a patient's treatment choices are appropriately justified, we recognise that there may be situations in which a patient might still wish to challenge treatment decisions.

Currently, a patient has limited ability to challenge their treatment under the Act. Should a patient with capacity wish to challenge the decision of the Responsible Clinician and SOAD, they only have a right to do so by way of judicial review.

We want to address this by seeking to introduce the ability for patients to challenge a specific treatment through the Tribunal. This would offer a faster, cheaper and more accessible alternative to judicial review. The challenge may be brought by a patient who has the relevant capacity to refuse a specific treatment at the time. Alternatively, if the patient lacks the relevant capacity, their IMHA or Nominated Person (NP) would be able to bring the challenge on their behalf, providing they have an Advance Choice Document stating their refusal to receive a specific treatment, which is considered to have been made with capacity at the time of writing.

Before a case is able to proceed to a full Tribunal hearing, a judge sitting alone would carry out a preliminary review of the case in a 'permission to appeal' stage. We propose that the preconditions for permission are:

- i. The Responsible Clinician and SOAD have confirmed that the treatment should be given and have set out the reasons for overruling the patient's refusal;
- ii. The patient, or their NP or IMHA, has set out the treatment refusal and rationale for it;
- iii. The application applies to a specific disagreement about an individual treatment decision, rather than a general desire not to be detained, or to not receive treatment; and
- iv. Any repeat application shows a material change in circumstances.

If permission is granted for a full hearing, this would be carried out by a single judge sitting alone. During the hearing, the judge would be responsible for determining whether the appropriate processes have been taken by the Responsible Clinician in overruling the patient's treatment refusal and therefore whether or not the decision to overrule the patient is sufficiently justified and appropriate.

The judge would not take any role in clinical decision-making and they would not be able to authorise the use of a specific treatment. However, the judge would be able to make a

finding that the Responsible Clinician should reconsider their treatment decision. The Review also recommended that the Tribunal should be able to order that a specific treatment is not given if it is found to disproportionately interfere with a patient's rights. We wish to consult on this point.

Consultation question 12: Do you agree or disagree that, in addition to the power to require the Responsible Clinician to reconsider treatment decisions, a the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 12a: Please give reasons for your answer

5. Improving the support for people who are detained

Nominated Person

One of the overarching aims of our planned reforms is to give people more choice and autonomy when subject to the Act. The Review highlighted that service users and stakeholders consistently found the current model of family and carer involvement is outdated and insufficient. This was found to be particularly true of the current Nearest Relative (NR) provisions.

The Nearest Relative has a specific set of rights and powers in relation to the patient. The Act includes a prescribed list which is used to determine the person who is given this role, and therefore the patient has no say in who it is who will take on these specific rights and powers. This can sometimes mean that patients are assigned an inappropriate Nearest Relative, who is not best placed to support their needs. In some instances, this can compound what is already a distressing time and even retraumatise people particularly where they have experienced gender-based violence. As recommended by the Review, we will seek to replace the Nearest Relative with a new statutory role, known as the Nominated Person, who the patient can personally select to represent them.

Choosing the Nominated Person (NP)

As part of an assessment under the Act, an individual will be asked to identify their Nominated Person. They will also be able to identify and record their Nominated Person before detention, through their Advance Choice Document.

If someone lacks the relevant capacity to make a nomination at the point of detention, and has not previously nominated anyone, an Interim Nominated Person will be appointed by an AMHP. The INP will be in place until the person has the relevant capacity to make their own nomination. The Code of Practice will set out guidance for AMHPs on how to identify the relative or friend most suitable to fulfil the INP role and enable flexibility in cases where people have in place court-appointed deputies, and people with powers of attorney.

People with the relevant capacity will have the right to opt out and not have a Nominated Person, if that is their preference. However, section 116 of the Act will still stand. This requires the local authority (where the functions of Nearest Relative under the Act have been transferred to them) to arrange for visits to be made to the patient and, where the patient is a child or young person in the care of a local authority by virtue of a care order, take such steps that might otherwise be expected to be taken by the patient's parents. This safeguard is important in the case of patients who have been detained for an extensive period of time and have no NP.

In addition to being able to identify someone to take on the formal role of Nominated Person, patients will also be able to identify other individuals who can receive information about their care and treatment, either by expressing their wishes and preferences while detained or in their Advance Choice Document.

What roles and powers will a Nominated Person have?

The new Nominated Person will have the same rights and powers to act in the best interests of the patient as Nearest Relatives have now. These include rights to:

- Object to the patient being made subject to the Act;
- Apply for the patient's discharge;
- Appeal to the Tribunal if this application for discharge is denied;
- Apply for the patient to be detained under the Act;
- Receive information from the hospital about the patient's care, detention or CTO, unless the patient objects to this.

In addition to the powers currently held by the Nearest Relative, we propose that the Nominated Person should also:

- Have the right to be consulted on statutory Care and Treatment Plans, to ensure they can provide information on the patient's wishes and preferences;
- Be consulted, rather than just notified, as is the case now, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO;
- Be able to appeal clinical treatment decisions at the Tribunal, if the patient lacks the relevant capacity to do so themselves and the appeal criteria are met;
- Have the power to object to the use of a CTO if it is in the best interests of the patient.

To support Nominated Persons to access and exercise these enhanced powers we will provide clear, detailed guidance on the powers of the Nominated Person role.

Consultation question 13: Do you agree or disagree with the proposed additional powers of the Nominated Person?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 13a: Please give reasons for your answer.

Improving support for patients in the criminal justice system

Currently, patients in the criminal justice system, who are subject to Part III of the Act, do not have the right to a Nearest Relative. We want to change this as we think it is important that all patients, particularly those who lack the relevant capacity, are supported during their detention by someone who is able to represent their wishes and preferences. We will introduce the Nominated Person for forensic patients, with powers limited to care and treatment planning.

Children and young people's right to choose a Nominated Person

For young people aged 16 or 17, we propose that they should have the same right to choose a Nominated Person as an adult, where they have the relevant capacity to make this decision. As with adults, where someone aged 16 or 17 does not nominate anyone, the AMHP would nominate the Interim Nominated Person (INP). In this case, we will advise in guidance that the first choice of INP should be the parent or guardian, where appropriate.

The position for children aged under 16 requires additional consideration. We believe that, providing a practitioner can establish that a child is "Gillick competent", which involves considering whether the child has sufficient understanding, maturity and intelligence to enable them to fully understand what is proposed, a child should be able to choose a Nominated Person. The Review also proposed this approach.

However, in such cases, the patient's right to choose a NP should not undermine the rights of parents, guardians, carers, or other individuals with parental responsibility over the child. If a child were to choose a NP who is not a parent, guardian, carer or person with parental responsibility, then this would not be to the detriment of the usual rights, outside of the Act, that such people would expect to have in order to support their child, including rights to information and to be consulted about decisions about their care.

Consultation question 14: Do you agree or disagree that someone under the age of 16 should be able to choose a Nominated Person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as “Gillick competence”)?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 14a: Please give reasons for your answer.

Overruling the Nominated Person: role of the Mental Health Tribunal

One of the current powers of the Nearest Relative, which will apply to the Nominated Person, is the ability to block admission, when someone is detained under the Act. Currently, if the Nearest Relative exercises this power, but the AMHP believes the grounds for this are unreasonable, the only means of overruling them is to remove or displace them as the Nearest Relative. This can prevent the Nearest Relative from continuing in their statutory role in supporting the patient while they are detained, even though they may be best equipped to protect and promote the patient's interest.

As the Nominated Person will have been identified by the patient as someone they wish to be involved in their care when detained under the Act, we think it is important that they maintain their right to object to detention, without forfeiting their role in the patient's care. We will therefore seek to legislate so that the NP's objection to admission can be temporarily overruled, as opposed to the NP being removed or displaced, to ensure that they continue to have a role in the patient's care and treatment while they are detained.

Currently, the power to displace the Nearest Relative sits with the County Court. However, we wish to explore whether the power to overrule or displace a NP should instead sit within the Tribunal Service's remit, which is potentially better equipped to make these kinds of decisions.

As this represents an additional burden on the Tribunal, we will consider how this would work in practice and whether these decisions could be made instead by a single judge sitting alone, to reduce pressure on the Tribunal workforce. In addition, legal aid currently funds patients' representatives in these County Court proceedings on a means tested basis. If these powers are transferred to the Tribunal, consideration is needed on whether representation should be funded on a non-means tested basis, in line with other proceedings before the Tribunal.

Advocacy

When someone is detained in hospital it can be a very confusing and distressing experience. In addition to enhancing support through improving NP provisions, we propose to enhance the critical role that Independent Mental Health Advocates (IMHAs) play in ensuring patients are supported and helped to exercise their rights.

IMHAs are independent of mental health services and can help people ensure their opinions are heard and they know their rights under the law. We will expand the role of IMHAs to offer a greater level of support and representation to every patient detained under the Act if they choose to take it up.

IMHAs are trained specifically to work within the framework of the Act and to enable patients to participate in decision-making. They are currently responsible for supporting patients to understand:

- Their legal rights under the Act and those of the people who are able to act on their behalf
- The particular parts of the Act which apply to them
- Any conditions or restrictions to which they are subject
- Any proposed or received medical treatment, and the reasons for that treatment
- The legal authority for providing that treatment
- The safeguards and other requirements of the Act which would apply to that treatment.

To ensure patients are able to benefit from the reforms to the Act proposed in earlier chapters, we propose to expand the role of IMHAs to include the following additional safeguards:

- Supporting patients to taking part in care planning
- Supporting individuals in preparing Advance Choice Documents
- Power to challenge a particular treatment where they have reason to believe that it is not in the patient's best interests
- Power to appeal to the Tribunal on the patient's behalf.

Consultation question 15: Do you agree or disagree with the proposed additional powers of Independent Mental Health Advocates?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 15a: Please give reasons for your answer.

Advocacy support for informal patients

The right to an IMHA was added to the Act in 2007. IMHAs are commissioned by Local Authorities to ensure independence from the detaining authority, which must make arrangements so that every qualifying patient who wants an IMHA gets one. The Act also provides a duty for hospitals and others to make sure that patients are aware that advocacy services are available. The statutory duty to provide IMHAs only covers people detained under the Mental Health Act. Other forms of advocacy are available to people in inpatient settings, including under the Mental Capacity Act and the Care Act.

However, when someone is on an inpatient ward, they may not always be aware that they have different rights and safeguards to other people on their ward. As IMHAs are trained in legislation and how to support people to exercise their rights within the Act, we think they are well placed to support informal patients to understand their rights, as was recommended by the Review. However, as we recognise that this will create an additional burden for Local Authorities, and advocacy providers, expanding the statutory duty to all inpatients will therefore be subject to future funding decisions.

Quality of Advocacy Services

High quality advocacy is critical to ensuring people get the support they need when detained and that people are able to exercise their rights.

The Review heard conflicting views around the current quality of advocacy support, including issues on training, accreditation, standardisation, accountability and regulation of advocates. We are also aware that advocacy services for patients with a learning disability or autistic patients can sometimes fall short and that advocates may benefit from training in this area. We are committed to ensuring that the advocacy available to all patients under the Act is of high quality.

We are working closely with City and Guilds as they revise the structure and content of the IMHA qualification, including ensuring the Act's legislation is part of the core learning so that IMHAs can advise patients appropriately on their rights.

In addition to this, there are possible options to professionalise the role, by introducing enhanced standards and accreditation, beyond the Advocacy Charter and Quality

Performance Mark, as well as inspection and registration, in line with other mental health professions. There are, however, counter arguments for preserving the informality of the role, for the reason that this may be a large part of the value that advocates bring. Formalising the profession may discourage more smaller bespoke services.

We would welcome views on ensuring patients are supported by high quality advocacy.

Consultation question 16: Do you agree or disagree that advocacy services could be improved by:

- **Enhanced standards** Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure
- **Regulation** Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure
- **Enhanced accreditation** Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure
- **None of the above, but by other means** Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation question 16a: Please give reasons for your answer.

Culturally appropriate advocacy

A priority in the delivery of higher quality services is the development of culturally appropriate advocacy for people of all ethnic backgrounds and communities, in particular for people of black African and Caribbean descent. The Review highlighted the potential for appropriate advocacy provision to be incredibly valuable to people from black, Asian and minority ethnic backgrounds, yet this is where the biggest gaps exist.

We have committed to launch a pilot programme of culturally sensitive advocates in partnership with Local Authorities and others, to identify how to respond appropriately to the diverse needs of individuals from black, Asian and minority ethnic backgrounds. This is an important step towards delivering an advocacy service that can effectively meet the diverse needs of all service users. Work to scope the requirements for these services has now completed and will inform the commissioning of pilots, which we hope to begin this year. Subject to successful learning from the pilots, and subject to appropriate funding, we will legislate for culturally competent advocacy to be available to detained patients.

Additionally, we will work with NHS England to undertake a review of current advocacy provision for people with a learning disability and autistic people to identify areas for improvement.

6. Community Treatment Orders (CTOs)

The purpose of CTOs, introduced in the Mental Health Act 2007, is to enable some inpatients, who might otherwise remain detained under the Act, to be discharged into the community with conditions intended to maintain ongoing contact with services, in order to provide support and prevent relapse.

However, patients on CTOs remain subject to the Act, sometimes for years. Furthermore, CTOs and the conditions attached to them may present a continuing restriction on a person's liberty. The decision to make person subject to a CTO should always therefore require careful consideration.

There are longstanding issues with CTOs. Firstly, they are used more often than was originally intended. Around 5,000 new CTOs are made annually, far higher numbers than intended when they were introduced in 2007. Secondly, where there is disparity, the evidence regarding CTOs is the starkest. NHS Digital's annual report on the use of the Act reported that in 2019/20 people included within the data category of black or black British people were now over ten times more likely to be given a CTO than white people.

The Review heard many views on the subject of CTOs, opinions ranged from arguments that they should be repealed entirely, to views that for many people they offer the least restrictive option and provide a vital framework under which patients can be discharged from hospital but retain a continuing link with services. However, it concluded that, whatever their merits, CTOs are used too often, patients stay subject to them for far too long, and their disproportionately high use on black people must be addressed.

We will reform CTOs so that they can only be used where there is a strong justification, they are reviewed more frequently and by more professionals, are time limited, and that people subject to them really need them to receive a genuine therapeutic benefit.

Criteria for use

We will revise the criteria for using CTOs, in line with the proposed revised detention criteria for section 3 to ensure that CTOs are used in a more consistent way.

We will change the criteria so that a CTO can only be used when there is a **substantial likelihood** of significant harm to the health, safety or welfare of the person, or the safety of any other person, and where a CTO will provide a therapeutic benefit to the patient.

We want to ensure that CTOs are only used where patients would receive genuine therapeutic benefit from the structure they provide to support continued engagement with mental health services. We will change the legislation to require evidence that the CTO will

be of benefit to the individual, based on a consideration of the patient's previous engagement with their treatment plan in the community. These new requirements should not create a barrier to prevent patients from being discharged to a CTO, when this represents the least restrictive option.

As with assessments for detention, we will also strengthen the requirement that the evidence and justification for the use of a CTO, against the new criteria, is clearly documented and regularly reviewed.

Making, renewing and extending CTOs

While we believe CTOs benefit some patients and provide the least restrictive option for them, we also recognise that they continue to restrict an individual's liberty. It's important, therefore, that the decision to put someone on a CTO is not taken lightly. We will, therefore, introduce a third decision maker. The initial decision to make a CTO will continue to be the responsibility of the Responsible Clinician and an AMHP. We will introduce a requirement for the community supervising clinician who will work with the patient while on a CTO to also be involved in the decision. This will support continuity of care between inpatient and community care, helping to address concerns, highlighted by the Review, around patients being discharged onto CTOs without any handover to the community mental health team.

Each time a CTO is renewed, this decision should also be agreed by the Responsible Clinician, the community supervising clinician and an AMHP, again to ensure those who are supporting the patient in the community are part of the decision as to whether the restrictions of the CTO are still required.

As is the case now, a CTO will be reviewed six months after it is made, and will then be extendable for a further period of six months, and after that point for a further period of 12 months. In line with the Review's recommendations, more professionals will be involved in decisions to extend a CTO – currently this is just a matter for the Responsible Clinician, but we will seek to legislate so that an AMHP and the patient's community supervising clinician must also agree. Although, if the Tribunal has recently considered a patient's CTO just the AMHP and the patient's community supervising clinician will be required to renew.

As well as CTOs being used more frequently than envisaged, once someone is on a CTO they can last for periods of years, sometimes placing restrictions long after they are needed, to little benefit for the individual. Going forward we will set an expectation that CTOs should end after a period of two years.

The patient should be discharged at or before this point, unless they have relapsed or deteriorated during that time. We will initially set this out as guidance in the Code of Practice, because we recognise that in some circumstances remaining on the CTO may

be beneficial to the patient. We will, however, keep this under review, and if we continue to see that people are subject to CTOs for extensive periods, we will look to limit their duration in legislation.

CTOs and the role of the Nominated Person

When putting someone on a CTO, the Nominated Person or Interim Nominated Person should be appropriately consulted, with the Act giving them a new power to object, in line with their existing power in sections 2 and 3. As will be introduced for sections 2 and 3, it will be possible to overrule a Nominated Person's objection to a CTO, without any additional consequence of removing them from that role.

Conditions of CTOs

We want to ensure that the conditions attached to CTOs are:

- Proportionate
- Guided by the principle of least restriction
- Tailored to the individual needs and circumstances of the patient
- Designed to deliver a therapeutic benefit to the patient

We will seek to revise the Act so that CTO conditions will need to be supported by evidence that they meet these requirements. As is the case today, and as was confirmed in the recent judgment in the case of [Welsh Ministers v PJ \(2018\)](#)^[5], the conditions of a CTO must not amount to a deprivation of liberty.

It is also important that conditions made are set out clearly to the patient, to ensure they understand:

- which conditions constitute advice (for example about lifestyle choices)
- which conditions are required in order for the CTO to be made (for example, about supported living arrangements, or engagement with medicines or other treatment)
- which conditions are statutory grounds for recall to hospital (currently, failure to be available for examination so that the CTO can be reviewed, or for examination so that treatment that requires certification to continue can be so certified. Our proposals to update the recall procedure are described below).

The Responsible Clinician should regularly review the conditions as the person progresses towards full discharge from the Act. This expectation will be set out in the Act's Code of Practice, as will a stronger expectation that clinicians should assure themselves that patients are able to understand the conditions they are required to follow.

The Mental Health Tribunal's consideration of Community Treatment Orders

When considering applications for discharge from a CTO, the Tribunal will need to consider whether or not the patient continues to meet the revised criteria for use, in terms of both therapeutic benefit to the patient and likelihood of harm.

In addition, the Tribunal will have the power to check the Responsible Clinician's justification for the conditions attached to a patient's CTO and recommend that they reconsider any which they believe are overly restrictive. However, the Tribunal will not be able to recommend changes to conditions that would impact on the patient's clinical treatment.

We think this is critical to making certain that CTO conditions are proportionate and are in line with the guiding principles.

Recalling patients on CTOs to hospital

Today, the patient's Responsible Clinician may recall a patient on a CTO if the patient needs to receive treatment for mental disorder in hospital, (including as an out-patient), or there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled.

We want to make the recall process more efficient, transparent and to ensure that this important decision receives appropriate consideration.

We will revise the criteria for recalling service users to reflect our wider changes around detention criteria, so that recall will only be possible when it is needed because there is otherwise a **substantial** risk of significant harm.

We also want to broaden the appropriate locations to which a patient may be recalled, allowing for alternatives in cases where treatment in a hospital is not needed. Currently, the legislation requires the patient to be recalled to a hospital if they need medical treatment in a hospital setting and if the Responsible Clinician finds that they have not complied with the conditions of their CTO. We think that when the patient does not require hospital treatment, the location should not be limited to a hospital and should be at the discretion of the Responsible Clinician.

Automatic trigger points for referral to the Mental Health Tribunal

Currently, there is an automatic referral to the Tribunal to review a patient's CTO at six months after the date the Order is commenced, but then not again until after three years. As we expect CTOs to end after 24 months, this will no-longer be an appropriate safeguard. We will consider bringing forward automatic referrals to the Tribunal for CTOs alongside other increases in automatic referrals.

There is also an automatic referral to the Tribunal when someone's CTO is revoked. In view of other changes to ensure that a patient's case for discharge is more frequently reviewed and scrutinised, we are proposing to remove this. This is discussed in the next chapter.

The future of CTOs

Since their introduction in 2007, CTOs have been used far more extensively than first anticipated, with people of black African and Caribbean descent over ten times more likely to be subject to them than white people. Service user and carer experiences also suggest that CTOs are sometimes overly restrictive and evidence on their clinical benefits is lacking.

This has led to calls to abolish CTOs. We intend to take forward reforms to CTOs and to monitor their effects over an initial five-year period. In the meantime, we hope that the changes set out above will increase the requirement for CTOs to have a therapeutic benefit and for them only to be used where there is otherwise a substantial risk of harm, introduce more clarity around what conditions mean for a person, and increase the scrutiny of the decisions that are made to put someone on a CTO, and keep them on it.

We expect to see a decrease in the use of CTOs and are committed to ensuring that any reduction in the use and duration of CTOs is matched by a reduction in disparities surrounding their application, particularly in relation to tackling the elevated use of CTOs among people of black African and Caribbean descent. Monitoring these racial disparities will form a key part of our assessment of the continued use of CTOs.

We will further review and update Government policy on the use of CTOs in line with the emerging evidence.

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

The Mental Capacity Act (MCA) provides the legal framework for people who need to make decisions for or on behalf of someone else who lacks the relevant capacity to make that particular decision. It sets out that decisions must be made in the person's best interests and which matters should be considered (or not) when making a best interests determination. Where a person over 18 is deprived of their liberty, the MCA's Deprivation of Liberty Safeguards (DoLS) can be used to protect the rights of the person in a care home or hospital.

In certain circumstances, where a person has a mental disorder, lacks the relevant capacity and is not objecting to detention or treatment, a practitioner may need to consider whether that person should be detained under the MHA* or instead made subject to a DoLS. The Review looked closely at the complexities that arise in these situations.

The interface between the MHA and DoLS is fully explained in the MHA's Code of Practice. This part of the Code will be revised to take account of the new Liberty Protection Safeguards (LPS)* which is due to replace DoLS by April 2022. It will first be published as part of the Code of Practice for the MCA and will later also form part of the MHA's Code.

* Explanatory text 6: References to the Mental Health Act

The White Paper generally refers to the Mental Health Act 1983 as "the Act", but this chapter refers instead to "the MHA" for clarity, as the Mental Capacity Act 2005 is also being discussed.

* Explanatory text 7: Overview of Liberty Protection Safeguards (LPS)

The LPS will be a simpler process that involves families more and gives swifter access to assessments, be less burdensome on people, carers, families and Local Authorities, and in hospitals and will allow the NHS, rather than Local Authorities, to make decisions about their patients.

The Review found that within this interface it is not always clear for practitioners whether the MHA or DoLS should be used if a person lacks the relevant capacity and does not appear to be objecting.

The Review argued that this results in uncertainty, where either the MHA or DoLS may be used, with the decision varying and depending not just on how the patient is presenting but also on who the decision is being taken by and where. Opinions differ over which of the two sets of legal safeguards are better for patients, with some arguing that the MHA is too

restrictive and that it is discriminatory to use it when DoLS might apply instead, and others arguing that the DoLS framework around review and challenge are too weak for some people affected by severe mental illness.

Furthermore, the CQC found in its report, Mental Health Act – The rise in the use of the MHA to detain people in England^{[3][4]}, that sometimes administrative difficulties with DoLS, such as needing to wait a long time for an assessor, mean that the MHA is used instead for patients.

The Government therefore accepts the finding of the Review that the MHA is still used in cases where it may be preferable to use DoLS, or in future the LPS.

The Review recommended that the solution to these issues is for a clearer dividing line to be introduced in legislation between the two Acts, based on whether or not a patient is clearly objecting to detention or treatment. The effect would be that all patients without the relevant capacity who do not object will receive care and treatment under the DoLS/LPS and not under the MHA.

The Government agrees with the Review that introducing this clearer dividing line could reduce some inappropriate uses of the MHA and could clarify what can be a 'grey' area for patients, their families and for practitioners. It would also go some way to addressing rising rates of detention under the MHA. The two legal regimes are very different, and the state powers of compulsion contained in the MHA are generally more appropriate for use in cases where it is clear the patient is objecting.

But the Review also made the point that there will be a number of complexities involved with introducing this change, first amongst these is that the DoLS are to be replaced with the new LPS by April 2022.

We anticipate that the new LPS framework will help to address the matter raised by the Review that the MHA is used in cases where DoLS/LPS provides a better alternative. For example, it will mean that, in future, if arrangements for detention are mainly taking place in an NHS hospital, the hospital's Trust will be able to authorise deprivation of liberty under the LPS without any necessary involvement from a Local Authority. This should streamline the process for decision makers in hospitals, as they can make referrals on their internal systems, and differs from DoLS where the Local Authority is the supervisory body in all cases. In addition, when implemented, LPS can apply to young people over 16, as opposed to DoLS only applying to people over 18. LPS are in part intended to help decrease the disproportionate administrative burden of DoLS, and the Government expects this will mean the LPS is more likely to be used when appropriate.

Given that the new LPS framework is yet to come into effect and may serve to address issues raised by the Review, we agree with the Review that it is important to assess the impact of its implementation, before introducing these reforms to the MCA/MHA interface.

In the meantime, we are seeking views on how to implement the Review's recommendation on establishing a clearer interface between the two Acts, and on how to address the complexities that are arising in practice now, so that we can implement legislation and guidance which is clear to interpret and use.

One such complexity is the fact that although assessing whether a patient is objecting is well established in clinical practice, it can still be difficult to identify, or a person's objection or consent can be fleeting, fluctuating or not expressed clearly. It can be particularly difficult to identify in patients with dementia or other cognitive impairments.

The Review proposed using the planned amendments to section 4B of the MCA to help address this concern. Section 4B will give health professionals the power to temporarily deprive a person lacking the relevant capacity of their liberty in order to give life sustaining treatment or carry out a vital act. It can be used either in an emergency case when a referral for LPS is not practical, or where the process to get an authorisation under the LPS or a court authorisation has been started and it is necessary to restrain the person for a certain activity while the process is being completed. The Review's view was that where there is genuine doubt as to whether a person is objecting to their admission, the hospital should be specifically enabled to formally start the process for LPS authorisation whilst they investigated whether there was in fact an objection. In our view, this could only be achieved through by amending the Mental Capacity (Amendment) Act.

Another complexity is that the DoLS and the LPS do not explicitly apply in cases where a person presents a risk to others, but the MHA does. The Review was written at the time the Mental Capacity (Amendment) Act 2019 was a Bill, and stated that its proposed interface would only work if the LPS could authorise deprivation of liberty on the basis of harm to others. However, amendments were made to the Bill to limit it, to some extent, to cases of harm to the person. We are therefore seeking views on what should happen in cases where a patient lacks the relevant capacity, needs to be detained mainly on the basis of risk to others, but does not object to admission or treatment.

To summarise the complexities and considerations that need to be made, it is best to return to the [Review's final report](#) ^[6]. This stated that the complexities involved in changing the dividing line between the MCA and the MHA mean that "The Government will need to consider the practical implications..., including testing guidance for the Code of Practice". The Review also stated that the new LPS arrangements will need "time to bed down" before such a change is introduced. The Government agrees on both these counts. We will therefore begin this process through consultation to ascertain views on the best way to proceed. This will need to be considered within primary legislation and alongside the implementation of LPS.

Above all, we are committed to reviewing the powers and safeguards available to make sure that, in future the interface is clear and that people who need to be detained and

therefore protected by safeguards, receive care under the legal provisions that best help to support them and serve their needs, whether this needs to be the LPS or the MHA.

Consultation question 17: How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances?

Prior consent to be admitted as an informal patient

The Review recommended that the Government should consult on whether the MHA should give individuals the right to consent in advance to admission to hospital for treatment for a mental illness. This would mean that, if an individual had given prior consent and they later become unwell and lose the relevant capacity, then they would be admitted as informal or voluntary patients, as opposed to being detained under the MHA or subject to the DoLS/LPS.

The principle that people should be able to make decisions which will endure in the event of future incapacity, including advance consent, is already recognised in law. However, we are aware that advance consent is often applied outside of mental health hospitals, and more commonly in relation to palliative care and end-of-life settings.

Establishing a provision in the MHA to enable people to consent in advance to informal admission would provide clarity in statute that this principle also applies in a mental health setting, making this right more accessible to people at risk of detention under the MHA.

The Review did, however, identify some concerns relating to this proposal. Most significantly, by giving prior consent to admission as an informal patient, the individual does not have access to the safeguards otherwise available to them if they were detained under the MHA or subject to DoLS/LPS. Another problem identified was that an individual consenting in advance may not be fully aware of the conditions, settings, care and treatment they might experience on admission and therefore the gravity of what they are agreeing to. The Review also felt there was a risk that, once admitted informally, the individual might not feel able to object to their being in hospital, perhaps due to coercion or because they are too unwell. This would mean they would remain informal when they should instead be transferred to a formal detention under the MHA.

To mitigate these issues, the Review suggested providing a 'get out' clause to prevent a person being held to their earlier advance consent, where it is unreasonable to do so. This follows the model originally proposed by [the Law Commission in its Mental Capacity and Deprivation of Liberty report](#)^[7] This clause could apply if a person withdraws their consent when they have the relevant capacity to do so, or if there are reasonable grounds to

believe that a person's advance consent was not appropriately informed, or if their actions are not compatible with their decision at the time of consent.

We think that the 'get out' clause proposed by the Review is already the case in the common law, but we accept that there may be advantages in amending the MHA and Code of Practice to confirm this position and by using the Code to help mitigate the risk of individuals unknowingly agreeing to conditions or settings that they would otherwise be unhappy with and prevent people being confined as a voluntary patient for longer than they would wish to be. This could be achieved by setting out in the Code the existing position that individuals must clearly articulate the particular arrangements to which they are consenting to in advance, including a time period over which their consent is valid.

As recommended by the Review, we wish to seek views about the use of advance consent to informal admission to mental health hospitals.

Consultation question 18: Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the MHA and the MHA Code of Practice to make clear the availability of this right to individuals?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 18a: Give reasons for your answer.

If agree:

Consultation question 18b: Are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Accident and Emergency (A&E)

We want to improve the powers available to health professionals in accident and emergency departments so that individuals in need of urgent mental health care, stay on site, pending a clinical assessment. Too often, the police must be relied upon to hold individuals who are in crisis and are attempting to leave A&E. Potentially leading to further distress to the individual.

This issue is partly to be addressed by the changes to section 4B of the MCA, which are due to come into force in 2022. These will have the effect of enabling health professionals in A&E to take steps to deprive a person of their liberty if it is necessary to provide life-

sustaining treatment or to prevent a serious deterioration in their condition. However, in these circumstances, section 4B would cease to apply if a referral is made for a MHA assessment. Furthermore, the holding power can only be used if the person lacks the relevant capacity and is over 16 and, in non-urgent cases, if a referral has been made to the LPS. This means that section 4b will rarely apply in the circumstances where it is necessary to hold an individual in A&E and police powers under the MHA are currently used.

Given the limitations of section 4B for the purposes of those attending A&E on the basis of mental ill health, we wish to consider extending section 5 of the MHA. This provides powers to hold a person temporarily, while their mental health is assessed, but it cannot currently be applied unless a person is already admitted as an inpatient.

While extension of section 5 was ruled out by the Review as it was considered overly restrictive, the Government believes that extending the existing holding powers in section 5 of the MHA could provide hospitals with a greater ability to ensure the appropriate safeguards are in place in a greater set of circumstances. Chiefly, extending section 5 would provide hospitals with the power to hold a person with the relevant capacity, who wants to leave A&E. It is also more obviously applicable in respect of those who may pose a risk to others and it includes a limit of 72 hours on the time that a person can be deprived of their liberty. The same time limit was proposed by the Review in relation to section 4B, but this amendment was not made to the MCA. Therefore, the time over which an individual can be temporarily held under section 4B will not be defined in statute. Instead, the powers could be used so long as it is necessary to give life sustaining treatment or carry out a vital act and, except in emergency cases, while the referral under the LPS or to the court has not been determined.

Finally, we believe that extending the use of section 5 may be more effective in addressing the issues described as it is simply more well established and widely understood by health professionals within hospitals. However, we propose that, should section 5 be extended, that the powers should only be available to senior clinicians to ensure that they are only used when it is absolutely appropriate.

We wish to consult on whether the planned amendments to section 4B are sufficient in providing the necessary safeguards for people who are attending A&E and who may be admitted on the basis of their mental health. Or, whether section 5 of the MHA should be extended to increase the scope of who could be temporarily detained, pending a clinical assessment.

Consultation question 19: We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the MHA?

- a) Rely on section 4B of the Mental Capacity Act only
- b) Extend section 5 of the Mental Health Act so that it also applies A&E, accepting that section 4B is still available and can be used where appropriate.

Consultation question 19b: Please give reasons for your answer

8. Caring for patients in the Criminal Justice System

Some people in contact with the criminal justice system may need to be admitted to hospital for treatment of a mental illness. This could be at the point they enter the criminal justice system, or later on should they become unwell in custody.

Part III of the Act sets out the framework for the care of these patients, including provisions to divert a person to hospital from court, prison or immigration detention in order for that person to access the inpatient care and treatment they require. It also includes provisions for offenders who present the highest risk, and so are subject to further restrictions over their care.

We want to ensure Part III of the Act supports patients to access the right care, at the right time, whilst adequately fulfilling our duty to protect the public.

Part III of the Act is guided by the principle that those who have committed a criminal offence should be able to access equivalent medical care and treatment to civil patients. That means that Part III patients will benefit equally from the majority of proposed reforms to the Act.

There are, however, some areas where reforms will differ, due to the nature of the different provisions under Part III, the need to protect the public from those who have been convicted of serious offences and the need to ensure care and treatment is appropriate for the person it serves. These distinctions are set out within respective chapters elsewhere, but in summary, include:

- Criteria for detention under the Act - where we do not propose to apply the reformed criteria to Part III patients, to ensure changing the threshold does not make it harder for those subject to the criminal justice system to access the care and treatment they need
- A Nominated Person for a Part III patient will have limited powers as discussed in
- Tribunal powers, and automatic referrals to the Tribunal - will differ
- Changes proposed to the detention criteria for individuals with a learning disability and autistic people will not apply to Part III patients

In Wales, criminal justice matters are reserved to the UK Parliament meaning, unlike health matters, they remain the responsibility of the UK Government. As such, the proposed changes set out in this chapter have the potential to apply across England and Wales, however, a different approach may still be appropriate between England and Wales. Since the justice system interfaces with different health arrangements in the two nations, we have been working with Welsh partners as appropriate to ensure that if

reforms are to apply across both nations that the impacts are understood and there is agreement from all partners.

Court Powers – aligning Magistrate and Crown Courts

The Act provides courts with powers to divert a person accused, or convicted, of criminal offences and in mental health crisis away from the criminal justice system and into hospital for the assessment and/or treatment they require. Because the powers available under the Act are different for the Crown Court and the magistrates' court, suspects and defendants are not always getting the mental health care they need at the earliest possible opportunity.

Currently, the powers of the magistrates' courts are limited compared to the Crown Court. The Crown Court, for instance, can remand a person to hospital for treatment under section 36 of the Act but magistrates' courts cannot. This is because magistrates' courts deal with less serious offences and lay magistrates have historically had less power to make decisions that extend beyond considering the facts of the case. Nevertheless, a defendant in a magistrates' court may well have the same nature or degree of mental illness as one in the Crown Court, and therefore the same need for treatment.

We want the Act to support suspects and defendants in accessing the mental health care they need at the earliest possible opportunity. We will consider the changes proposed by the Review alongside wider reforms suggested by the Law Commission in their 'Unfitness to Plead' report. This recommended greater alignment between the Crown Court and magistrates' courts in managing defendants who lack capacity to participate effectively in a criminal trial, as well as wider adjustments to court procedures where mental health and other needs are at play.

Secure Transfers

Whilst some people will be in mental health crisis at the point at which they come into contact with the criminal justice system (i.e., are charged with or convicted of offences); others may experience a relapse in a pre-existing condition or become unwell for the first time during their period in custody.

We are determined to improve the system to ensure that those individuals who meet the criteria for detention under the Act are not being held in prisons or Immigration and Removal Centres inappropriately. Through ongoing work by health and justice partners and the changes set out below, we will ensure that this does not continue and that any prisoner who requires care and treatment under the Act is swiftly transferred to an inpatient setting.

This chapter next discusses the position in England. Partners in Wales will also be giving consideration to the proposals as they would affect devolved responsibilities for health and (potentially) local Government.

Statutory Time Limit

We recognise that, when people serving a custodial sentence need to be transferred to a mental health inpatient service under the Act, too many experience delays in the referral, assessment and transfer processes. There can be similar delays in the pathway for when individuals are transferred back to prison from hospital, which equally need to be addressed.

To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we will introduce a 28 day time limit, split into two sequential, statutory time limits of 14 days each: first from the point of initial referral to the first psychiatric assessment, and then from the first psychiatric assessment until the transfer takes place. This decision follows significant public consultation run by NHSEI. NHSEI will be issuing the final version of its guidance on transfers and remissions shortly, reflecting the beginning of the introduction of this change.

We need to be cautious in ensuring that a statutory timeframe does not prevent us from considering the most appropriate placement and treatment that can be provided for individuals. Stakeholders, including the Royal College of Psychiatrists, have argued that enshrining the time limit in statute could result in unintended consequences if not carefully managed. For example, clinicians may avoid recommending hospitalisation if they, or their employing authority, are likely to be penalised for not meeting the deadline. As each case is different and complex, there may also be occasions when a longer assessment period is required.

In view of these concerns, although we propose to amend the Act to introduce a statutory time limit, we will not commence this provision until the new NHSEI guidance is properly embedded. We will also develop a stronger monitoring system to enable us to better understand and provide greater transparency on how the transfer process is working.

Consultation question 20: To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28 day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?

Yes/No/Not sure

Consultation question 20a: Please explain your answer

Independent Role to Manage Patient Transfer

It will remain for the Secretary of State for Justice formally to approve the transfer of a prisoner to the secure hospital system. However, we will establish a new designated role for a person independent of the health or criminal justice systems for the purpose of managing the process of transferring people from prison to hospital when they require inpatient treatment for their mental health. This role would help to ensure that institutional barriers are overcome, and the patient's needs are put first. It would largely mirror the Approved Mental Health Professional (AMHP) role in civil settings, being involved right at the start of the process, from the point of initial referral for assessment, through to liaising with the range of organisations which may need to support someone's return to prison/IRC. This should ensure that those transferred from a mental health setting back to prison/IRC have appropriate aftercare or social care arrangements in place on their return to prison.

We are consulting on views as to where a new prison/IRC transfers and remissions co-ordinator role might best sit and what their remit should be.

One potential option is to expand the remit of AMHPs. As set out above, there are clear parallels between the responsibilities and the requirement for independence of the proposed new role and those of an AMHP. We are, however, mindful of the range of responsibilities AMHPs already have, and the recruitment challenges faced by the workforce. We are also concerned that AMHPs may not have the internal system knowledge and/or levers to meaningfully navigate and influence existing providers, NHSEI Health and Justice and Her Majesty's Prison and Probation Service (HMPPS), which are responsible for managing secure transfers.

Another option is to create an entirely new role that would sit within NHSEI or across NHSEI and HMPPS. We think that there are benefits to placing the responsibility within organisations that already play a key role in the secure transfers process, and which have the levers to overcome delays in the process. We are aware that this would mean the new role is not entirely independent, but we think that someone does not necessarily need to be employed by a separate organisation to be able to take an independent (i.e. patient-centric) perspective. It would, however, be important that the new role should sit in a separate team to that responsible for commissioning or providing beds and that their prime responsibility is to the needs of the patient.

We want to hear your views on which of these options we should pursue in order to help speed up the transfer process, or if you have any alternative ideas on how this recommendation might be addressed.

Consultation question 21: We want to establish a new designated role for a person to manage the process of transferring people from prison or an Immigration Removal Centre to hospital when they require inpatient treatment for their mental health. Which of the following options do you think is the most effective approach to achieving this?

- Expanding the existing Approved Mental Health Professional (AMHP) role in the community so that they are also responsible for managing prison/ IRC transfers
- Creating a new role within NHSEI or across NHSEI and HMPPS to manage the prison/IRC transfer process
- An alternative approach (please specify)

Consultation question 21a: Please give reasons for your answer

We acknowledge that all of the above changes are dependent on collaborative efforts between the MOJ, HMPPS, Home Office, DHSC and NHSEI and NHS Wales; we commit to continuing to work closely together to take forward these important areas of work.

Advocacy support for patients waiting to transfer from prison or immigration removal centres

The Review also recommends extending the statutory right to an IMHA to patients awaiting transfer from a prison or an immigration detention centre. We feel that there is close overlap with this proposal and recommendations around the creation of a new statutory, independent role to manage transfers from prisons and immigration removal centres, which would aim to ensure that the least restrictive option for immigration detainees was considered. We are considering the role of the IMHA and how best to provide advocacy support for individuals awaiting transfer alongside the creation of this new independent role.

Prison as a Place of Safety

In some cases, courts are forced to divert defendants who require care and treatment in an inpatient setting, some of whom may not yet be convicted, to prison as there is no hospital bed available.

We will work with sentencers, health service commissioners and clinicians to ensure that there is a clear, timely pathway in which sentencers have confidence to transfer people

directly from court to a healthcare setting where a mental health assessment and treatment can be provided, under the relevant section of the Act.

We are conscious that removing the legal provisions that set out when prison can constitute a place of safety in certain contexts, without ensuring that viable alternatives are properly established and commissioned, may leave sentencers without an alternative in some circumstances. We therefore believe that it is important to prepare for any legislative change with the relevant adaptations on the ground, supported by the necessary new investment. We will consider introducing guidance for the courts and will ensure that the necessary adaptations and investment are in place before legislative changes are commenced as a final step to delivering this objective.

Restricted Patients

Restricted patients are mentally disordered offenders who are detained under Part III of the Act in hospital for treatment and who are subject to special controls by the Secretary of State for Justice. The overall aim of the restricted patient system is to protect the public from harm from offenders who have generally committed serious and very violent offences, while at the same time recognising patients' rights to treatment for their illnesses.

There are three types of restricted patient:

- Those who are **diverted** from prison to hospital for treatment at the point of sentencing via a hospital order (section 37), but the sentencing judge deems a section 41 restriction order necessary to protect the public from 'serious harm'. This group represents almost 80% of all restricted patients*;
- Prisoners who are **transferred** by the Secretary of State to detention in hospital for treatment but who normally continue to be managed as prisoners in terms of their release. We set out above the plans for improving the process of transfer. Prisoners serving a sentence are transferred under section 47/49, around 15% of all restricted patients. Prisoners on remand or immigration detainees are transferred under section 48/49, around 5% of all restricted patients.
- Those on a **hybrid order (section 45A)** where the court has imposed a sentence of imprisonment but at the same time directed that they be detained in hospital (who are treated for practical purposes as transferred prisoners). This represents around 1% of all restricted patients.

* Explanatory text 8: Restricted patient population figures

[Restricted patient population figures as of the end of 2019](#)^[8]; 5314 patients under S37/41, 1088 patients under S47/49, 307 patients under S48/49, 90 patients under S45A (other admission reasons include 'unfit to plead' and 'not guilty by reason of insanity')

Management of restricted patients

For restricted patients detained in hospital, the responsible clinician must seek the consent of the Justice Secretary to allow the patient leave, to transfer the patient to another hospital or to discharge the patient. In practice, these decisions are made under approved delegated authority by officials in the Mental Health Casework Section (MHCS) in HMPPS.

The MHCS has eradicated a backlog which had arisen prior to the Review and has since taken further significant steps to reduce the length of time it takes to consider applications for consent from responsible clinicians. In July 2019 MHCS published, for the first time, [targets for timeliness of decisions](#)^[9]. Nine out of thirteen targets were met over the first year of the targets being in place.

Other changes introduced mean responsible clinicians no longer need to submit individual applications where a patient needs to leave hospital for medical treatment elsewhere. This has reduced applications by around 800 per year (against a total of around 10,000 applications of all types).

During the second quarter of 2020/21 decisions on transfer applications took an average of 14 days compared to an average of 52 days in 2017/18 and applications for escorted leave took an average of 10 days during Q2 of 2020/21, compared to 125 days at the peak of the backlog in January 2018.

We are also proposing that the Tribunal is empowered to make a statutory recommendation in relation to community leave or transfer to a different hospital, which the Justice Secretary must consider when taking such decisions.

Conditionally discharged patients

Restricted patients subject to a section 37 hospital order with a section 41 restriction who no longer meet the statutory test for detention in hospital must be discharged. This could either be an absolute discharge, with no conditions and no further powers over the patient or, if deemed appropriate by the Tribunal or the Justice Secretary, a conditional discharge. A conditional discharge allows patients to move into the community while adhering to certain conditions and enables them to be recalled to hospital if necessary, to protect the

public from harm. There were 2,821 conditionally discharged patients in the community in 2019.

Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. This has traditionally been a local authority social worker (although other professionals can also take on this role). Social supervision is an important role, balancing public protection with the care and support of conditionally discharged patients. Social supervisors work closely with the Mental Health Casework Section and can request recall of patients to hospital. Despite this important function, there is currently some confusion about where this role should sit and a lack of national guidance about how it should operate, leading to local divergence in practice and standards.

We wish to strengthen and develop the role of social supervisor and are consulting with stakeholders across the sector on how best to achieve this. For example, this could include specifying the professionals that can undertake the role, and the approval, training and qualifications required.

Consultation question 22: Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of Social Supervisor could be strengthened?

Release of transferred prisoners by the Parole Board

For transferred prisoners who are eligible for parole, which includes those serving life imprisonment or another indeterminate sentence*, and some determinate sentence and recalled cases, currently the relevant Tribunal and then the Parole Board are separately required to consider decisions on discharge and release respectively. We recognise that the average length of time between the Tribunal hearing and the Parole Board decision is too long.

To address this, HMPPS has been working with the Parole Board and the Tribunals to streamline processes so that a Parole Board hearing can take place swiftly after a Tribunal hearing for eligible transferred prisoners. A working group has been considering the procedural and operational changes that will be required in order to commence a pilot to test options to substantially reduce the time taken to convene a Parole Board hearing after a Tribunal decision in cases of transferred prisoners. Timelines for the pilot were delayed as a result of COVID-19. Work is currently underway to ensure that the pilot will commence as soon as is practicable.

* Explanatory text 9: Definition of indeterminate prison sentences

An indeterminate prison sentence does not have a fixed length of time. There are a number of types of indeterminate sentence, including Life and Imprisonment for Public Protection (IPP). The Parole Board are responsible for deciding whether a prisoner on an indeterminate sentence can be released from prison.

Giving the Tribunal the power to discharge someone with conditions which restrict freedom in the community

As with all patients detained under the Act, restricted patients should be supported to progress through their pathway of care, while taking care to safely manage the potential risk they pose.

This risk, including potentially violent, dangerous, or inappropriate sexual behaviour, would require continuous supervision to be managed safely in the community.

There is currently no effective legislative mechanism by which this small number of patients could be discharged from hospital by either the Justice Secretary or the Tribunal with the necessary care and supervision needed to protect the public from this risk*. As found by [the Supreme Court Judgment in the case of MM](#)^[10], where such measures amount to a deprivation of liberty they must properly and lawfully be imposed.

We want the reformed Act to support these few patients, who have very distinct needs and risks, to progress through their pathway of care, and to be supported so that their risk is managed in the most appropriate and least restrictive way – including in the community where it is appropriate.

* Explanatory text 10: Impact of Supreme Court judgement in MM

Following the Supreme Court judgment in MM, an interim operational policy was implemented to allow a number of patients, who would otherwise have had to immediately return to hospital, to remain in a community setting on long-term section 17 leave. This provides a temporary operational solution while legislative change is considered.

See MHCS Guidance (Jan 2019) Discharge with conditions that amount to a deprivation of liberty [here](#)^[11].

We are proposing the introduction of a new power of ‘supervised discharge’ which would enable discharge a restricted patient with conditions amounting to a deprivation of that person’s liberty, in order to adequately and appropriately manage the risk they pose. We

propose that this type of order would be subject to annual review by the Tribunal in line with the Court of Protection decisions on similar cases. The use of this new discharge power would be closely monitored to ensure that conditions amounting to deprivation of liberty were only applied when necessary and proportionate. This supervised discharge would be applicable only to restricted patients, and available irrespective of decision-making capacity. It would be **applicable only where such a patient:**

- Is no longer therapeutically benefitting from hospital detention under the Act; but
- Continues to pose a level of risk which would require a degree of supervision and control amounting to a deprivation of their liberty; and so, could not be managed via a conditional discharge. Therefore;
- This would be the only least restrictive alternative to hospital.

We are continuing to consider the appropriate threshold in relation to risk and how this power would be operated. We will consider suitable oversight of these patients in the community alongside proposals to strengthen the role of the social supervisor, as outlined above.

Consultation question 23: For restricted patients who are no longer therapeutically benefitting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty.

Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 23a: Please give reasons for your answer.

If agree:

Consultation question 24: We propose that a ‘supervised discharge’ order for this group of patients would be subject to annual Tribunal review. Do you agree or disagree with the proposed safeguard?

Strongly agree/ Agree/ Disagree/ Strongly disagree/ Not sure

Consultation question 25: Beyond this, what further safeguards do you think are required?

Victims of unrestricted patients

We are aware that there is currently inconsistent provision of information to victims of those offenders who become subject to the Act without a restriction order (unrestricted patients) whom courts do not consider to represent a serious risk of harm to the public (and so need not be subject to a restriction order). This disparity is evident both in the level of information and the way in which the information is provided.

The Government's Victims' Strategy committed to reviewing and improving the processes by which victims of mentally disordered offenders (MDOs) are given information. We are working to address concerns that victims of unrestricted patients do not always receive timely, accurate information about key developments in the offender's case. We recognise that although the Act's Code of Practice sets out existing responsibilities, the current structure has proved difficult for victims to navigate.

To date, a working group led by the Ministry of Justice's Victim Policy Team and consisting of the HMPPS Victims Team, MHCS, DHSC, Royal College of Psychiatrists and NHSEI has:

- Agreed that Victim Liaison Officers (VLOs) from the National Probation Service will be assigned to victims of unrestricted patients, as soon as resources allow. This has been reflected in the revised Code of Practice for Victims' of Crime.
- Explored how we can ensure that health professionals responsible for providing information to victims of MDOs, including via VLOs, understand the need to provide appropriate, accurate and timely information to all victims of MDOs and carry out their role mindful of NHSEI's and DHSC's commitment to supporting the revised Code; We have identified that potentially, responsibility for updating victims and VLOs could sit with providers' Mental Health Legislation teams.
- Agreed with the Care Quality Commission (CQC) that it will include, in its inspection and monitoring methodology, consideration of health provider services' compliance with principles in the revised Victims' Code and guidance in relation to duties to victims and VLOs.
- Undertaken significant engagement with key stakeholders on whether it would be appropriate to give victims of MDOs in England and Wales the right to submit a Victim Personal Statement (VPS) to the Mental Health jurisdiction of the First-tier Tribunal in a way which is consistent with the statutory test which the Tribunal has to apply when considering whether to discharge a detained patient. We are continuing to explore options that would enable policy change to allow victims to submit and read a victim personal statement (VPS) to the First Tier Tribunal (Mental Health). It would not mean that the Tribunal has to take account of the VPS when applying the statutory test, having regard to the clinical evidence before

it. However, it would allow victims to explain to the Tribunal what the impact of the patient's offending was and continues to be and would thereby assist the Tribunal in understanding why victims have requested certain conditions to be attached to the patient's discharge.

- Recommended a change to the Domestic Violence, Crime and Victims Act 2004 (DVCV) so that victims of both restricted and unrestricted patients can make representations requesting conditions, be this an exclusion zone and/or no contact, when the Responsible Clinician requests community leave.
- Recommended a change to the DVCV Act so that victims of both restricted or unrestricted patients are informed when community leave is granted and of the victim related conditions that are put in place.
- Recommended a change to the DVCV Act so that information is provided to victims of unrestricted patients in the same way as restricted patients, changing the relevant clauses so that information comes via the National Probation Service VLO rather than the hospital, and removing the provision that victims of unrestricted patients are informed of the name and address of the hospital.

Within Wales, consideration must also be given to how the provision of information to victims of crimes committed by unrestricted patients is working and to what extent the guidance given in the Code of Practice to the Mental Health Act (for Wales) 2016 that provider organisations have a person nominated to promote the rights of victims, is consistently applied in practice.

9. People with a learning disability and autistic people

We are committed to reducing the reliance on specialist inpatient services for people with a learning disability and autistic people and to developing community alternatives. We want everyone to have the opportunity to live a full and rewarding life in their communities. Providing appropriate support in the community can ensure that people with a learning disability and autistic people are not living in an inappropriate institutional setting.

In *Building the Right Support*, published in 2015, NHS England, the Local Government Association and the Association of Directors of Adult Social Services (ADASS) set out the national plan for developing community alternatives to hospitals. *Building the Right Support* set out the aim of a reduction of between 35% and 50% of inpatient provision with alternative care provided in the community.

The NHS Long Term Plan, published in January 2019, committed to reduce the number of people with a learning disability and autistic people who are inpatients in mental health hospitals by 50% by 2023/24 compared to March 2015. This would be achieved through investment in specialist community provision including intensive, crisis and forensic community support and seven day a week specialist multi-disciplinary services and crisis care in every area.

Building the Right Support anticipates that some people with a learning disability and some autistic people may, at times, be admitted to mental health inpatient services. Where this is the case, the inpatient admission should be high quality, the least restrictive and for the shortest time possible. The inpatient setting should also be close to home to ensure a connection can be maintained with family and friends.

Yet, over a number of years we have seen high profile cases of quality failings where a common theme was that detained in-patients with a learning disability and autistic people were not receiving sufficiently therapeutic or reasonably adjusted care. This was reported in the case of Bethany and in individual cases reported in the CQC's interim report of its thematic review of restraint, seclusion and segregation (May 2019) and in its final report (22 October 2020); and in evidence to the Joint Committee on Human Rights enquiry (November 2019 and June 2020). The exposure of abuse at Whorlton Hall in May 2019 and at Cygnet Yew Trees this summer is confirmation that some detentions cannot be justified.

These cases provide evidence that for some people with a learning disability and autistic people, the use of the Mental Health Act to detain someone for assessment and/or treatment, however justifiable or beneficial initially, can lead to perpetuated detention. While this could be true of other people detained under the Mental Health Act, sensory needs of autistic people and people with a learning disability and reduced ability to self-advocate may exacerbate these risks.

Co-occurrence of mental health conditions

The Act's Code of Practice (paragraph 20.20) is clear that whilst it is possible for someone on the autistic spectrum to meet the criteria in the Act for detention without having any other form of mental disorder, this is expected to be very rare and that hospital treatment is very rarely likely to be helpful for an autistic person.

We know that the inpatient setting can be particularly challenging for autistic people as it can often fail to meet their sensory and communication needs. This can lead to a deterioration in their condition. As the CQC thematic review states, sensory overload can result in severe distress which can be displayed as challenging behaviour. Autistic people may find it difficult to cope with a new and unpredictable environment and unfamiliar sensory stimuli.

Yet, we know that the number of autistic people without a learning disability who are detained as inpatients under the Mental Health Act is increasing. The [Assuring Transformation dataset](#)^[12] shows that since March 2015, the number of people with a learning disability who are not autistic has declined by around 40% (Sept 2020). However, between March 17 and September 2020, the number of autistic people without a learning disability who are mental health inpatients has increased by 4%.

We know more now about the link between mental health and autism, than we did when the national Autism Strategy, Think Autism, was published in 2014. We know 7 in 10 autistic children have a mental health condition, with 4 in 10 autistic children having more than one associated condition. Almost 8 in 10 autistic adults experience mental health problems, which is much higher than the incidence of mental health problems in the general population.

It may be that people admitted for mental health problems are being increasingly identified as also being autistic through better diagnosis before or during admissions. However, it is a growing concern that admissions of autistic people are increasing contrary to the Act's Code of Practice and current policy.

The Act itself contains a specific qualification for people with learning disability. The Code of Practice (paragraph 20.7) states that "a person with a learning disability can only be considered to have a mental disorder for the purpose specified in section 1(2B) of the Act, without another concomitant mental disorder, where the learning disability is associated with one or both of the following further features: abnormally aggressive behaviour, or; seriously irresponsible conduct." Both abnormally aggressive behaviour and seriously irresponsible conduct are described in the Code. This qualification recognises that detention under the Act where detention is not associated with a co-occurring mental health condition should only occur in specific circumstances.

Detention under the Mental Health Act

We acknowledge the considerable concern about admission of people with a learning disability and autistic people to mental health hospitals under the Act, where such an admission could become protracted or may not result in someone receiving an appropriate therapeutic intervention.

We want to limit the scope to detain people with a learning disability or autistic people under the Act. Both learning disability and autism are lifelong conditions, which cannot be removed through treatment. However, we recognise that some people with a learning disability and autistic people may require treatment for a mental illness and we want to ensure that people receive high quality and safe care that is the most appropriate for them.

We propose to revise the Mental Health Act to be clearer that for the purposes of the Act we do not consider autism or a learning disability to be mental disorders warranting compulsory treatment under section 3. The proposed revisions would allow for the detention of people with learning disability and autistic people for assessment, under section 2, of the Mental Health Act, when their behaviour is so distressed that there is a substantial risk of significant harm to self or others (as for all detentions) and a probable mental health cause to that behaviour that warrants assessment in hospital. The intention is that this additional behaviour 'qualification' would strengthen and expand the current qualification for learning disability to include an assessment of what is driving abnormally aggressive behaviour or seriously irresponsible conduct.

The assessment process under section 2 should seek to identify the driver of this behaviour, and whether a mental health condition, physical condition or response to environmental or life change, is the driver of this behaviour. If it is identified that a mental health condition is the driver, there may be continued justification for detention under the MHA, and the patient might in such cases follow a treatment pathway under section 3 for the mental health condition. Where the driver of this behaviour is not considered to be a mental health condition, for example due to an unmet support need, unmet social or emotional need, or an unmet physical health need (including untreated pain), grounds for a detention under the MHA would no longer be justified and the detention should cease.

Such a detention for assessment on the basis of distressed behaviour should only be considered after all alternatives to de-escalate have been considered and the assessment should be reasonably adjusted to accommodate the sensory and specific needs of people with a learning disability and autistic people. We would expect that a community Care, (Education) and Treatment Review (CETR) is carried out in advance of a detention and that evidence from such a CETR is considered as part of any decision to admit. We envisage that the process of admission for assessment of people with a learning disability and autistic people should be very different in future reflecting its use only when other

options have been tested and with a presumption that detention should be avoided wherever possible.

We intend to introduce these changes only for civil patients. We want to ensure that accused people and offenders whom the courts or the Secretary of State might currently divert to an inpatient setting are not forced into the Criminal Justice System, which is not able, or indeed intended, to cater for their needs.

Consultation Question 26: Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people:

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation Question 26a: Please give reasons for your answer

Consultation Question 27: Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation Question 27a: Please give reasons for your answer

Consultation Question 28: Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act Applies to people with a learning disability and autistic people?

Yes/No/Not sure

Consultation Question 28a: Please give reasons for your answer

Consultation Question 29: We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation Question 29a: Please give reasons for your answer

Consultation Question 30: 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 autistic people?

Putting Care, (Education) and Treatment Reviews (CETRs) on a statutory footing

Where someone with learning disability or an autistic person is detained for treatment under the Act, due to co-occurring mental health condition, we want to ensure that progressing a patient towards discharge is a priority from day 1 of detention. The introduction of Statutory Care and Treatment Plans will ensure that this is the case.

For people with a learning disability and autistic people, we propose that there is a statutory requirement for the Responsible Clinician (RC) to consider the findings and recommendations made as part of Care, (Education) and Treatment Reviews (C(E)TRs) in the patient's Care and Treatment Plan. Any deviation from the recommendations set out by a C(E)TR should be justified and explained by the RC. C(E)TRs are conducted by a multidisciplinary panel and were introduced as part of NHS England's commitment to transform services for this group. They aim to identify the care needs of a patient and provide recommendations on how barriers to their progress can be overcome. We know that C(E)TRs are effective in reducing hospital admissions when they are undertaken correctly and acted upon. As such, we want to give C(E)TRs statutory force to make sure that they play a more important role in informing the care and treatment of patients.

More information on our proposals on Care and Treatment Plans can be found at Chapter 4 of this White Paper.

Consultation Question 31: Do you agree or disagree that the proposal that recommendations of a Care and Treatment Review (CTR) for a detained adult or of a Care, Education and Treatment Review (CETR) for a detained child should be formally incorporated into a Care and Treatment Plan and Responsible Clinician required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?

Strongly agree/Agree/Disagree/ Strongly disagree/ Not sure

Consultation Question 31a: Please give reasons for your answer

Ensuring an adequate supply of community services for people with a learning disability and autistic people

In our response to the JCHR (22 October 2020), we agreed with the Committee that more needs to be done to ensure that the right services are available in the community for people with a learning disability and for autistic people, both to prevent unnecessary admissions and to speed up discharges.

We committed to consult, through this White Paper, on the creation of new duties on Local Authority and Clinical Commissioning Group (CCG) commissioners to ensure an adequate supply of community services for people with a learning disability and autistic people with the express intention of reducing the use of and need for mental health inpatient services.

Any duty that requires an adequate supply of services to be commissioned for people with a learning disability and autistic people could create new funding requirements if there is not already sufficient supply in place. We will undertake a formal new burdens assessment to establish implications for local Government, informed by the consultation responses.

In the JCHR response, we also committed to consult on creating a related duty on commissioners that would ensure every local area understands and monitors the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population. The aim would be to enable better planning for provision and to avoid unnecessary admissions to inpatient settings. This could involve Local Authorities and NHS commissioners working together to identify and monitor the support needs of individuals by way of a 'risk' or 'support' register, often described as a Dynamic Risk Stratification and Support register, including an 'at risk of admission' component. Such a register would have to comply with data protection obligations. The establishment of such registers is existing NHS England policy and is contained in guidance but is not a legislative requirement on commissioners presently. As such, there is no formal requirement on local Government to participate. By having this duty, in addition to the duty described above, we consider that this would increase the likelihood of effective joint action being taken locally and would require commissioners to focus attention on people with a learning disability and autistic people in their population. We expect this to lead to greater provision of appropriate community based services and a reduced reliance on inpatient care.

Consultation Question 32: 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?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation Question 32a. Please give reasons for your answer.

Consultation Question 33: We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local “at risk” or “support” register. Do you agree or disagree with this?

Strongly agree/ Agree/Disagree/ Strongly disagree/ Not sure

Consultation Question 33a: Please give reasons for your answer.

Pooled budgets

Section 75 of the NHS Act 2006 is the existing mechanism and enabling tool for, amongst other matters, pooling budgets. It enables an NHS body and a local authority to enter into a partnership arrangement for the purposes of jointly exercising the functions of the NHS body or the health-related functions of the local authority if the arrangements lead to an improvement in the way in which those functions are exercised.

In our response to the JCHR we agreed that there may be more that can be done specifically in relation to pooling budgets for services for people with a learning disability and autistic people and are seeking views on this here.

Consultation Question 34: What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?

10. Children and Young People

The improvements to the mental health legislative framework that this White Paper proposes will be available to children and young people. We want to strengthen the rights of children and young people, to ensure they are involved in decisions about their care, that they can challenge these decisions, and, above all, to ensure that they are only detained for treatment in hospital when it is absolutely necessary.

Of course, there are particular considerations and sensitivities involved in caring for children and young people who are suffering from mental health problems so severe that they need to be detained for treatment. Children and young people are often especially vulnerable, and there are also complexities involved with balancing their rights and ability to make decisions, with the rights of their parents or carers, particularly for children aged under 16. The Review made recommendations on these matters, which are discussed in this chapter.

NHS Long Term Plan commitments to improve support for children and young people

Our proposed reforms to the legislation will be supported by major improvements to children and young people's mental health services, delivered under the NHS Long Term Plan.

The NHS will introduce a full crisis care service for children and young people by 2023/24. This will combine crisis assessment, brief response, and intensive home treatment functions, and will be available nationally on a 24/7 basis. Development of this comprehensive offer will build on the establishment of 24/7 crisis lines created at pace during the initial response to COVID-19. These changes will improve the experience of children and young people and reduce pressures on accident and emergency departments, paediatric wards and ambulance services.

By 2023/24, there will be 345,000 more children and young people aged 0-25 accessing mental health services, including through some new school and college mental health support teams. A new approach to young adult mental health services for people aged 18-25 will also be put in place to support the transition to adulthood. In selected areas, the NHS will also develop new services for children who have complex needs that are not currently being met, for example, as a result of trauma or sexual assault.

Improving the Mental Health Act for children and young people

The legislative changes set out in this White Paper will benefit children and young people. The rights we plan to introduce for patients - to have Advance Choice Documents, Care and Treatment Plans, and to choose a Nominated Person - will all be available to children and young people detained under the Act, as will the enhanced rights we will introduce for patients to refuse treatments, to receive faster second opinions on treatment, and to apply to the Tribunal.

In addition, we will ensure Care and Treatment Plans are provided to all children and young people when they are receiving inpatient care, whether or not they are under the Act. To deliver this, we will put on a statutory footing the requirements that already exist for such plans within the national service specification for Tier 4 Child and Adolescent Mental Health Services.

Children and young people will be able to choose their Nominated Person. However, we recognise that there are complexities around introducing this right for children under the age of 16, where they have the necessary intelligence, competence and understanding to choose the person who represents them. In particular, we want to ensure that parents maintain all the usual rights with regards to their child as they would expect in cases where a child decides to choose someone other a person with parental responsibility as the Nominated Person. These issues are discussed more fully in chapter 5 and there is an opportunity to respond to consultation question 14 on this issue.

Children and Young People – autonomy and decision making

The Review's chapter on children and young people made a close examination of matters to do with children and young people and how practitioners should assess the competence, as well as the capacity, of young patients to make decisions about their care and treatment.

In summary, the Review argued that there is a need to reform the current arrangements in legislation and guidance in order to provide clarifications for professionals, for young patients, and for parents and carers. We will maintain existing legislation for these matters and will look to make improvements to the guidance.

The earliest opportunity to do this is the revision of the Mental Capacity Act Code of Practice, which is currently ongoing, to take account of the introduction of the new Liberty Protection Safeguards. Specific recommendations made by the Review about children and young people and decision making are considered below.

Young people aged 16 and 17

The Review recommended that the Mental Health Act and its guidance should make clear that the Mental Capacity Act (MCA) should provide the only test of the capacity of 16 and 17 year olds. Although Chapter 19 of the Mental Health Act's Code of Practice is already clear that the MCA should provide this test, as it does for adults, it allows for practitioners to consider other circumstances, including that a 16 or 17 year old may be unable to make a decision because they may be overwhelmed by his or her surroundings and situation. The Government is considering this recommendation at present as part of its current work to review and update the Mental Capacity Act's Code of Practice.

The Review also recommended that young people aged 16 and 17 who lack capacity should not be admitted on the basis of parental consent, which the Government agrees with, and which has recently been established by [the Supreme Court in the matter of D \(A Child\)](#)^[13].

Children aged under 16

For children aged under 16, in all matters of clinical decision making, practitioners need to assess whether a child has "Gillick competence", which involves considering whether the child has sufficient understanding, maturity and intelligence to enable him or her to fully understand what is proposed, and to make a decision about consent.

The Review took the view that this professional judgement would benefit from a formal test. It recommended that, although the MCA does not apply to children aged under 16, its functional test, as set out in section 3 of the MCA, could be used as a framework to assess capacity to make a decision. This would have the advantage of bringing together the same test for all children and young people and would provide a clearer basis of evidence for decisions made on their capacity.

As the Review noted, the MHA [Code of Practice](#)^[14] already takes the principles contained within the Section 3 MCA test and recommends that practitioners use them. The Government appreciates that there are different opinions about matters to do with children and young people's rights, and for under 16s matters to do with assessing their capacity and competence. These matters are ultimately for the Code of Practice rather than the Act itself and will form a focus for consultation when we come to review the Code.

11. The experiences of people from black, Asian and minority ethnic backgrounds

The degree of inequality

The most profound inequalities exist across mental health services and under the Act for people from ethnic minority communities, and in particular black African-Caribbean people. [NHS Digital's MHA Annual Figures 2019/2020](#)^[15], show that black British people are over four times more likely than white British people to be detained at all and are over ten times more likely to be subject to a Community Treatment Order (CTO). As well as higher rates of detention, Black British people also experience poorer outcomes. During detention, Mental Health Bulletin data* suggests that black patients may be subject to a level of restraint that is three times higher than that of white British people.

There are marked differences between the pathways of people of black African and Caribbean descent and white British people for mental health care. [Analysis by BMC Medicine](#)^[16] shows that black people are more likely to come to the attention of mental health services through contact with the police or the criminal justice system, rather than via a referral from a GP. This points to the existence of inequalities around access to mental health services well before people are detained under the Act. There are also cultural factors to consider, people from black, Asian and minority ethnic backgrounds may engage with services later, because of perceptions held within their communities for example around not recognising mental health problems early, on levels of associated stigma, as well as a distrust of services. [A qualitative study into the perceived barriers to accessing mental health services among black and minority ethnic \(BME\) communities by the British Medical Journal](#)^[17] notes that tackling the disparity in detention rates requires a multi-pronged approach, looking not just at care and treatment under the MHA, but also access to services, and the disparity in outcomes from earlier interactions with the mental health system.

Our intention is that enhanced patient voice, supported by advocacy, coupled with a greater reliance on evidence, increased scrutiny of decisions and improved patient's right to challenge, will begin to address the disparity in outcomes, and in turn detentions. Black people should not be treated less favourably than people from other groups – whether in mental health services, by the NHS or by public services as a whole. This cannot continue, and the Government and the NHS will prioritise tackling these issues. Although many of the changes set out in this White Paper will have a positive impact on people from black, Asian and minority ethnic groups, the scale of disparity that exists means that specific targeted interventions will also be vital.

The Advancing Mental Health Equalities Strategy summarises the core actions that NHS England and NHS Improvement will take to bridge the gaps for communities faring worse

than others in mental health services. It is a call for all mental health services to take concrete steps to fight stigma and inequalities across the sector. The Strategy's aim is to improve access, experience and outcomes for groups with protected characteristics, including age, ethnicity and sexual orientation.

* Explanatory text 11: Explanation of Mental Health Act Bulletin

Note the Mental Health Act Bulletin is an experimental dataset and therefore limitations apply to the interpretation of this data. You can find out more information about the Mental Health Act Bulletin [here](#)^[18].

Patient and Carer Race Equality Framework

The Patient and Carer Race Equality Framework (PCREF) will support NHS mental healthcare providers and Local Authorities to improve access and engagement with the communities they serve. Service user and carer feedback, alongside an organisational competency framework, will enable organisations to understand what steps they need to take to make improvements in access, experience and outcomes for individuals of diverse ethnic backgrounds.

Monitoring data on equality at board level is crucial to facilitate appropriate action. The PCREF will be a practical tool which ensures services fulfil their existing obligations under the Equality Act 2010, in accordance with the Public Sector Equality Duty.

The PCREF will not be a set of nationally imposed competencies and standards; we have tried this in the past and it has not been effective at delivering behavioural change. It is essential that the Framework draws on the experience of BAME patients and carers, as well as the sector, for it to be effective. The PCREF will support organisations to:

- Identify areas for improvement in the experience of patients from ethnic minority backgrounds, especially for people of black African and Caribbean descent - The areas for improvement ('competencies') will apply across all mental health services, including inpatient wards, community mental health services, and IAPT talking therapies.
- Work with communities to identify which competencies should be strengthened, and put in place strategies, interventions and actions to improve them in an iterative manner.
- Provide a recurring feedback loop to the Board, Trustees, stakeholders and the public to keep them informed of progress.

Progress on developing, testing and rolling out the PCREF is gathering momentum, with co-production at the centre of the work. NHSEI has engaged a number of early learning sites, mobilised a steering group, consisting of experts by experience and Trust representatives, to develop the PCREF and examples of emerging positive practice have been collated to support rapid improvements. Engagement with patients, carers, NHS staff and other stakeholders will continue into 2021, to ensure the PCREF supports improvements in care.

Ahead of national roll-out, and in line with the recommendations of the Review, the PCREF will be tested in different mental health services and settings to ensure the final framework delivers the results we should rightly expect.

Culturally appropriate advocacy

A lack of cultural understanding can make already poorer outcomes worse for patients from black, Asian and minority ethnic backgrounds, and potentially reinforce barriers to earlier engagement with services. Advocates are well placed to help patients voice their individual needs and can be crucial to establishing a better foundation for appropriate care and treatment. However, we know that advocacy support can be poor at taking to account the specific needs and experiences of people from Black, Asian and Minority Ethnic groups.

The development of culturally appropriate advocacy for people of all ethnic backgrounds and communities, in particular for people of black African and Caribbean descent, will be a major priority in our plans to deliver higher quality services that respond appropriately to the diverse needs of individuals.

The Government has also already announced funding to pilot culturally appropriate advocacy services. Work to scope the requirements for these services has now completed and will inform the commissioning of pilots, which we hope to begin next year. Subject to successful learning from the pilots, and subject to appropriate funding, we will legislate for culturally competent advocacy to be available to detained patients

Data and research priorities

Data and research are the cornerstones of developments in health.

The [National Institute for Health Research launched an open call in December 2019](#)^[19] to tackle the gap in the current research base as identified by the Review, including: research to identify and explain the issues that lead to mental health problems in a wide range of ethnic minority communities, particularly people of black African-Caribbean descent; pilot and evaluate interventions that improve the outcomes of people from ethnic minority

communities, with a focus on people of black African and Caribbean descent; and develop tailored early interventions for children and young people of black African and Caribbean descent, particularly those at risk of exclusion from school. Up to £4m in total will be allocated to projects judged to be of sufficiently high scientific quality and relevance with projects expected to have started by February 2021.

Changes in the workforce – longer-term impact

The Review found that parts of the current mental health workforce often fail to reflect the population which they serve. This is clear in professions such as clinical psychology and occupational therapy. There is also a significant under-representation of people of black African and Caribbean descent across the mental health professions at more senior level – specifically among decision-making professionals operating the Act, such as psychiatrists, and among service managers.

The Review clearly argues that the mental health workforce needs to be more diverse. The Government is fully supportive of this and there are several programmes in place to improve the diversity of the workforce. The Preparation for Work scheme across the NHS aims to improve the representation of people from black, Asian and minority ethnic backgrounds through employability programmes, supported internships and traditional work experience programmes. The NHS Leadership Academy has also developed a programme, Ready Now, to support leaders from ethnic minorities to rise to senior levels within the NHS.

The NHS People Plan for 2020/21 also places emphasis on a more inclusive NHS where a diverse and representative workforce are supported to thrive.

NHSEI's Advancing Mental Health Equalities Taskforce, in collaboration with Health Education England's (HEE) Equalities subgroup, is working to address the workforce priorities outlined in the NHS Long Term Plan, to develop and implement strategies to enable a more diverse and inclusive mental health workforce that is reflective of the population it serves. This includes workstreams to increase fairness of access to, and inclusion in, mental health training programmes.

HEE is taking action to increase representation and inclusion in mental health professions, starting with clinical psychology. Training in clinical psychology will, from 2021, be commissioned so that courses are held to account on targeted improvements in representation, such as the introduction of contextual recruitment processes and positive action initiatives. These measures aim to remove systemic obstacles to inclusion.

Reduction in the number of CTOs

Around 5,000 CTOs are made each year, considerably more than the number estimated by the Government prior to their introduction. NHS Digital reports that people included within its data category of black or black British people are over ten times more likely to be given a CTO than white British people compared to their representation in the general population. Qualitative evidence gathering suggests that CTOs are often experienced as coercive and restrictive by people who are subject to them, although the Government accepts that they are the 'least restrictive option' for a small number of people.

A key aim of these reforms will be for the number of CTOs to decrease – both by achieving reductions in the future use of CTOs, and by introducing increased scrutiny of CTOs, so that where they are used, they do not last for extensive periods of time.

It is essential that any reduction in their use and duration also entails a reduction in the disparity of their use. We intend to reflect the strengthened criteria for detention under section 3 of the Act in the criteria for making a CTO, so that it will be harder to use a CTO unless the patient is likely to genuinely benefit from the structure they provide.

Policing and Ambulances

Use of police vehicles to convey people in crisis who have been detained under police powers under the Act risks making patients feel that they are being criminalised for their mental health, which is why the Government and the NHS accepts the Review's recommendation to improve ambulance provision for urgent mental health cases.

For people from black, Asian and minority ethnic backgrounds, there have been too many tragic cases in recent years, as recorded in [the 2013 report from the Independent Commission on Mental Health and Policing](#)^[20], which was established to investigate the experiences of black people in particular. The report highlighted several cases in London where people died "when or after the person had travelled in a police van and been highly agitated and distressed during the journey". Progress has been made since then, led by the Association of Ambulance Chief Executives, to ensure that ambulance Trusts now recognise mental health crises as emergencies, and to work more closely with the police to monitor how people are being conveyed to hospital under the Act.

The NHS Long Term Plan outlines the commitment to introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or conveyance by police to accident and emergency. The NHS will also introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls and increase the mental health competency of ambulance staff through an education and training programme.

Decreasing the duration of detention

Reforms to the detention criteria, which will increase emphasis on therapeutic benefit and make clearer what we mean by the risk posed by an individual to warrant detention, will ensure that a person is detained only when it is absolutely necessary. By clarifying and strengthening the criteria used to justify detention, and introducing greater scrutiny of decisions around a patient's continued detention, we hope to achieve a culture in which less restrictive alternatives to detention are preferred and, when an individual is detained, that they progress towards discharge more quickly. We will introduce legislation and wider frameworks to ensure that patients are also able to have greater say over their care and treatment. Where they disagree with decisions, they will be able to more meaningfully make a challenge. We hope that these changes will ensure that a person's dignity is respected, their autonomy is preserved and that the experiences and outcomes of patients detained under the Act are improved.

While these changes will apply to all, we will strive to make sure that these important changes benefit patients of black African and Caribbean descent, whose experiences and outcomes under the Act are persistently poorer than other ethnic groups.

PART 2: Reforming Policy and Practice Around the New Act to Improve Patient Experience

The first part of this White Paper sets out the changes we plan to make to the Act, to ensure the legislation works better for people.

This section describes how the Government and the NHS will work, along with other partners, to bring about an overall culture change within mental health services, so that people have a far better experience of care under the Act. We want everyone's care to be of the highest standard. Great care is therapeutic care. We know that while a person is detained under the Act, for them to recover and be discharged, they need to be in a supportive, therapeutic environment, receive care and treatment from appropriately trained staff, and receive patient centred care that ensures that they are viewed and treated as an individual.

We must also improve the care people receive in the community, to continue to support recovery after detention, or to keep people well and hopefully prevent crisis and detention. We must also continue to build on the progress made in recent years to support people in crisis, as the right care at this critical time can help prevent detention.

These improvements in care and patient experience will be led by staff. We are already taking steps with the NHS to drive up the quality of inpatient care and improve patient experience, to ensure everyone is treated with the dignity and respect they deserve. We know that there are already examples of excellent practice. We need to build on this, and share best practice, to ensure consistent standards across the board.

Transforming mental health services - The NHS Long Term Plan

The NHS Long Term Plan includes ambitions for radical transformation of mental health services, backed by an additional £2.3bn of new investment a year by 2023/24, and with a renewed focus on services for people with severe mental illness. A key ambition of the Long Term Plan is to provide integrated models of mental health care across primary, community and secondary care services and to improve therapeutic services, so that patients have better experiences of inpatient care and better outcomes. It also seeks to reduce lengths of stay in all in adult acute inpatient mental health settings to make sure that everywhere meets the current average of 32 days (or fewer) by 2023/24.

Quality Improvement Programme

In addition to improving mental health services, we will take steps to create the best ward cultures to improve patient experience, to ensure everyone is kept safe and receives the best, therapeutic care. This will require strong clinical leadership and a renewed focus on improving patient choice and empowerment. To do this, a comprehensive implementation support plan will be developed in partnership with NHSEI and HEE. This will include a National Quality Improvement (QI) programme led by NHSEI, which will look specifically at care under the Act to enable and support this system-wide drive for change. The QI programme will support the system to address issues around quality, patient experience, leadership and culture. NHSEI is working with a range of stakeholders to scope the programme, with experts by experience taking a key role in its development and delivery alongside professionals.

The scoping phase will identify the specific reforms to the Act which are most likely to benefit from a QI approach; potential areas of focus may include improved care planning, reducing inequalities, improved partnership working, improved assessment processes, greater levels of safety, and the dignity and respect experienced by service users.

Once developed and tested, subject to future funding, the programme will be rolled out nationally to support all mental health providers and local systems.

Inpatient safety and risk

The safety of patients in mental health services, whether detained under the Act, or informal patients, will always be the paramount concern of health services.

NHSEI launched a new [NHS Patient Safety Strategy in 2019](#)^[21] which sets out how the NHS will improve patient safety incident data collection and learning. This includes work to enhance the local response to patient safety incidents including local investigations. The Strategy will drive improvements to the ways we communicate with the NHS about new and emerging risks to safety and actions to mitigate them. A dedicated Mental Health Safety Improvement Programme (MHSIP) aims to tackle priority mental health safety issues; sexual safety for inpatients; reducing restrictive practice; and reducing suicide and deliberate self-harm.

However, this work should not be at the expense of developing and maintaining truly therapeutic environments that support people to recover. The Review highlighted how decisions focused solely on safety can be at the expense of therapeutic environments and good quality care, and can contribute to cold and unwelcoming environments. This is something that we wish to avoid, and we will work with Arm's Length Bodies (ALBs) and stakeholders to consider how best to ensure that the implementation of new patient safety interventions and programmes have positive contributions to the therapeutic environment.

Sexual Safety

It is essential that patients feel safe in inpatient settings and that steps are taken to provide protection from sexual and physical assault. Findings from the CQC, [the Women's Mental Health Taskforce](#)^[22] and the Review indicate that this has not always been the case. As part of the MHSIP, the Sexual Safety Collaborative was launched in October 2019. It is working to produce a set of standards around sexual safety for mental health and learning disability inpatient pathways, with a strategy to measure and support quality improvement via a national quality improvement collaborative. This will support inpatient mental health teams in mental health Trusts in England to use QI to improve sexual safety on their wards.

Restrictive Practice

The CQC has raised concerns about the use of restrictive practice when caring for people who use mental health or learning disability and autism services; high numbers of people continue to be restrained and are subject to restrictive practice. Research has also demonstrated that people from black, Asian and minority ethnic backgrounds experience excessive use of seclusion and that restraint is used disproportionately both on people from these backgrounds and on women and girls.

Despite guidance supporting positive and proactive care, designed to avoid these practices, large variation in practice across different units, for people with similar needs, was observed and reported in the 2017 State of Care review of mental health and learning disability services. In recent months, the CQC has raised concerns that the reduced availability of staff to keep people safe may have increased restrictive practice in the context of the COVID-19 pandemic.

The initial phase of targeted work to reduce restrictive practice has demonstrated a number of encouraging improvements. The MHSIP will build on this work to refine the interventions ahead of scale-up across England.

Suicide

The NHS Long Term Plans outlines how suicide reduction will remain an NHS priority for the next decade, with particular emphasis on suicide prevention and reducing deliberate self-harm within mental health services.

Approximately a quarter of people who die by suicide are in contact with mental health services at the time of their death. Of people who die by suicide whilst using an inpatient mental health service, a quarter were absent without leave (AWOL), at the time of their death. When, tragically, people take their own lives whilst using inpatient services,

ligatures (with and without ligature anchor points) continue to be the most common means by which they do so. Progress has been made against the previous Secretary of State's 'Zero Suicide' ambition for mental health inpatients, with all Mental Health Trusts developing Zero Suicide Plans.

Taking a quality improvement approach, the Mental Health Safety Improvement Programme (MHSIP) will focus specifically on reducing AWOL episodes, the risk of suicide of staff working within the healthcare system, and suicide in acute general hospitals. It will also support the adherence to national guidance for ligature anchor point management.

Further, a bespoke national suicide reduction support package delivered in partnership with the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) and National Collaborating Centre for Mental Health (NCCMH) will support local areas in their quality improvement plans as part of the national suicide prevention programme.

The physical ward environment

Inpatient settings should offer rehabilitative environments that enable the delivery of therapeutic care, and support patient recovery. They should also facilitate social interactions and activities, which help patients regain their independence. The NHS Long Term Plan set out a renewed commitment to pursue the most ambitious transformation of mental health care England has ever known. It states that there is "wide variation in the quality and capability of these acute mental health units across the country" and acknowledges that capital investment will be needed to upgrade the physical environment for inpatient psychiatric care.

The Government and NHSEI have already started to improve the physical environment of hospitals, making them far better places to stay and to work in. We have committed to eradicate dormitory provision, ensuring that every person who is admitted to a mental health hospital has the dignity and privacy of their own bedroom with an en suite bathroom. This is an important step towards improving sexual safety in mental health services and towards ending breaches of single-sex accommodation, as recommended by the Women's Mental Health Taskforce. These new facilities will also support our drive to improve infection control on wards. The Government has committed over £400m for this purpose and has identified 1,200 beds that will receive this upgrade over the next four years.

NHSEI will work with stakeholders from across the sector, including experts by experience, to review whether the guidance and data collection on mixed sex accommodation is adequate for mental health settings. This process will enable us to determine whether the existing guidance needs to be revised, better communicated or measured differently.

In October last year, the Prime Minister confirmed that 40 hospitals will be built by 2030 as part of a package worth £3.7 billion. This includes funding for building projects for two mental health hospitals, St Ann's in Poole, Dorset, and Northgate in Morpeth, Northumberland. For many mental health sites, specific investment in a current site is a more suitable clinical option than a full replacement hospital – and we have many schemes underway, and completed, to do this.

The Government will also be inviting bids for a further 8 schemes. Further details will be announced in due course, and a proportion of these will be for new mental health hospitals.

This funding is in addition to the over £400 million of investment we have announced in improving mental health estate since July 2017. This includes £72.3 million for Greater Manchester Mental Health NHS Foundation Trust to develop a new adult mental health inpatient unit and £33 million to Mersey Care NHS Foundation Trust for a 40-bed low secure unit for people with learning disabilities, both of which were included in the £850 million capital funding for 20 hospital upgrades announced by the Prime Minister in August 2019.

In addition, the Department of Health and Social Care spent almost £19 million in capital last year on central programmes to support mental health services. This includes schemes to deliver Perinatal Mental Health Mother and Baby Units to deliver more personalised care to expectant and new mothers with serious mental ill health.

The role of the Care Quality Commission

The CQC has consistently reported that many people continue to experience care that is not person-centred and does not fully protect their rights. Its [State of Care report 2019/20](#)^[23] highlighted that some NHS Trusts and independent services need to improve the quality of care they provide.

Key issues identified include a lack of community care provision, leading to people not being able to access the right care at the right time which results in people reaching crisis point and ending up in hospital, sometimes far away from their homes. Then, once people are admitted to hospital, they are not always receiving appropriate care and treatment, with poor coordination and joint working between acute and mental health services, delays in assessments and securing beds and inadequate and unsafe ward environments.

Patients being placed far from their homes and families also increases the risk of closed cultures developing. A closed culture is a poor culture in a health or care service that increases the risk of harm, abuse and human rights breaches. CQC has expressed concern that this risk has increased in mental health services during the COVID-19

pandemic, with restrictions on people's movements and services having to limit or stop families from visiting loved ones.

Over the next year the CQC will be working with people who use services, families, providers, frontline staff and other stakeholders to improve the way that they regulate services where there is a closed culture, or a high risk of a closed culture developing.

In recognition of the critical role ward culture can play in someone's care and treatment, and in their recovery, we recognise the need to inspect and monitor improvements on ward culture. CQC has committed to changing its methodology, updating internal guidance and inspection assessment frameworks so that its inspectors focus on the quality of ward social environments, and assess whether wards are therapeutic environments which promote recovery.

The CQC is reviewing how it assesses all wards in mental health and learning disability services, informed by its own findings on the quality of inpatient care, as well as the recommendations of the Review and the ambitions of the NHS Long Term Plan.

The CQC is focusing on the assessment of specific factors including the physical fabric of wards including their layout, the safety of fixtures and fittings and the provision of same-sex accommodation and single bedrooms with an en suite bathroom. For wards with dormitories, the CQC will assess whether the Trust has a credible plan to eliminate them and what has been done to mitigate any adverse impacts. The CQC will expect Trust boards to be aware of the quality of the inpatient estate and to have taken action to obtain funding for improvements.

The Review recommended that the Government considers how the CQC's monitoring role may be extended so that it would consider the effectiveness of local joint working through assessing how the Act and Code is working in local areas, rather than looking at services in isolation. We support this recommendation in principle and would like to explore how this could improve the quality (including safety) of care delivered for patients and their experience of the care pathway, for example looking into reasons for delayed admissions and discharge and using this information to support improvements locally whilst recognising the roles of other national bodies in this space. This proposal would increase the CQC's oversight in monitoring the Act in local areas and allow for the identification of issues in the detained patient pathway as well as monitoring the effectiveness of joint working between organisations. It would extend the CQC's current monitoring role under section 120 of the Act, where it looks at information from a range of sources to identify where there could be concerns with service provision. However, the CQC would not be responsible for regulating or taking enforcement action against CCGs, Local Authorities or any other partner organisation in exercising their powers under the Act. We intend to explore what, if any, changes in legislation might be needed to make sure CQC can effectively discharge an extended monitoring power co-operatively with system partners.

We will work with the CQC and national bodies including NHSEI and Local Authorities to consider how best to extend this role and publish proposals for consultation at a later stage. We expect the recommendations to complement the wider work being taken forward to improve the quality and safety of patient care.

Consultation question 35: How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?

Supporting people in the community

We are committed to improving the care and treatment of inpatient care, both for people subject to the Act and for informal patients. We must also improve support in the community to prevent people reaching the point where they have to rely on crisis or inpatient services, and also to support recovery after discharge from hospital. We will shift the focus from reactive care to preventative measures and early intervention in the community.

We are aware that poor provision of care in the community can also sometimes lead to delays to an individual's discharge from the Act. Addressing gaps in community mental health services is essential if we are to overcome these delays and ensure that, once patients are discharged, they are supported to remain well and are not later re-admitted.

The NHS Long Term Plan commits to expanding services for people with severe mental illnesses, delivered through new models of integrated primary, community and social care, so that by 2023/24, at least 370,000 adults and older adults have greater choice and control over their care and are supported to live well in their communities. The new models will incorporate care for people with eating disorders, mental health rehabilitation needs and those with a diagnosis of a 'personality disorder', among other groups.

The [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#)^[24], sets out the detail behind these commitments and how they will be implemented over the next four years, with information about how funding will be spent.

We are currently testing the new models of integrated primary and community care for people with severe mental illnesses ahead of national roll-out from April 2021. Over £70 million across 2019- 2021 has been provided to 12 early implementer sites, ahead of over £750 million additional transformation funding becoming available to all STP/ICS areas in England from 2021/22- 2023/24. While the majority of planned activities of these early implementer sites had to be paused due to the first phase of COVID-19, the programme is continuing as far as is practicable. The testing of new models also includes testing four week waiting times for generic adult and older adult care in line with the Clinically-led Review of NHS Access Standards. Meanwhile, from 2019/20 onwards, all Clinical

Commissioning Groups have been in the process of receiving year on- year increases in baseline funding to bolster community mental health provision and will continue to receive these increases up to and including 2023/24.

NHSEI is monitoring the implementation of the new community models, including their potential impact on detention rates, to generate insights that will inform the delivery of the Long Term Plan commitments in future years and any further policy development that may be necessary ahead of or alongside national roll-out.

Care planning in the community

The NHS has held a longstanding ambition to support and treat people in the right place, at the right time, shifting more care from acute settings into the community and people's homes.

To enable this, more planned and personalised packages of care are required that can meet the needs of individuals. High-quality care and support plans are the key to delivering this, as they enable people to stay independent for longer, to have more control and responsibility over their care by setting their own aims and goals and to shape that care in a way that works best for them.

This is a more connected and joined-up approach to care; not only focusing on the person, but involving those that matter to them too. Every care plan should be co-produced, with the person at the centre. Ultimately, the care plan should be produced by them and for them; adequately supported by the system, expertise and information.

Universal, personalised care planning is something that we are striving towards. This ambition is reflected in the NHS Long Term Plan, which aims to make personalised care the norm and has been a key part of local authority support for people with a mental health issue under the Care Act 2014.

All people in contact with community mental health teams, inpatient care and/or social services should have a high-quality care plan. We wish to ensure that this encompasses the new Statutory Care and Treatment Plan, alongside 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 Review recommended placing this joined-up care plan on a statutory footing, but before we do so, further work is required to establish how we can best bring the necessary elements of the care plan together.

Currently, the majority of people already receiving a service from secondary mental health services, should already have a care and support plan in place and those with eligible social care needs should have a social care and support plan under the Care Act.

Further work is required to understand the underpinning reasons why these plans can vary in both quality and frequency. Overcoming these issues will be crucial to delivering high quality care plans to all patients. NHSEI's community mental health transformation programme includes a clear expectation that all new models significantly improve the quality of coproduced, personalised care and support plans in place for people with severe mental illnesses in the community.

Many areas have also found that having social workers and housing support workers linking in with the acute wards is helpful. This can ensure that discharge planning under s117 aftercare is more effective, that patients have easier access to their rights under the Care Act and that some of the issues that cause delayed discharges, such as access to housing or specialist community support, can be planned earlier and more effectively.

We intend to explore how the existing care plans interlink to understand how any new statutory care plan could work in practice, whilst also conducting work to explore how we can ensure that quality of care planning is consistently high, with limited variation.

We will also be exploring what further information, guidance and support we can provide to commissioners on care planning and the practicalities and implications that placing care planning on a statutory footing would have on the workforce. This work is ongoing, and we will keep this recommendation under review as this work progresses.

Section 117 national guidance

Section 117 aftercare was introduced to the Act in 1983 to provide patients with a statutory right to aftercare following discharge from the Act. While this provision places a duty on health and social care systems, the Review highlighted that there has been a lack of clarity over who is responsible for providing and funding the care and in which locality. This results in delays to providing care to potentially highly vulnerable people.

We will work in close collaboration with Local Authorities, ADASS, ADCS, NHSEI and service users to update national guidance so that there is greater clarity on how budgets and responsibilities should be shared to pay for section 117 aftercare. We will also develop a clear statement in the new Code of Practice of the purpose and content of section 117 aftercare.

Supporting people in a mental health crisis

Whilst we are committed to improving care in the community, which we hope will help reduce the number of people going into crisis, we must also ensure that when someone is in crisis, they get the right care, at the right time. When people reach mental health crises but are not able to access timely, appropriate care, the consequences can be devastating.

Between June 2018 and March 2019, coroners investigated deaths of seven people who were assessed as requiring admission, but for whom no mental health bed was available.

The COVID-19 pandemic has brought this into sharp relief. The CQC's recent report highlighted that some areas had received complaints of lack of access to community support during the pandemic, leading to first-time detentions for some patients, and that some services have reported that A&E departments were functioning as a first contact for people in mental health crisis due to lack of alternatives during the first COVID-19 lockdown.

It is vital that we transform mental health crisis care so that people with urgent mental health needs get the responses they need. For too long, mental health crisis interventions have had to rely on the police, ambulance or A&E being the only 24/7 services that the public can access in the first instance.

We are taking action. We want emergency mental health services to be available for people when they need them, whether before or during a crisis to prevent detention under the Act.

Work is underway as part of the NHS Long Term Plan to enhance services. To support the COVID-19 response, NHSEI asked all local areas to ensure that urgent mental health advice and support is available to people of all ages through open access NHS 24/7 telephone help lines. This ambition was originally expected to be delivered for adults by March 2021 and children and young people by March 2023/24. As of May 2020, every area had implemented a 24/7, all age urgent NHS mental health telephone service which can be accessed by any member of the public and can be found on a [new NHS.UK service finder](#)^[25]. This means that 2020 will be the first NHS winter campaign, where there is a national option for people with urgent mental health needs that is not solely to call 999. The wider objective remains that by 2023/24, the whole country will have crisis care support available at all times of the day and night, for people of all ages, fully accessible via NHS 111.

Significant progress has also been made towards the NHS Five Year Forward View for mental health ambition on 24/7 Crisis Resolution Home Treatment (CRHT) teams for adults. In 2017, under 50% of services were 24/7 or accessible to people not known to services. Now almost all teams are staffed to high fidelity, open to self-referral and operate 24/7. The ambition is on track for all areas to have 24/7 CRHT by March 2024.

The Long Term Plan also makes provision to increase complementary and alternative services to traditional NHS crisis care models, with a particular focus on investment in local voluntary, community and social enterprise (VCSE) services such as crisis cafes and crisis houses.

The Long Term Plan also includes the first dedicated national investment that recognises the mental health response carried about by ambulance services. Investment has commenced, and will continue over the next 3 years, to embed mental health professionals in 111/999 telephone triage as well as supporting on-scene response to mental health calls.

Field testing of access and waiting time standards for urgent and emergency mental health care with 11 sites as part of the clinical review of standards began in October 2019, with much of the work paused by COVID-19. Standards for people with mental health needs in A&E are expected to be included in any new roll out of new A&E access standards. Testing and engagement on new access standards for community crisis services will continue through 2020/21, with an intention to carry out sector engagement on potential new standards during 2021/22.

Use of police custody

While people experiencing a mental health crisis should receive support in a clinical environment, the police play an important role in responding to people in mental health crises. In 2018/19, the overwhelming majority of people detained by police officers under section 136 of the Act were taken to health-based places of safety, rather than to police custody.

To help ensure that in future all people in a mental health crisis are taken to a clinical environment, where they can receive the care and support they urgently need, we have committed to update sections 135 and 136 to remove police stations as a designated place of safety by 2023/24. However, before we can do this, we will have to make sure that the system is ready. This may require new capital funding to be available to provide the estate needed, including health-based places of safety, in those areas that need them.

The police accept that protecting people in mental health crises is part of their core business, but transfers to health services need to happen more quickly, so that patients receive care and support when they need it, and police officers can safely support patients to gain access to health services and return to their duties.

We will establish a national agreement between mental health services, social care and the police to ensure that people detained under section 136 are safely and effectively transferred into health services in a timely way, while ensuring the ongoing safety of all concerned.

Ambulance conveyance

Ambulance services have a major role in providing emergency support to people in a mental health crisis. However, statistics collected by the Home Office show that more people in a mental health crisis are conveyed to hospital by police than by ambulance. This is for a number of reasons, including police decisions not to call or wait for an ambulance to arrive.

The Act's Code of Practice is clear that ambulances or other health transport arranged by the police should be used to convey people after a section 136 detention. The NHS Long Term Plan has committed to a dedicated national investment programme to improve the capacity and capability of the ambulance service to meet mental health demand. This will see £70 million additional revenue investment by 2023/24 for additional mental health professionals to deliver mental health specific initiatives and extra capacity in ambulance services, such as having mental health staff based in 111/999 (integrated urgent care) control rooms to improve telephone triage and support, as well as a national programme to increase mental health training and education of ambulance staff.

A national programme to develop standards and specifications where required, and to provide implementation support is under way as new funding became available in CCG baselines from 2020/21. There is a specific focus on defining and sharing good practice and ensuring that the improvements made to ambulance response align with the overarching Long Term Plan vision for integrated urgent care and a universal single point of access.

The mental health workforce

The Government is absolutely committed to improving mental health services for everyone who requires mental health support. Expanding and developing the mental health workforce is vital to fulfilling this commitment.

The Government will be working with NHSEI, HEE, Skills for Care and the Chief Social Worker's office over the coming months to look at further national support requirements, including on training on the changes to the Act, and supporting meaningful co-production and the development of expert-by-experience leadership roles within providers and local systems.

We have already committed to increasing both the level and staff skill mix on acute inpatient mental health wards. We will seek to help minimise unnecessary time spent in hospital, and at the same time improve outcomes, through the development of new roles and by increasing access to multi-disciplinary staff groups such as peer support workers, psychologists, social workers, occupational therapists and other Allied Healthcare Professionals.

The reforms to the Mental Health Act will require additional workforce over and above that to be delivered through the NHS Long Term Plan, including the expansion of the Responsible Clinician workforce. The reforms will also create new demands on advocates, Approved Mental Health Professionals, and Second Opinion Appointed Doctors. These estimates are included in our Impact Assessment.

We have programmes of work under way to meet the mental health workforce ambitions required to deliver on the NHS Long Term Plan by 2023/24. These include commitments to expand community mental health and crisis services, to prevent admission and where necessary provide more alternatives to admission and improving the availability of therapists and peer support workers in inpatient settings.

The mental health workforce expansion we need to see over the next four years will be challenging for the system to deliver, with past issues exacerbated by the pandemic.

In July last year HEE published *We are the NHS: People Plan* which provides national and local steps to be taken through the remainder of 2020/21 to support NHS staff. The People Plan includes commitments for HEE to prioritise training the future mental health workforce to boost the number of advanced clinical practitioners, psychiatrists and mental health nurses. In 2020/21 this will include training and support for over 100 additional responsible clinicians. HEE has also developed the New Roles in Mental Health Programme, which includes support for mental health social work, AMHPs and Peer Support workers.

The taskforce for Children and Young People's inpatient care is also looking at driving up staff recruitment and ensuring that staff have the right qualifications and values to operate effectively in inpatient settings. They are also developing robust education programmes to upskill and improve retention of the current workforce, which will provide valuable lessons for staffing in adult inpatient settings.

Diversity of the Workforce

The Review identified issues around the mental health workforce failing to reflect the patient population, potentially leading to gaps in the delivery of meaningful support to people from ethnic minority backgrounds.

Within the NHS, we want to increase the number of people of black African and Caribbean descent, who are particularly poorly represented in senior mental health professions, most significantly in the fields of psychology and occupational therapy. The Government has several programmes in place to improve the diversity of the workforce: the Preparation for Work scheme across the NHS aims to widen participation and employability programmes, and supported internships and traditional work experience programmes focus on improving the representation of ethnic minority groups. In addition, HEE is implementing

actions to increase representation and inclusion in mental health professions, starting with clinical psychology, requiring all training courses to make specific progress in this area.

We also want to support the promotion of people of black African and Caribbean descent to senior levels in all mental health professions, especially psychiatry, clinical psychology, occupational therapy, mental health nursing and management, where this group is most underrepresented. The NHS Leadership Academy supports this endeavour with their Ready Now programme, which facilitates leaders from ethnic minorities to rise to senior levels within the NHS. HEE is also investing in a mentoring for leadership scheme for black, Asian and minority ethnic psychological professionals to support equitable progression to leadership and management.

To understand whether these programmes and other similar work is having an impact, it is crucial that we have high quality ethnicity data on the workforce. HEE collates ethnicity data on students currently completing HEE's commissioned pre-registration Healthcare programmes and NHS Digital publishes data on the ethnicity of the NHS workforce, highlighting equality and diversity issues within the NHS.

While current work provides a good starting point for improving the diversity of our workforce, we know there is further to go to meet our ambitions, particularly in ensuring more people of black African and Caribbean descent are recruited into the skilled workforce and supported to rise to senior positions. The Interim NHS People Plan, published in July 2019, and the subsequent 2020/21 People plan both emphasise that the NHS must do more to advance equality and diversity and to develop leaders who have the knowledge, skills and behaviours to create and sustain cultures of compassion and inclusion.

The 2020/21 People Plan, along with the NHS COVID-19 phase three recovery guidance, set out the urgency required to intensify efforts across teams and organisations. They require all local areas to take action to identify a named executive board-level lead for tackling inequalities and to publish action plans to set out how their board and senior staff will at least match in proportion the BAME composition of their overall workforce or community, whichever is higher.

In social work, there is also action under way. The Chief Social Worker, Social Work England, the British Association of Social Workers, the Association of Directors of Social Services and the Local Government Association are committed to implementing improvements to race equality and diversity.

Scoping work is being undertaken by Skills for Care and the Chief Social Worker's office, supported by Local Authorities on a new workforce race equality programme to improve the oversight and leadership of this area in social work and social care. The AMHP workforce plan, new AMHP service standards and the Workforce Race Equality Standard (WRES) guidelines, which have also been published, outline how these ambitions can be

met by Local Authorities and Principal Social Workers. Social Work England, the regulator for social workers, is also supportive of incorporating the principles of the PCREF into requirements for AMHP training, as well as the reapproval processes, which it will review in 2021. The PCREF is supported by the National Workforce Plan for AMHPs and the workforce race equality framework for social work that is currently under development.

Improving Staff Morale

The Review highlighted evidence supporting the link between positive staff experience and high-quality patient care and noted that this has not been sufficiently exploited in the mental health setting.

The Government and NHS England agree that improving staff experience can have a significant impact on the quality of patient care, as well as boosting staff morale and retention. This is why improving the health and wellbeing of our staff was a commitment of the NHS Long Term Plan and is central to the 2020/21 NHS People Plan.

The NHS is striving to become a beacon of good practice in helping staff maintain and improve their physical and mental health and wellbeing through the Improving Health and Wellbeing programme. This programme embeds NHSEI's evidence-based NHS Health and Wellbeing Framework which provides Trusts with diagnostic tools and suggested interventions to help them improve access to services for those staff who need this support.

The programme is being rolled out across 22 Trusts delivering mental health services and aims to have a positive impact on staff morale in NHS Trusts, thereby potentially improving the experience of all patients, including those who are detained. We are planning to roll out this programme across the remainder mental health Trusts over the next three years.

The 2020/21 People Plan contains a chapter on staff wellbeing and support, which sets out the support NHS staff can expect from their employers, including safe spaces to rest, psychological support, sickness support and risk assessments for vulnerable staff, including BAME staff.

Further, the COVID-19 pandemic has presented a unique and unprecedented challenge for many health and social care staff, who are caring for people in unfamiliar and challenging clinical and support roles. It is therefore essential that staff have rapid access to mental health support when required. NHSEI has developed a specific national support offer, which is available at people.nhs.uk^[26] for NHS staff, which includes:

- A dedicated health and care staff support service, including confidential support via phone and text message;

- A specialist bereavement support helpline for those who have sadly lost friends and family – whether from COVID-19 or otherwise;
- A pilot of a specialist relationship counselling service with the charity Relate; and
- A partnership with the Money and Pensions Service (MaPS), to launch a financial wellbeing offer.

A comprehensive mental health offer is also in development, following investment from NHSEI, to strengthen mental health support for healthcare staff in all local areas and ensure rapid access to evidence based mental health services. This includes:

- A centrally commissioned service for people with complex needs: a national support service particularly for critical care staff who research suggests are most vulnerable to severe trauma;
- Mental health and wellbeing hubs: nationwide outreach and assessment services, ensuring staff receive rapid access to evidence based mental health services; and
- The development of [wellbeing and psychological training](#)^[27], set to be rolled out this winter.

Data and digital

We have set out plans to reform the Act, and the care and practice around it. To support the implementation of these reforms we must also look at the infrastructure and processes which impact on the day to day operations of the Act. The Government is committed to working with all the organisations involved in the operation of the Act to bring about improvements to data collection and to new digital approaches to service delivery.

This ambition has been accelerated during the pandemic period in 2020, with many staff and patients benefitting from a new focus on online and digital consultations and assessments. These have been used in some circumstances to mitigate impacts of the pandemic – not just in mental health but right across the health service.

The immediate implications for the Act have been twofold.

Firstly, the Government and NHSEI have had to consider whether digital and online methods can suffice for medical assessments made for the purposes of the Act. NHSEI [issued guidance](#)^[28] on this matter in May 2020, which included the Department of Health and Social Care's view that the Act may be interpreted to allow for this. The guidance, did however, state that it is always preferable to carry out a Mental Health Act assessment in person.

Secondly, there has been a long-standing desire amongst practitioners and Act administrators to remove the legislative barriers that prevent the greater use of digital means for the completion and communication of the Act's various statutory forms. This requirement was made more acute by the pandemic, when staff have needed to work more flexibly to account for a reduced workforce and public health measures around social distancing and non-essential travel. The Government amended legislation to allow for the electronic communication of forms through the Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 in October 2020, which came into force on 1 December 2020.

We anticipate that this change will enable staff to work more efficiently and, in doing so, ensure that patients access the care they need in a more timely manner.

We are now working to establish how the Act's pathway may be modernised in other ways. We want to investigate service maturity across the Act's pathway, map key information flows, and identify business and technical capability requirements so that we can eventually look to deliver a "digital first" approach to processes and procedures, governed by the Act. This work is crucial to ensuring that people under the Act can access the benefits of a modern, world-class health care system.

Finally, we agree with the Review that improving data is a critical enabler to the wider system changes and ambitions set out in this White Paper. Better data supports transparency and scrutiny and is critical to informing ongoing reform and improvement, and to monitor the impact of change. The NHS Mental Health Implementation Plan 2019/20 – 2023/24 states NHSEI's commitment for substantially improved mental health data quality over the coming years. It will increase the coverage, consistency, quality and breadth of national data. Seeking improvements to Mental Health Act related data is a part of this plan.

NHS-led improvements provide a real opportunity for providers to take critical insights into their operation of the Act, including trends in location assessment requests, time of day, length and reasons behind delays, assessment outcomes and demographic information. Service commissioning and provision could be better informed by better mental health data, which will support developments in care both to inpatients and within the community.

Impact Assessment

Consultation question 35: In the impact assessment, we have estimated the likely costs and benefits of implementing the proposed changes to the Act. We would be grateful for any further data or evidence that you think would assist Departments in improving the methods used and the resulting estimates. We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc, that might inform what effect the proposals would have on the following:

Different professional groups, in particular:

- How the proposals may impact the current workloads for clinical and non-clinical staff, Independent Mental Health Advocates, Approved Mental Health Professionals, Mental Health Tribunals, SOADs etc; and
- Whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered.

Service users, their families and friends, in particular:

- How the proposal may affect health outcomes;
- How the proposals may improve the ability for individuals to return to work, or effects on any other daily activity;
- Whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered; and
- Any other impacts on the health and social care system and the justice system more broadly.

Alternatively, please email your response to MHAconsultation2021@dhsc.gov.uk and include what question you are responding to and your organisation (if appropriate).

Annex A: Proposed changes to Part IV of the Mental Health Act

Table 2 – when treatment can be administered under categories 1-3 and key changes from current provisions

	Category 1	Category 2	Category 3
Requirements for administering treatment under reformed Part IV	<p>Treatment can only be administered if the patient has capacity and is consenting.</p> <p>Plus, a Second Opinion Appointed Doctor (SOAD) needs to certify that the patient is capable of understanding the nature, purpose, and likely effects of the treatment, that the patient consents and that it is appropriate for the treatment to be given. The SOAD must consult with two others before certification can be given.</p>	<p>Treatment cannot be given to the patient with capacity who is refusing, or if they have refused in an Advance Choice Document (ACD), unless s62(1)(a) and (b) urgent criteria are met. In this case, high court judge pre-approval must be secured, supported by two medical opinions (as per s58(3)(b) and (4)).</p> <p>If the patient lacks capacity and has not refused the treatment in an ACD, treatment can be given where s62(1)(a) and (b) urgent criteria are met so long as the CQC is informed and the justification is recorded for scrutiny.</p> <p>If the patient lacks capacity and urgent criteria is not met, then the wishes/preferences of the patient should be considered by SOAD with similar requirements to s58 (6)</p>	<p>If the patient with capacity refuses, or has refused in an ACD, and urgent criteria are not met, then a SOAD must certify that no other clinically appropriate treatment is available which is more acceptable to the patient. SOAD certification is at day 14 of detention (once Care and Treatment Plan is signed off).</p> <p>Treatment can be given to a patient with capacity, who is refusing treatment, without SOAD certification, if s62(1)(a) and (b) and (d) urgent criteria are met. Or, if the patient has refused in an ACD then treatment can be given without SOAD review where s62(1)(a), (b), (c) and (d) urgent criteria are met.</p> <p>If the patient is lacking capacity and does not have an ACD, then the wishes/preferences of the patient must be considered and treatment certified by SOAD at 2 months since treatment commenced.</p>
Changes	No substantive	If patient refusing in an	When patient is not

	Category 1	Category 2	Category 3
from current provisions	change from current section 57.	<p>ACD, treatment cannot be given except with the prior approval of a judge where s62(1)(a) and (b) urgent criteria are met. The application to the court must be accompanied by two medical opinions.</p> <p>When the patient lacks capacity and urgent criteria are not met, treatment decisions must consider patient's wishes and preferences.</p>	<p>consenting to treatment, SOAD certification is earlier: day 14 of detention if the patient has capacity or is refusing in an ACD; at 2 months if patient lacks capacity and has no ACD.</p> <p>The urgent criteria is different for patients with capacity, giving them the right to have their treatment refusal respected, even if this means that they experience serious suffering.</p> <p>For people who lack capacity, have no ACD, and urgent criteria are not met, efforts must be made to understand their wishes/preferences and take these into account.</p> <p>When treatment is given compulsorily, it should be in the smallest dose and over the shortest period possible, to be effective.</p>

Category 1 Treatments: most invasive

In line with the provisions within section 57 of the current Act, administering the most invasive treatments will require the patient to have the relevant capacity and to consent to the treatment. A SOAD will have to certify that the patient is capable of understanding the nature, purpose, and likely effects of the treatment in question, that the patient consents and that it is appropriate for the treatment to be given. The SOAD should consult with two other persons in accordance with section 57(3), before they can certify that the criteria are met.

Patients will not be able to consent to category 1 treatments through Advance Choice Documents. They must have relevant capacity and be consenting at the time of the proposed treatment.

Category 2 Treatments: invasive

If a patient has **the relevant capacity**, they must consent to this treatment before it can be administered. The clinician should confirm that the patient has relevant capacity to consent. If the patient has the relevant capacity and refuses to consent, but it is deemed that urgent treatment is necessary to save the patient's life or prevent a serious deterioration of their condition, as is currently described in section 62(1) (a) and (b)* (Page 112) of the Act, a High Court Judge would have to approve its administration. The application to court must be accompanied by two medical opinions.

If a patient lacks the relevant capacity to consent and has refused a category 2 treatment via an **Advance Choice Document, or if the treatment is in conflict with a decision made by a donee of a lasting power of attorney, a court-appointed deputy or the Court of Protection**, the same process would have to be followed prior to administration, with a High Court Judge approving the necessity of urgent treatment (section 62(1)(a) and (b) would apply), with the application accompanied by two medical opinions.

If the patient lacks the relevant capacity to consent but has not refused the treatment via an Advance Choice Document, treatments in this category can only be administered once a SOAD has certified that it is clinically appropriate and ascertained the patient's wishes and preferences as far as possible. To do this, the SOAD should consider any statements of preference previously made by the individual, particularly at a time when they had the relevant capacity, as well as considering the individual's beliefs and values. Where appropriate, the SOAD should consult with the Nominated Person, family, or others who are concerned with the person's welfare. The exception to this would be when the urgent criteria are met as currently set out in 62(1) a) and b) of the Act. In these circumstances, treatments could be administered, but the Care Quality Commission would need to be informed of the decision and provided with the clinician's records for scrutiny.

* Explanatory text 12: Mental Health Act 1983, Section 62(1) ...

- (a) Which is immediately necessary to save the patient's life; or
- (b) Which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- (c) Which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- (d) Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or to others.

Category 3 Treatments: all other medication

This category represents the biggest change from current legislation. Currently, the vast majority of medical treatments for mental disorder can be administered for a period of three months without the need for consent, even if the patient has the relevant capacity to refuse treatment. We want to change this so that the administration of these treatments is subject to far greater legal requirements regarding the patient's consent and their right to refuse treatment.

Most crucially, we will bring forward the point at which a SOAD must certify a patient's treatment, from 3 months, to when their Care and Treatment Plan has been signed off by the Clinical or Medical Director at day 14 of detention. This will apply to a patient with capacity who is refusing treatment or who has refused it in an Advance Choice Document.

If a patient **with the relevant capacity** refuses to consent to a category 3 treatment, but it is immediately necessary to save the patient's life, to prevent a serious deterioration of their condition, or to prevent the patient from behaving violently or being a danger to themselves or others, as is currently described in section 62(1) (a), (b) and (d) the Responsible Clinician will be able to overrule this refusal and administer the treatment, without the approval of a SOAD.

If a patient **lacks the relevant capacity to consent and has refused the treatment via an Advance Choice Document**, the Responsible Clinician will be able to overrule this refusal and administer the treatment if it is immediately necessary to save the patient's life, to prevent a serious deterioration of their condition, or to prevent the patient from behaving violently or being a danger to themselves or others, as is currently described in section 62(1) (a), (b) and (d), and when it was needed to alleviate serious suffering (as described in section 62(1) (c)).

If in both of the above cases, the urgent criteria are not met, but the Responsible Clinician wishes to overrule the patient's refusal of treatment, then a SOAD will have to certify that they are satisfied that no other clinically appropriate treatment is available which is more acceptable to the patient. This brings forward the requirement for a SOAD from the current provision of 3 months, to the point at which their Care and Treatment Plan has been signed off at day 14 of detention. Where medical treatment is given against the patient's wishes, it should be in the lowest dose, and for the shortest period necessary to be effective.

If the patient **lacks the relevant capacity to consent but has not refused the treatment via an Advance Choice Document**, treatments in this category may be given following an assessment by the clinician, that as far as possible the treatment meets the wishes and preferences of the patient. As is now the case, the care and treatment of patients without the relevant capacity would then be subject to a review by a SOAD to certify that the treatment is appropriate and that it should be given. However, instead of that occurring at 3 months, we propose to bring this forward to 2 months.

Glossary

Key Terms	Definition
Advance Choice Document	A written statement that sets down your preferences, wishes, beliefs and values regarding your future care.
Advocacy	Activity by an individual or a group providing support to express the views and wishes and to stand up for the rights of people with mental health illness
Approved mental health professional	An approved mental health professional is a person qualified and authorised by the local authority to undertake assessments under the mental health act and decide whether detention under the Act is appropriate
Attorney	A person (aged 18 or over) appointed under the Mental Capacity Act who has the legal right to make decisions on behalf of a person in relation to their welfare, property or affairs of a person
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (e.g. to consent to treatment), because they cannot understand, retain, use, or weigh the information relevant to the decision

Key Terms	Definition
Care Act 2014	An Act designed to improve people's independence and wellbeing. Local Authorities have a duty to assess people's wellbeing and care needs.
Care and Treatment Plan	A document that sets out what a patient needs, and how this will be provided whilst detained under the MHA. This should include how regard has been taken for the known wishes and preferences of the patient, the aims of the assessment and treatment during detention, and any proposed timescales before improvement might be expected. The Care and Treatment Plan should have a statutory footing and is critical to ensure the new treatment detention criteria is met. The Care and Treatment Plan will be considered by the Tribunal as part of any review of a detention.
Care Programme Approach	A care planning system used mainly with people in England who receive specialist mental health care services. This involves an assessment, care plan and a care coordinator to oversee it. People who receive care should be involved in their care.
Children Act 1989	An Act relating to children and young people and those with parental responsibility for them.
Code of Practice	Shows professionals how to carry out their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005.
Coercive Reward	Rewarding a patient to cooperate with mental health or other professionals involved with their care
Community Treatment Order	Can be used when someone is discharged from detention in a hospital under the Mental Health Act, to ensure they undergo supervised community treatment.
Compulsory admission or treatment	Admission or treatment for mental disorder given under the Mental Health Act, which may be against the wishes of the patient.
Convention on Rights of Persons with Disabilities	Protects the rights and dignity of persons with disabilities
Coproduction	As defined in the Care Act - when you as an individual influence the support and services you

Key Terms	Definition
	receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered.
Court of Protection	The specialist court, set up under the Mental Capacity Act 2005, to deal with issues relating to people who lack capacity.
Court Appointed Deputy	A court appointed person who legally takes care of health, wellbeing and finance for someone with health problems. Also referred to as deputyship.
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, Community Treatment Order, guardianship, or conditional discharge.
Dignity	The right to be valued, respected and treated ethically.
Deprivation of liberty	Depriving a person of their freedom to act in the way they choose, usually in a care home or hospital after completion of a statutory assessment process, which includes an assessment that the detention is in the best interests of the person.
Deprivation of Liberty Safeguards	An authorisation under the Mental Capacity Act 2005 given by a 'supervisory body' (a local authority or, in certain circumstances, the Welsh Ministers) which authorises a deprivation of liberty in a care home or hospital after completion of the statutory assessment process
European Convention on Human Rights	The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998
Human Rights	Substantive rights set out in the European Convention on Human Rights, and largely incorporated into UK law by the Human Rights Act 1998
Independent Mental Health Advocate	A person providing advocacy under the provisions of the Mental Health Act 1983
Informal admission	Admission of someone who is being admitted for a mental disorder and who is not detained under the Mental Health Act

Key Terms	Definition
Joint crisis plan	A plan to support people during future periods of mental health crisis
Liberty Protection Safeguards	The new process introduced by the Mental Capacity Act (Amendment) Bill to replace the Deprivation of Liberty Safeguards (see above)
Mental disorder	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia
Mental Capacity Act	The Mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people, aged 16 years and over, who lack capacity, both where they lose capacity at some point in their lives, for example as a result of dementia or brain injury, and where the incapacitating condition has been present since birth
Mental Health Act 2007	Made several key changes to MHA 1983, laying down provision for the compulsory detention and treatment of people with mental health problems
Part 3 of the MHA	Part 3 of Act, known as the 'Forensic Sections', deals with patients who have been involved in criminal proceedings.
Pain-based restraint	A type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person when pain is involved
Protected characteristics	It is against the law to discriminate against someone because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are called protected characteristics.
Renewals	The process by which the period of detention under a section of the mental health act is renewed
Respect	Due regard for the feelings, wishes, or rights of others
Responsible Clinician	The Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the

Key Terms	Definition
	Mental Health Act
Restraint	A type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person
Restricted patients	Patients who, following criminal proceedings, are made subject to a restriction order where it appears that it is necessary to protect the public from serious harm
Safeguards	The presence of specific measures within the MHA 1983 that provide an important protective counterbalance to the extensive powers that are inherent in the Act.
Second Opinion Appointed Doctor	The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.
Section 2	Assessment, patients can be kept in hospital for up to 28 days to allow for medical assessment. An approved mental health professional (AMHP) needs to apply to hospital. Patients have the right to appeal to a tribunal within 14 days, to appeal to hospital managers and to see an IMHA
Section 3	Treatment under section 3, patients can be detained in hospital for treatment for up to 6 months. An AMHP needs to apply to the hospital. Doctors may renew for 6 months then 12 months and patients appeals are allowed every 6 months
Section 117	Health, social care and support services in the community following discharge from hospital and to avoid future admission; especially the duty of the responsible health services and local authority to provide after care under section 117 of the Act, following the discharge of a patient from detention for treatment under the Act.
Section 135	Warrant enabling a police officer to enter premises to either: remove a person to a place of safety to make an application under part 2 or

Key Terms	Definition
	other arrangements for their care or treatment or take (retake) into custody someone liable to be detained under the Act
Section 136	An emergency power which allows patients to be taken to a place of safety from a public place if a police officer considers that a person is suffering from mental illness in need of immediate care
Seclusion	Seclusion refers to the supervised containment and isolation of a patient, to contain behaviour that threatens harm to others
Tribunal	The First Tier Tribunal is an independent panel that can discharge you from the Mental Health Act. The tribunal hearings take place at the hospital. The tribunal has to decide if you meet the criteria for being sectioned. Tribunals have the power to: discharge you from your section, recommend that you get leave, recommend supervised community treatment instead of staying in hospital, decide on a delayed discharge or conditional discharge, transfer you to another hospital, or meet up again if their recommendations are not followed.

PART 3: The Government's Response to The Independent Review of The Mental Health Act

The Independent Review of the Mental Health Act reported in December 2018 and made 154 recommendations to the Government. The Review's findings and recommendations have led development of the Government's plans to reform the Act, and policy and practice around it, as set out in the White Paper.

Below we provide the Government's response to each of the Review's recommendations. Some of the recommendations have been grouped by theme, and so the order in which the responses are made sometimes departs from the Review's original numerical listing.

Taking forward the commitments to reform, as set out in the White Paper and in the response below, is subject to consultation and affordability. The transformational proposals set out in this White Paper will therefore be subject to future funding decisions, including at Spending Review 2021.

New Mental Health Act Purpose and Principles

- 1. A purpose and a set of principles should be included in the Act itself.**
- 2. There should be four new principles covering: choice and autonomy, least restriction, therapeutic benefit, and the person as an individual.**
- 3. MHA regulations and forms should be amended to require professionals to record how the principles have been taken into consideration, and to enable local auditing and monitoring and CQC to consider this as part of their monitoring and inspection role.**

The Government agrees that the Principles recommended by the Review are the right ones. We have put these at the centre of our considerations of the reforms that we propose to make.

We want to set out these four principles up front in the Act, as well as in the Code of Practice, to emphasise their centrality to the provisions. Moving forward, as we prepare to amend legislation through a new Mental Health Bill, the Government's decisions will be guided by the new principles.

We also accept the recommendation to update the Act's regulations and forms to ensure that the principles are embedded in day to day practice. We are consulting on where beyond the Act and the Code of Practice people would like to see the principles to have the biggest impact and we will use this feedback to support the practical application of the principles and the translation of them into a reformed Mental Health Act and Code of Practice.

Making decisions about care and treatment

4. Shared decision-making between clinicians and patients should be used to develop care and treatment plans and all treatment decisions as far as is practicable.

5. It should be harder for treatment refusals to be overridden, and any overrides should be recorded, justified and subject to scrutiny

6. Statutory advance choice documents (ACDs) should be created that enable people to make a range of choices and statements about their inpatient care and treatment. These should be piloted to identify the detail needed to inform/impact practice.

7. Decisions about medication should, wherever possible, be in line with the patient's choice and patients should have a right to challenge treatments that do not reflect that choice.

8. Patients should 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.

9. Patients should be able to appeal treatment decisions at the Mental Health Tribunal (MHT) following a SOAD review.

We accept the Review's recommendations to support the guiding principle of patient choice and autonomy. This Government has committed to seek to legislate so that patients have greater control over their treatment. We intend for Care and Treatment Plans to become a statutory requirement for any patient detained under the Act. The Plan should reflect the patient's preferences and, as far as possible, demonstrate shared decision making between clinician and patient. This should happen whether or not the patient has capacity to make decisions about their care and treatment. Where a patient's wishes or preferences have been overruled, this must be recorded by the Responsible Clinician, including the justification for doing so. This will be subject to scrutiny.

We have already accepted the Review's recommendation to introduce statutory Advance Choice Documents. These will allow people to set out in advance the care and treatment they would prefer, and treatments they wish to refuse. An individual's Advance Choice Document will be followed if they later lack the relevant capacity to express their wishes at the time, unless the Act specifies otherwise.

We agree that decisions about medication should, wherever possible, be in line with the patient's choice. We intend to amend Part IV of the Act to create a new framework for consent and refusal of medical treatment, which will enable patients to have a greater say in their treatment and ensure that their wishes and preferences are upheld as far as possible and are more difficult to overrule.

We accept the recommendation to give patients the right to challenge treatment decisions at a much earlier point in detention. Patients, or their Nominated Person or Independent Mental Health Advocate (IMHA) acting on their behalf, will be able to request a review by a Second Opinion Appointed Doctor (SOAD), if the patient's Care and Treatment Plan does not reflect their wishes and preferences. This right will be available from day 14 of detention, when the Care and Treatment Plan must be finalised.

Where the patient has not consented to treatment because they lack the relevant capacity to do so, the current requirement for a SOAD to review their treatment will be brought forward from 3 months to 2 months.

We will seek to expand the role of the Mental Health Tribunal (MHT), to consider treatment challenges brought by the patient or their Nominated Person or IMHA, in cases where the patient has had their treatment refusal overruled by their Responsible Clinician and this has been upheld by a SOAD.

10. The Government and the CQC should consider ways to resource the likely increase in SOAD reviews, looking at how the model of SOADs can evolve.

The reforms set out in this White Paper will increase access to SOADs, and so will place additional requirements on this workforce. We accept this recommendation and will work with CQC to progress a detailed impact analysis of the SOAD service and to test new SOAD systems and processes. This will be used to inform the future model of delivery.

11. The Government should consult upon:

- **Whether the MHA should provide that a person can consent in advance to confinement for medical treatment for mental disorder, or to empower an attorney or court appointed deputy to give consent on their behalf; and**
- **What safeguards would be required.**

Advance consent can already legally be given in certain situations but is not widely recognised or implemented in psychiatric hospitals. We therefore accept this recommendation and will seek views on whether the Act should be amended to more clearly provide the ability to consent in advance. This would mean that people could consent in advance to being treated informally at a point in the future when they become unwell, rather than be made subject to the Act, if that is what they would prefer. The Review recommended that the Government consults on this matter and we are doing so.

12. Mental healthcare providers should be required to demonstrate that they are coproduced mental health services, including those used by patients under the MHA.

The Government accepts this recommendation. All providers of mental health care, including those which detain people under the Act, should have a process in place that ensures that health services are co-produced. Developing the model of care in partnership with service users should not only lead to higher quality, more responsive and accountable services but should also have a therapeutic benefit for individual patients. Both providers and commissioners should be able to demonstrate that this is happening.

Currently the CQC puts the onus on providers to demonstrate this and asks a number of key questions, under the umbrella question, 'Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable service?'

NHSEI have also commissioned a toolkit for commissioners and providers to support meaningful and effective co-production which services can readily access.

In addition, DHSC is considering this recommendation with NHSEI to identify further system support that might be required to enable providers to effectively co-produce services. It is expected that this could include training for both staff and experts by experience and the development of expert-by-experience leadership roles within providers and local systems.

Nominated Person

13. Patients should be able to choose a new Nominated Person (NP) to replace the current Nearest Relative (NR) role under section 26 of the MHA.

14. A new Interim Nominated Person (INP) selection mechanism should be created for those who have not nominated anyone and do not have capacity to do so.

15. Patients should have greater rights to choose to disclose confidential information to additional trusted friends and relatives, including through the NP nomination process or advance choice documents.

16. NPs should have the right to be consulted on care plans.

17. Patients under Part III of the MHA who are not currently eligible to have a NR should have limited eligibility for a NP/INP in relation to care planning.

19. NPs and INPs should be consulted about a renewal of a patient's detention, extension of a community treatment order, transfer from one hospital to another, and discharge, rather than simply notified.

20. NPs should have a power to challenge treatment before the MHT where the patient does not have capacity to do it themselves.

The Government accepted the recommendation for patients to be able to choose a Nominated Person (NP) on publication of the Review in December 2018. This will replace the current Nearest Relative provisions.

Patients will be able to identify their NP in their Advance Choice Document or at the point of detention. We agree with the Review that there should be a process in place for when the patient lacks the relevant capacity to choose an NP. We propose that in these circumstances an Interim Nominated Person (INP) should be appointed by an AMHP. We intend to develop guidance for the AMHP on how they should identify a suitable person.

As per the Code of Practice, patients will also be able to identify other individuals who can receive information about their care and treatment, either by expressing their wishes and preferences while detained or in their Advance Choice Document.

We agree with the Review's recommendations to provide the NP with further powers (recommendations 16, 19, 20). NPs should have the right to be consulted on statutory Care and Treatment Plans, the power to challenge treatment on the patient's behalf, and the right to be consulted rather than notified on changes concerning the patient's detention under the Act. As this gives additional powers to the Nominated Person with regard to an individual's detention, we are consulting on these changes.

We accept the Review's recommendation to introduce limited eligibility for Part III patients to have an INP/NP, in relation to care planning.

21. NPs should be given improved support, which could include courses provided by recovery colleges, support lines or online materials.

We agree in principle with the Review's recommendation to provide improved support to NPs and we will look at how we can do this through the Code of Practice.

18. The county court power to displace a NR should be replaced with an MHT power to overrule or displace a NP, and only contested nominations should be heard in court.

The Government agrees in principle with the Review's recommendation. However, we wish to first understand how this would work in practice and whether it is proportionate in terms of the implications for the Mental Health Tribunal and Legal Aid Agency.

We will also be taking into consideration implications for the legal aid fund, which currently pays for representatives of patients in these proceedings before the County Court on a means tested basis. Tribunal proceedings are not means tested and so we need to explore whether legal aid will remain means tested if the proceedings are transferred to the Tribunal. This will be considered further as part of our Means Test Review, which will look at the thresholds and criteria for legal aid entitlement. The Review is due to report in 2021 with a public consultation to follow.

Advocacy

22. The statutory right to an Independent Mental Health Advocate (IMHA) should be extended so that it includes:

- a) All mental health inpatients, including informal patients;**
- b) Patients awaiting transfer from a prison or an immigration detention centre;**
- c) People preparing their advance choice documents (ACDs) that refer to detention under the Mental Health Act.**

24. The statutory definition of IMHA advocacy should be amended to cover advocacy around care planning and Advance Choice Documents.

We accept the Review's recommendations that the right to an IMHA should be extended to all inpatients (22a), recognising how important it is for all patients to understand and exercise their rights in mental health inpatient settings and we will expand the role of IMHAs to support patients to access additional safeguards set out in the White Paper, including: helping patients to inform their statutory Care and Treatment Plan and prepare their Advance Choice Document (22c and 24); supporting patients to exercise their increased rights to challenge detention; and supporting patients to appeal treatment decisions.

In addition, we plan to extend the statutory eligibility to access an IMHA to informal inpatients, recognising how important it is for all patients to understand and exercise their rights in mental health inpatient settings (22a).

Taking forward these ambitions will be subject to securing funding, as they represent a new cost for Local Authorities. A burdens assessment process is underway with the Local Government Association.

We agree in principle with the recommendation to expand advocacy support to patients awaiting transfer to hospital from a prison or an immigration removal centre (22b). We have considered this recommendation alongside the recommendation to create a new statutory, independent role to manage transfers from prisons and immigration removal centres (131), and their responsibility in considering a least restrictive option for immigration detainees (140). We are consulting on how we should approach introducing a new role for managing transfers and we will await responses before deciding on how to take forward these closely linked recommendations on advocacy and support.

23. IMHA services should be ‘opt out’ for all who have a statutory right to it and the CQC should monitor access.

We wish to see more people accessing advocacy support. We will continue to work with Local Authorities and advocacy providers with the view to making IMHA services available to everyone. We will consider making advocacy services ‘opt out’ and, as part of this, whether funding is needed or if there is capacity within the system to manage additional uptake of IMHAs among patients.

25. Further consultation should be undertaken on the training of advocates and quality standards, balancing the requirement for better quality services overall with the need for tailored interventions for specific groups.

26. Commissioning by Local Authorities should be strengthened, so that:

- a) Guidelines make it clear that IMHAs are best placed to provide support in cases where there is an overlap with Care Act / MCA advocacy;**
- b) Services are commissioned on the basis of existing quality standards;**
- c) Providers are required to provide quarterly reports to their commissioners about issues and trends, incorporating input from trust staff, families/carers and clients;**
- d) The requirement for IMHAs to be available to meet the needs of different groups, particularly ethnic minority communities, is strengthened, in light of the Public Sector Equality Duty**

We accept the Review's recommendation to consult further on the training of advocates and quality standards and how these can be improved. We will be working closely with colleagues in the Local Government association and ADASS to develop guidance on this. We have also committed to launch a pilot programme of culturally sensitive advocacy in partnership with Local Authorities and others, to identify how advocacy can respond appropriately to the particular needs of individuals from black, Asian and minority ethnic backgrounds.

We accept the recommendation to strengthen the commissioning of advocacy services. We will work with LAs and organisations such as ADASS, the LGA and the association of mental health providers to review and strengthen commissioning guidelines for advocacy services to reflect the key role of IMHAs and have effective performance reporting to support continuous improvement and delivery against quality standards. We would suggest that as a minimum an annual report should be prepared by providers, with the opportunity for quarterly exception reporting as required.

We will also be working closely with Local Authorities to develop the commissioning arrangements for organisations providing IMHA services and the training and support expectations for advocates to ensure that inpatients are also supported to access their rights under the Care Act and Mental Capacity Act.

Additionally, we will work with NHSEI to undertake a review of the current advocacy provision for people with a learning disability and autistic people to identify areas for improvement.

Complaints

27. Section 132 of the MHA should be amended to require managers of hospitals to provide information on making complaints to patients and their nominated person.

28. Staff dealing with complaints should have an understanding of the MHA so they are aware of the particular impact of detention.

29. Information going to hospital boards should be separated between complaints made by patients detained under the MHA and complaints made by informal patients.

30. The Government and CQC should take steps to improve the systems that handle complaints from patients and their carers across providers, commissioners, police and Local Authorities to improve transparency and effectiveness across the system.

We accept that section 132 should be amended in line with the Review's recommendation and that staff dealing with complaints should have an understanding of the Act so they are aware of the particular impacts of detention.

We agree in principle that information going to hospital boards should be separated by complaints from formal and informal patients, however, we need to explore how we can operationalise this.

The Government agrees in principle with the recommendation to improve the systems that handle complaints. Further work is needed to establish what steps need to be taken to achieve this and we will work with the CQC to look at the Mental Health Act complaints process.

31. Local Safeguarding Adult Boards should ensure that safeguarding arrangements support organisations to discharge their safeguarding duties and ensure that there are effective processes in place to identify, investigate and take action on safeguarding issues.

We accept this recommendation. We are committed to preventing and reducing the risk of harm to people in vulnerable situations. We want to see a focused and effective safeguarding system including inpatient units, where harm or risk of harm is identified, acted upon effectively and ultimately prevented.

The Care Act 2014 placed adult safeguarding on a statutory footing for the first time, empowering Local Authorities to investigate and take action where they have reason to suspect that an adult in their area with care and support needs is at risk of abuse or neglect.

In addition, the Care Act requires each local authority to set up a Safeguarding Adults Board (SAB) in order to provide assurance that local safeguarding arrangements and partners are acting to help and protect adults who may be at risk of abuse or neglect.

We are working with the Local Government Association and others to understand how central Government can best support Local Authorities in discharging this duty.

Deaths in detention

32. A formalised family liaison role should be developed to offer support to families of individuals who die unexpectedly in detention.

We agree in principle with this recommendation, but we are exploring a different approach. The Government agrees that there is a need to better support families and carers of those who are bereaved, and that a family liaison service is a good way to do this. National

Guidance on Learning from Deaths (NQB, March 2017) and Guidance for Trusts on engaging with bereaved families and carers (NQB, July 2018) recommends that Trusts should engage meaningfully and sensitively with bereaved families and carers, and that developing a well-trained, supported and motivated family liaison service is an effective way to provide a compassionate service to them. The NQB's guidance of July 2018 states that this should be a distinct service and points towards examples of Trusts which have successfully implemented this service as demonstrating good practice. The Government does not intend to make the provision of a family liaison service a requirement of Trusts.

When someone dies by suicide whilst detained, as set out in the NHS Long Term Plan, suicide bereavement support services to families and staff will be rolled out in every area of the country by 2023/24.

33. Families of those who have died should receive non-means-tested legal aid.

In February 2019, the Ministry of Justice (MoJ) published its Review of Legal Aid for Inquests. This concluded not to introduce non-means tested legal aid for bereaved families to attend inquest hearings. The evidence gathered as part of this review on financial eligibility will be considered as part of our wider Means Test Review, looking at the thresholds and criteria for legal aid entitlement. It was initially intended that this review would conclude in summer 2020, but it has been delayed due to the COVID-19 outbreak. The intention is that this review will now conclude in Spring 2021. We will then publish a full consultation paper setting out future policy proposals in this area and will seek to implement any final recommendations as soon as practicable.

34. Guidance should make clear that a death under Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards (LPS) in a psychiatric setting should be considered to be a death in state detention for purposes of triggering the duty for an investigation by a coroner and an inquest with a jury should be held.

The changes made on 3 April 2017 to the Coroners and Justice Act 2009, by section 178 of the Policing and Crime Act 2017, provide that the death of a person subject to DoLS is not considered to be a death in state detention for the purpose of a coroner's investigation. This means that there is no statutory requirement for such deaths to be reported to the coroner (unless there are other complicating factors). The Mental Capacity (Amendment) Act 2019 will maintain this position for Liberty Protection Safeguards when it is implemented.

Therefore, while we do not accept the Review's recommendation to amend guidance, as this would be contrary to the legislation, the introduction of medical examiners will strengthen safeguards by providing independent scrutiny of the death certification process and ensuring that, where appropriate, deaths under DoLS/LPS are referred to coroners. This will improve the quality of death certification by providing expert advice to doctors based on a review of the relevant health records. The medical examiner will allow the

concerns of bereaved families and carers to be considered from the start and avoid unnecessary distress for the bereaved that can result from unanswered questions about the certified cause of death or from unexpected delays when registering a death. All deaths going forward will, therefore, be reviewed either by the medical examiner or the coroner.

Mental health services and preventing detention

35. 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.

37. The Government should resource policy development looking into alternatives to detention, and prevention of crisis.

74. There should be better access to long-term support for everyone to keep them well and prevent admission.

We accept these recommendations. Since the Review was published, the NHS Long Term Plan has set out an ambitious agenda to transform mental health care in the community. This will see an expansion in mental health services for people with severe mental illnesses, to support them to maintain their independence for as long as possible. We want to shift the focus from reactive care to prevention and early intervention in the community. This is crucial to delivering on the principle of least restriction and preventing avoidable detentions under the Mental Health Act. Where an urgent response is needed, this should be provided by enhanced crisis teams, which the NHS is now working to put on a 24/7 footing. In response to the COVID-19 pandemic, the ambition to have 24/7 publicly available phone lines for urgent mental health support was brought forward to May 2020. The wider objective remains that by 2023/24, the whole country will have crisis care support available at all times of the day and night, for people of all ages, fully accessible via NHS 111.

36. Research should be carried out into service models and clinical/social interventions that affect rates of detention.

We accept this recommendation and in December 2019, the National Institute for Health Research launched an open call for evidence, which takes forward this recommendation. The application process took place earlier last year. Proposals have been reviewed and an announcement on those projects that will be funded under this programme will be made in due course.

38. There needs to be a concerted, cross-organisation, drive to tackle the culture of risk aversion. This will need to include the Chief Coroner, CQC, NHSE, NHSI,

ADASS, LGA, patients, carers and provider boards, to understand the cultural drivers behind their different conceptualisations of risk and how they can be harmonised.

We agree with the principle of this recommendation.

The main driver of reform in this area will be our proposals to clarify and strengthen the detention criteria to make more explicit how serious the harm must be to justify detention and/or treatment, or how likely it is that the harm will occur. If there is a culture of risk aversion as the Review argued, these changes would do much to address it. For example, requiring that the risk of harm posed by the individual is also evidenced and recorded, will encourage professionals to focus on more than the individual's presenting behaviour and their perceived likelihood and severity of the harm.

On the matter of a wider cross-agency review of how different sectors consider risk, we agree that it is important that this should happen, and we will undertake further work to develop the appropriate mechanism and consider further which agencies or officials might be involved. This would, however, only involve the Chief Coroner if the discussions were around deaths in mental health detention.

Criteria for detention

39. People should be treated as an inpatient with consent wherever possible. In order to give the informal admission more prominence section 131 of the MHA should be moved so that it sits above sections 2 and 3 of the Act.

We agree with this recommendation in principle, and we will seek to take this forward as we bring forward a Bill to amend the Act.

40. A patient's capacity to consent to their admission must always be assessed and recorded, including on the application form.

The Government accepts this recommendation. The Code of Practice already states that practitioners "need to be familiar with the principles and main provisions of the Mental Capacity Act to understand when a person may lack capacity to make a particular decision". We will revise the relevant statutory forms so that a patient's capacity to consent to their admission must always be assessed and recorded at the admission stage.

42. Detention criteria concerning treatment and risk should be strengthened to require that:

- a. Treatment is available which would benefit the patient, and not just serve public protection, which cannot be delivered without detention; and**

- b. There is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person without treatment.**

We accept the Review's recommendation to strengthen and clarify the detention criteria. We will seek to make legislative changes that clarify the reasons for detention, ensure that detention only occurs when it is absolutely appropriate, and to influence decisions so that people receive care in the least restrictive way possible, as well as to make a clear requirement that a therapeutic benefit is needed to justify detention.

However, we also need to ensure that any changes to the detention criteria do not make them so stringent that people who need the protection of the Act can no longer be legally detained. We are therefore consulting on these proposals.

Statutory Care and Treatment Plans

43. Detention should require a comprehensive statutory Care and Treatment Plan (CTP) to be in place within 7 days and reviewed at 14 days. This should set out:

- a) The full range of treatment and support available to the patient from health and care organisations;**
- b) Any care which could be delivered without compulsory treatment;**
- c) Why the compulsory elements are needed;**
- d) What is the least restrictive way in which the care could be delivered;**
- e) Any areas of unmet need (medical and social);**
- f) Planning for discharge (including a link to the Statutory Care Plan recommended in the Care Planning and Aftercare chapter);**
- g) How specifically the current and past wishes of the patient (and family carers, where appropriate) have informed the plan;**
- h) Any known cultural needs.**

73. 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.

We accept these recommendations. When a patient is detained, we agree that their Statutory Care and Treatment Plan should be in place by day 7 and reviewed by day 14.

We agree with the proposals put forward by the Review for the contents of the Care and Treatment Plan, and we are consulting on whether anything else should be included.

Better discharge planning is critical to ensuring people are not detained for any longer than is necessary and are supported to settle back into the community. Planning for discharge and estimated discharge dates will both be required elements of statutory Care and Treatment Plans as will ensuring that their rights under the Care Act are assessed.

Length of detention

44. The Code of Practice should be amended so that, where a person has been subject to detention under section 3 within the last twelve months, an application for detention under section 2 can only be made where there has been a material change in the person's circumstances.

45. The Code of Practice should make it clear that section 3, rather than a section 2, should be used when a person has been already subject to section 2 within the last twelve months.

We agree with the objectives of this recommendation, however, the Code of Practice already states that section 3 should be used in cases where “the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment as an informal patient are already sufficiently established to make it unnecessary to undertake a new assessment under section 2”.

The Government will review the Code of Practice in full in due course and will seek to further clarify these requirements.

46. The detention stages and timelines should be reformed so that they are less restrictive through:

- a) Introducing a requirement for a second clinical opinion at 14 days of a section 2 admission for assessment;**
- b) Extending the right of appeal for section 2 beyond the first 14 days;**
- c) Reducing the initial maximum detention period under section 3 so that there are three detention periods in the first year of 3 months, 3 months and 6 months;**
- d) Introducing a new time limit by which a bed must be found following an order for detention;**

e) Requiring the responsible clinician and the Approved Mental Health Professional (AMHP) to certify 10 days in advance of a Tribunal hearing for section 3 that the patient continues to meet the criteria for detention.

We accept these recommendations and we have set out our intention to reform the process for detention and give patients better support to challenge detention. Increasing the scrutiny of detention is a critical element of this reform agenda.

We will make Care and Treatment Plans a statutory requirement of detention. The Plan will be subject to internal scrutiny and approval by the Medical or Clinical Director or equivalent within the first 14 days of detention. For patients detained for assessment under section 2 of the Act, the Care and Treatment Plan will understandably be less clearly developed at the 7-day and 14-day stages, but we propose that it should be complete enough to inform decisions on whether to detain the person further or to discharge.

We agree that the right to appeal for section 2 patients should be extended to within the first 21 days, to give the patient greater opportunity to appeal the decision for detention and to ensure that there is sufficient time for the hearing to be listed and conducted before the section expires. The Tribunal Procedure Committee (TPC) commenced a consultation on 11 February 2020 on revising the time limit in which a tribunal must be held after receiving an application. Feedback in response to this will be taken into account as part of our response to this recommendation.

Since the commencement of the TPC consultation the country has entered a period of lock down due to the coronavirus pandemic. As a result, the TPC made emergency changes to the Tribunal Procedure Rules on a temporary basis by the Tribunal Procedure (Coronavirus)(Amendment) Rules 2020, to allow cases to be dealt with across all jurisdictions during the pandemic. The amendments included, by paragraph 2(5), the change to rule 37 of the Health, Education and Social Care Rules 2008 proposed in the TPC consultation following a ministerial direction, and an extension of the timeframe for starting the hearing of an appeal under Section 66(1) (a) of the Mental Health Act 1983 in the First-tier Tribunal from 7 to 10 calendar days, with the option of extending the time limit further if 10 calendar days is still not practicable.

The TPC considers it appropriate to delay making a decision on a permanent change so that the effects of temporary changes introduced during the COVID-19 pandemic can be monitored and the results assessed before it makes a final decision. Accordingly, the TPC will return to this matter in due course. We will increase the requirements for scrutiny of detention for patients under section 3, in line with 46c. This will mean that the patient's case for detention will be more regularly subject to scrutiny by the Responsible Clinician and other decision makers. The patient will also have an additional opportunity to access the Tribunal, as this can be exercised once in each detention period.

We agree that detention should be certified ahead of a Tribunal, and we will be introducing the requirement that certification is provided to show that the patient continues to meet the detention criteria 10 days in advance of a Tribunal hearing, but we think that the Responsible Clinician alone should do this, rather than it also being an additional duty for AMHPs. This is because the Responsible Clinician is already required to make the case to the tribunal that the detention criteria continue to be met as part of the Tribunal process. We do not think it is necessary to make this a duty of the AMHP as well as we are concerned that to do so might delay the patient's access to the Tribunal.

We agree in principle with the recommendations to limit the delay between assessment and finding a bed. However, the NHS plans to go beyond the recommendation to introduce a time limit by which a bed must be found and will introduce appropriate access and waiting time standards for urgent and emergency mental health care.

Field testing of access and waiting time standards for urgent and emergency mental health care with 11 sites as part of the clinical review of standards began in October 2019, with much of the work paused by COVID-19. Standards for people with mental health needs in A&E are expected to be included in any new roll out of new A&E access standards. Testing and engagement on new access standards for community crisis services will continue through 2020/21, with an intention to carry out sector engagement on potential new standards during 2021/22.

The NHS Mental Health Implementation Plan 2019/20 – 2023/24 states that all local areas have a workplan and trajectories in place to reduce Out of Area Placements, which will deliver improvements to local systems/bed capacity management. To support sustainable local capacity management beyond 2020/21 and ensure that acute mental health care remains therapeutic and purposeful from the outset, new funding has been secured to increase the level and mix of staff on acute inpatient wards.

Challenging detention

47. 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.

We accept in principle the Review's recommendation that the Tribunal should be able to grant leave from hospital or direct a transfer to a different hospital when considering a patient's case and we will seek to ensure that this is given effect in the legislation.

Furthermore, in line with the Review's recommendation, we want to reflect in legislation that this is not a new appeal right but extends the Tribunal's powers, when considering a patient's discharge under their existing rights of appeal.

However, we understand that it may not be possible for health and Local Authorities to give effect to the Tribunal's direction in relation to provision of services in the community. We therefore intend to reflect in legislation that there is an obligation on authorities to take all reasonable steps to follow such a direction and to provide an explanation to the Tribunal if they are unable to do so. We propose that healthcare bodies and Local Authorities should be given a period of 5 weeks to do this.

48. Where the Tribunal believes that conditions of a patient's detention breaches the Human Rights Act 1998 they should bring this to the attention of the CQC (or HIW in Wales).

We agree in principle with this recommendation. There is already a process that outlines how a Tribunal judge who believes that the conditions of a patient's detention breach the Human Rights Act 1998 should bring this information to the attention of the CQC (or HIW in Wales). This guidance, published on the judicial intranet, is currently being reviewed by the judiciary. Tribunal medical members are also duty bound by [the General Medical Council's 'Good Medical Practice' guidance](#)^[29] to "take prompt action" if they believe that a patient's safety, dignity or comfort is being compromised.

49. The Tribunal should be given performance information by their local providers.

We do not accept the recommendation that the Tribunal should be provided with performance information about the performance of their local providers.

The Tribunal already receives an extensive documentation to inform their decision making. Whilst the information provided will vary on a case by case basis, in all cases the Tribunal will receive a statement of information about the patient, [the Responsible Clinician's report and the Social Circumstances report](#).^[30]

We do not consider that receiving general performance information would assist the Tribunal in carrying out its legal function in considering whether or not an individual patient meets the statutory criteria for detention or in considering whether appropriate treatment is available for the patient.

50. A statutory power should be introduced for IMHAs and Nominated Persons to apply for discharge to the Tribunal on behalf of the patient.

We accept this recommendation and will introduce a new statutory power for Independent Mental Health Advocates (IMHAs) to exercise a patient's right to apply on their behalf. This would be in addition to the powers currently held by a patient's Nearest Relative, which we intend will transfer to the new Nominated Person role.

51. A power should be introduced for SOADS and the CQC to refer a patient to the tribunal following a change in circumstances. This would expand, but not replace the current powers of the Health Secretary under section 67 of the Act.

We agree that SOADS should be able to refer patients to the Tribunal. We believe that the current powers under section 67 are sufficient to allow SOADS and CQC to do this, by application to the Secretary of State for Health and Social Care.

52. There should be an automatic referral to the tribunal 4 months after the detention started, 12 months after the detention started, and annually after that.

53. For part III patients, automatic referrals should take place once every 12 months.

We agree with the Review's recommendations that raising the frequency of automatic referrals would help further ensure that patients have their case heard. We plan to put in place the necessary legal framework to allow the time periods for automatic referrals to change, by introducing a power in the Act to do so.

However, this policy, when considered alongside the increased right to apply to the Tribunal for patients detained under section 3, and the expansion of Tribunal's function to considering treatment challenges and cases relating to the NP, will place significant additional strain on the Tribunal. Making too many requirements on the system at once could lead to delays and long waits to have appeals heard, which risks reducing patients access to the Tribunal, rather than increasing it. Prior to making changes to automatic referrals, we therefore need to ensure that the new timeframes for automatic referral proposed by the Review are appropriate and ensure there is sufficient capacity in the system to take them forward. We therefore wish to consult on whether the timeframes proposed by the Review are appropriate.

Deprivation of liberty: MCA or MHA?

39. In order to be detained under the MHA, the patient must be objecting to admission or treatment. Otherwise they should be admitted informally or (as set out further under 'Deprivation of Liberty: MCA or MHA?') be made subject to an authorisation under the framework provided for under the MCA.

54. 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.

The Government agrees with the Review, which stated that the complexities involved in making such a change mean that “The Government will need to consider the practical implications of the new dividing line between the MCA and MHA, including testing guidance for the Code of Practice, perhaps in pilot areas”. The Review also stated that the new LPS arrangements will need “time to bed down” before such a change is introduced. The Government agrees on both these counts. This will need to be considered within primary legislation and alongside the implementation of LPS. We will therefore begin this process through consultation to ascertain views on the best way to proceed. Above all, we are committed to reviewing the powers and safeguards available to make sure that in future the interface is clearer and that people who may be subject to either the LPS or the MHA receive care under the legal provisions that best help to support them and serve their needs.

55. 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.

We agree that emergency powers are needed, and particularly in accident and emergency departments. We are consulting on which would be the most suitable legal route to achieve this – either section 4B of the Mental Capacity Act, as recommended by the Review, or section 5 of the Mental Health Act.

The Review recommended in particular that, because there is no time limit specified under the amended section 4B, that the Department of Health and Social Care place a 72-hour limit in the MCA, which was being amended by Parliament at the time of publication. In the event, this change was not made, but section 4B is available for use when circumstances demand it.

56. Amendments to the MCA, the Codes of Practice, and relevant procedures before the Court of Protection and Tribunal should be made to clarify the position in relation to those in the community subject to both the MCA and the MHA. Dual authorisation under s.17 MHA and DoLS/LPS should not be required.

We agree with the aims of this recommendation to clarify the procedures of the Court of Protection and the Tribunal, but significant work is required to address operational issues. A working group will be established to consider the possibility of cross-ticketing judges to determine issues under both the MHA and DoLS/ LPS regime, where a person is in the community and subject to both the MCA and MHA. We agree also that dual authorisation under section 17 of the Act and DoLS/LPS should not be needed and will clarify in the Code of Practice that this should be the expected approach.

Community Treatment Orders

57. The criteria for Community Treatment Orders (CTOs) should be revised in line with detention criteria.

58. The onus should be on the responsible clinician to demonstrate that a CTO is a reasonable and necessary requirement to maintain engagement with services and protect the safety of the patient and others. The evidence threshold should be raised for demonstrating that contact with services has previously declined, and that this led to significant decline in mental health.

59. Applications for a CTO should be made by the inpatient responsible clinician, with the community supervising clinician who will be responsible following discharge, and an Approved Mental Health Professional (AMHP).

We accept these recommendations and will revise the criteria for using CTOs so that they reflect the proposed amended criteria for section 3 detentions around risk and therapeutic benefit. We will also seek to amend the legislation to require that, in order to subject an individual to a CTO, the Responsible Clinician must provide evidence that the CTO will be of benefit to the individual, based on a consideration of the patient's previous engagement with their treatment plan in the community. We agree also that the initial decision to make a CTO should be the role of a greater number of professionals - the Responsible Clinician, an AMHP and the community supervising clinician.

We think that these changes will ensure that CTOs are used in a more targeted way and only when patients are likely to genuinely benefit from the structure they provide to help support continued engagement with mental health services.

60. The Nominated Person/ Interim Nominated Person will have the power to object to both applications and renewals of CTOs.

We agree with the recommendation that, as well as being consulted on the use of the CTOS, the Nominated Person or Interim Nominated Person should have the power to object to their use on behalf of the patient. We are consulting on this and the other proposed additional powers of the Nominated Person or/ Interim Nominated Person.

61. CTOs should have an initial period of 6 months, renewed at 6 months and then 12 months. Each renewal must involve two approved clinicians and an AMHP, unless the tribunal has recently reviewed the order.

62. CTOs should end after 24 months, though the responsible clinician should be able to make a new application.

We agree with these recommendations. As is the case today, a CTO will be reviewed six months after it is made and will then be extendable for a further period of six months, and after that point for a further period of 12 months.

In line with the Review's recommendations, more professionals will be involved in decisions to extend a CTO – currently this is just a matter for the Responsible Clinician, but we will seek to legislate so that an AMHP and the patient's community supervising clinician must also agree. Although, if the Tribunal has recently considered a patient's CTO just the AMHP and the patient's community supervising clinician will be required to renew.

We agree with the Review that CTOs can last far too long, therefore we want to introduce the expectation that CTOs should usually end after a period of 24 months, and at that point the patient should be discharged unless they have relapsed or deteriorated during that time. We will initially set this out in the Code of Practice and if we continue to see that people are subject to CTOs for extensive periods, we will consider reflecting this in legislation.

63. As well as considering discharge, the Tribunal should, when refusing to discharge from the CTO, be able to order changes to the conditions of a CTO.

We do not agree it would be appropriate for the tribunal to order changes to the conditions of a CTO. Ordering changes to a CTO could lead to the Tribunal getting too involved in the details of a patient's treatment plan, without the history and required expertise of the patient's clinical team. However, we do think the Tribunal has a role to play in checking that any condition attached to a patient's CTO is the least restrictive option available to the patient, which we intend to reflect in legislation.

64. If no appeal is made to the Tribunal in each time period there will be an automatic referral.

As above, we agree that raising the frequency of automatic referrals would help further ensure that patients have their case heard. We plan to put in place the necessary legal framework to allow the time periods for automatic referrals to change, by introducing a power in the Act to do so.

However, this policy alongside the increased right to apply to the Tribunal for patients detained under section 3, and the expansion of Tribunal's function to considering

treatment challenges and cases relating to the NP, will place significant additional strain on the Tribunal. Making too many requirements on the system at once could lead to delays and long waits to have appeals heard, which risks reducing patients access to the Tribunal, rather than increasing it.

Prior to making changes to automatic referrals, we therefore need to ensure that the new timeframes for automatic referral proposed by the Review are appropriate and ensure there is sufficient capacity in the system to take them forward. We therefore wish to consult on if the timeframes proposed by the Review are appropriate.

The Review, in an unnumbered recommendation, said that patients should be able to 'opt out' of their case being automatically referred to the Tribunal, to prevent patients having to go through the tribunal process if they do not feel ready to be discharged. While we can see the value of introducing an opt-out model, we are concerned that an opt-out model could conflict with Article 5 of the European Convention on Human Rights, which requires that a system is in place to enable a person or someone on their behalf to access a court for a review of their detention even if they do not object to their detention. For patients who do not want to engage with the Tribunal proceedings, perhaps because they might find the process distressing, they are not obliged to do so. We therefore do not intend to take forward this recommendation.

65. The recall criteria should be updated and the process should be reformed to make it simpler.

66. Recall to alternative locations should be considered.

We accept these recommendations. We will seek to revise the criteria for recalling service users on CTOs to reflect our wider changes around detention criteria, so that recall will only be possible when it is needed because there is otherwise a substantial risk of significant harm.

The revised detention criteria would draw on changes to section 3 on which we are consulting.

We agree with the Review that the process for recalling service users to hospital must be updated to make it more efficient, transparent and to ensure that this important decision receives appropriate consideration.

We agree that the legislation should broaden the appropriate locations that a patient can be recalled to, in such cases where treatment in a hospital is not needed. Currently, the legislation requires the patient to be recalled to a hospital if they need medical treatment in a hospital setting and if the Responsible Clinician finds that they have not complied with the conditions of their CTO. We think that when the patient does not require hospital

treatment, the location should not be limited to a hospital and should be at the discretion of the Responsible Clinician.

67. Independent Mental Health Advocate services should be commissioned specifically for people on CTOs that requires providers to proactively approach the patient and offer their services.

We agree in principle with this recommendation, and statutory eligibility for IMHAs already extends to patients on CTOs. However, to ensure that the appeals process can be fairly accessed by all and that patients have the opportunity to exercise their rights, we wish to explore the viability of IMHA services being proactively offered to service users with CTOs.

68. The effect of recommendations on CTOs should be reviewed in no more than five years' time, with a view to abolish CTOs if outcomes are not improved.

We agree with the need to make reforms to CTOs and to review progress. We will seek to make the reforms recommended by the Review and to monitor their effects over an initial five year period. We will further review and update Government policy on the use of CTOs in line with the emerging evidence.

Inpatient settings and ward environment

69. Wards should not use coercive behavioural systems and restrictions to achieve behavioural compliance from patients, but should develop, implement and monitor alternatives.

70. Providers should take urgent action to end unjustified use of 'blanket' restrictions applied to all patients.

We accept both of these recommendations. There is a significant cross-Arm's Length Body (ALB) programme of work aimed at reducing restrictive interventions within all NHS commissioned mental health, learning disability and autism services. The programme has been underpinned by three workstreams, which together go some way to addressing the Review's recommendations regarding the reduction of coercive behavioural systems and restrictions. While NHS England and NHS Improvement provided the overarching leadership to this programme, the CQC, HEE and Royal College of Psychiatrists were all key players in delivering the individual workstreams, set out below along with progress made to date:

Data definitions and recording - led by NHSEI, the CQC and NHS Digital – which delivered a national set of definitions for restrictive practices and required mandated reporting through the Mental Health Services Data Set (MHSDS) from 2019.

- Work continues to improve the data quality of Provider submissions. Revised definitions and new data items have been implemented in Version 4 of the Mental Health Service Data Set (MHSDS) to ensure there is a clear and consistent approach to measuring use of restraint and key related information. Further additions to the data set are expected in Version 5 from October 2021. This will bring reporting in line with the requirements of the Use of Force Act 2018 which include statutory obligations for providers to collect and submit data about their use of restrictive interventions; ensure their staff receive certified training in the use of restrictive interventions; and develop, publish and review a Restrictive Interventions Reduction Programme. Findings from the data collection will inform the next phase of work to reduce restrictive practice.

Training and Accreditation - all training providers, commissioned by the NHS to deliver training on use of restraint to mental health and learning disability services, are required to be certified in line with standards developed by the [Restraint Reduction Network](#)^[31]. These standards have been developed to ensure training promotes human rights and supports necessary cultural change to reduce reliance on restrictive practices, ensuring focus is not purely on technical skills.

Certification of training suppliers commenced in April 2020 with an accredited certification route for Training Providers established with the United Kingdom Accreditation Service (UKAS). Work is ongoing to ensure the new training requirements are embedded in future iterations of the NHS Standard Contract, meaning that from April 2021 all providers will be expected to roll out certified training to all staff. Compliance will also be included in CQC regulation.

Quality Improvement Offer - The Reducing Restrictive Practice (RRP) collaborative, established in October 2018 by NHS Improvement in partnership with CQC, as part of a wider Mental Health Safety Improvement Programme (MHSIP), aimed to reduce restrictive practice (measured by number of restraints, seclusions and rapid tranquilisations) in the participating wards. This was delivered through collaboration with experts and experts by experience; the development of tools and resources; testing approaches to deliver trauma informed care; and supporting wards to develop and carry out their own quality improvement plan. 38 wards in hospitals across the country became involved in the collaborative. Each ward had its own QI coach, supported by bimonthly learning sets, with access to specifically designed support materials. Over an 18-month period, there was a 15% reduction in the overall use of restrictive. [The collaborative recently published a resource booklet](#)^[32], detailing learning to date on reducing the use of restrictive practices.

The Cross ALB programme is now reviewing the plans for national workstreams and developing a refreshed plan of action for 2020-2022. The CQC has recently published a [report](#)^[33] detailing its findings into a thematic review of restraint, seclusion and long-term

segregation. DHSC, NHSE, providers and CQC are developing responses to the recommendations made following this review.

In addition to the specific work underway to reduce restrictive practice, the NHS Long Term Plan also made a funded commitment to improve the therapeutic offer from inpatient mental health settings. Underpinning this commitment is new investment in interventions and activities in hospital, through increased access to multi-disciplinary staff groups such as peer support workers, psychologists, occupational therapists and other Allied Healthcare Professionals throughout an inpatient admission. New funding for this was first made available from March 2020 and will continue to increase until 2023/24. This process will take the interface with the existing Restrictive Interventions Programme into account and identify how improving the therapeutic offer in hospital can contribute to further to reducing coercive behavioural systems and restrictions.

NHSEI will also lead additional scoping with ALB colleagues to identify if further work is required and with which national body this would best sit. This will specifically consider further actions to support ending the use of blanket restrictions by providers, which would build on the existing expectations set out in the Act's Code of Practice, that blanket or global restrictions in particular settings should be avoided without very clear justification. There may also be a need to strengthen the existing text on restrictions within the Code of Practice and the CQC's role in monitoring its implementation.

Care planning/aftercare

71. There should be a Statutory Care Plan (SCP) for people in contact with CMHTs, inpatient care and/or social care services.

The NHS has held a longstanding ambition to support and treat people in the right place, at the right time, shifting more care from acute settings into the community and people's homes. In practice, this means shifting from reactive care towards a focus on prevention, services in place based around early intervention and support in the community. Within social care, there has been a similar development and focus on personalised and strength-based care and support planning since the introduction of the Care Act in 2014.

To enable this, more planned and personalised packages of care are required that can meet the needs of individuals. High-quality care and support plans are the key to delivering this, as they enable people to set their own aims and goals, so they can secure the support and care required to achieve them.

We fundamentally agree with the Review's recommendation that all people in contact with community mental health teams, inpatient care and/or social services should have a high quality care plan that identifies their rights and needs from both health and care services. We wish to ensure that this joined-up care plan encompasses the new Statutory Care and

Treatment Plan, alongside 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). Prior to placing this on a statutory footing, further work is required to establish how we can best bring the necessary elements of the care plan together.

Currently, the majority of people already receiving a service from secondary mental health services, or receiving social care services, should already have a care and support plan in place, under the Care Programme Approach or the Care Act. Further work is required to understand the reasons why these plans can vary in both quality and frequency and to develop integrated care planning that ensures all areas are covered in one plan. Overcoming these issues will be crucial to delivering high quality care plans to all patients. There have been important developments in personalised health budgets, with a legal right to these under section 117 aftercare, designed to work alongside personal social care budgets.

We intend to explore how the existing care plans interlink to understand how any new statutory care plan could work in practice, whilst also conducting work to explore how we can ensure that quality of care planning is consistently high, with variation limited. The roll out of the community mental health framework, which supports local areas to develop new models of personalised care and support planning that incorporate the Care Act, will be an important part of this research.

We will also be exploring what further information, guidance and support we can provide to commissioners on care planning and the practicalities and implications that placing care planning on a statutory footing would have on the workforce. This work is ongoing, and we will keep this recommendation under review as this work progresses.

72. There should be a statutory duty for CCGs and Local Authorities to work together to deliver the SCPs.

77. The effectiveness of joint working arrangements should be subject to monitoring and review by the Care Quality Commission.

Strong co-operation and joint working between Local Authorities and Clinical Commissioning Groups is essential when delivering both health and social care strategic commissioning plans to meet the needs of their populations, and statutory care plans for individuals. However, we consider that these duties are already in place.

The Health and Social Care Act 2012 established that each Health and Wellbeing Board ‘must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.’ In addition, both the Health and Social Care Act 2012, and the Local Government and Public Involvement in Health Act 2007, specify that Local Authorities and respective partner CCGs have a duty, through Health and Wellbeing

Boards, to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). Statutory guidance on JSNAs and JHWSs, published in 2013, states that JSNAs ‘must assess current and future health and social care needs within the health and wellbeing board area and it is important to cover the whole population, and ensure that mental health receives equal priority to physical health’. The membership of Health and Wellbeing Boards must also include representatives of the relevant local authority and a representative of each relevant local CCG, and both must have regard to the JSNA and JHWS as part of their commissioning planning.

Given this, although we agree in principle with the recommendation to create a new statutory duty on joint-working, specifically around statutory care plans, we think this is already covered within existing duties and responsibilities.

Similarly, while we fully agree that the effectiveness of joint working arrangements should be subject to monitoring and review, we believe that this is already possible via existing mechanisms, so we do not think it is necessary to take forward this recommendation. For example, NHSEI has a duty to complete an annual assessment of CCGs, which includes assessing joint working. This is done through the NHS Oversight Framework, which replaced the CCG Improvement and Assessment Framework (IAF) and the provider Single Oversight Framework from 2019/20 and will inform assessment of CCGs going forwards. Similarly, the CQC has previously conducted a series of local system reviews, to assess how services and organisations are working together to care for certain cohorts of people and it has [recently launched Provider Collaboration Reviews](#)^[34] to identify themes and learning to help providers of local health and care systems work more effectively together.

Whilst we fundamentally agree with this recommendation, it is our view that existing mechanisms in place largely cover this. The focus of our work will therefore be on how we consolidate and strengthen the existing mechanisms in place to assess the effectiveness of joint working arrangements, while exploring further opportunities to enhance this as policy progresses.

However, there is potentially scope to strengthen these duties in the future. For example, if we legislate for integrated personal budgets, which combine social care and health funding around the bespoke needs of an individual, both Local Authorities and CCGs will have responsibilities to work together to deliver that plan and support the individual, as they currently do for personal budgets and personal health budgets. As work around these areas progresses, we will keep this recommendation under review.

75. There should be a clear statement in the new Code of Practice of the purpose and content of the SCP and section 117 aftercare.

76. There should be national guidance on how budgets and responsibilities should be shared to pay for section 117 aftercare.

We accept these recommendations. We will work in close collaboration with Local Authorities, ADASS, ADCS, NHSEI and service users to update national guidance so that there is greater clarity on how budgets and responsibilities should be shared to pay for section 117 aftercare. We will also develop a clear statement in the new Code of Practice of the purpose and content of section 117 aftercare.

Hospital managers

78. The managers of the hospital should continue to have the duty to scrutinise applications for detention, and should have a duty to scrutinise renewal documents.

81. The managers of the hospital (those who actually manage the hospital) should continue to have the power to discharge a patient where fundamental errors have been made in either the admission or renewal paperwork.

We accept these recommendations. We agree that hospital managers should continue to scrutinise applications for detention and retain their duty to scrutinise renewal documents. They should also continue to exercise the power to discharge a patient where there are fundamental errors in the admission or renewal paperwork.

79. The power of associate hospital managers to order discharge following a hearing should be removed.

Although we agree with the Review that removal of this right would be compensated for by improving the patient's access to the Tribunal, we have heard differing views from stakeholders on the effectiveness of Associate Hospital Manager hearings. We therefore wish to consult on whether we should remove the power of Associate Hospital Managers to discharge patients from detention or from a CTO as part of managers' panel hearings.

80. The Government and the CQC should consider developing a new independent 'Hospital Visitors' role, the main purpose of which is to monitor day-to-day life in the hospital and ensure that patients are treated with dignity and respect.

We agree with the objective of this recommendation. Instead of creating a new 'Hospital Visitors' role, we wish to look to existing organisations to provide this additional scrutiny.

There are already several established roles which have a duty to monitor services and to support individuals when detained or on a ward. These include IMHAs, peer support workers, CQC's Mental Health Act reviewers and complaints teams.

We are currently considering how to involve the CQC, patients, carers and providers in the next steps we will take to achieve the aims of this recommendation.

Inpatient social environments

82. 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 and this should be reflected in ratings and enforcement decisions.

The Government accepts this recommendation. The CQC is undertaking a programme of work to improve how it assesses the quality (including safety) of inpatient wards. Key topics include ensuring wards are high-quality, safe environments which support recovery, and which are well-led and promote a culture of engagement and co-production.

The CQC has committed to changing its methodology, updating internal guidance and inspection assessment frameworks so that its inspectors focus on the quality of ward social environments, and assess whether wards are therapeutic environments which promote recovery. Further, the CQC is reviewing how it assesses all wards in mental health and learning disability services, informed by its own findings on the quality of inpatient care, as well as the ambitions of the Long Term Plan and the recommendations of the Review.

Work will continue with the MH Directors of Nursing forum to communicate changes in guidance and processes to the mental health hospitals sector.

This work, along with the CQC's findings about the quality (including safety) of mental health wards, are intended to be a prominent part of the improvement plan agreed with NHS Mental Health trusts that participate in the Mental Health Safety Improvement Programme led by NHSEI.

83. Patients should have a daily one-to-one session with permanent staff in line with NICE guidelines.

The Government agrees with this recommendation. NHSEI acknowledges that daily one-to-one contact with staff is an important part of therapeutic care whilst in hospital.

Delivery of this recommendation will be supported by NHSEI's Long Term Plan commitment to improve the therapeutic offer of acute inpatient care. To support these improvements in inpatient care, new funding has been secured to increase the level and mix of staff on acute inpatient wards. Increased access to multi-disciplinary staff groups such as peer support workers, psychologists, occupational therapists and other Allied Healthcare Professionals throughout an inpatient admission, will be key to ensuring everyone receives at least daily one-to-one support from ward staff. The commitment is supported by a funding commitment of £46 million by 2023/24.

However, in line with the wording of the Review's original report and recognising that clinical teams usually comprise a mixture of permanent and locum staff, contact should not be limited to permanent staff only.

Inpatient physical environments

84. The physical environment of wards needs to be improved, through co-design and coproduction with people of relevant lived experience, to maximise homeliness and therapeutic benefit and minimise institutionalisation.

85. The prompts and guidelines currently used for inspections in the assessment frameworks specific to mental health inpatient care should be reviewed with input from patients and their carers.

87. 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 Government agrees with the Review's findings that the physical ward environment needs to improve in some local areas.

We will improve the physical environment of hospitals, making them far better places to stay and to work within, and will increase the quality of inpatient care and to nurture a positive staff culture.

The CQC is reviewing how it assesses all wards in mental health and learning disability services. It is focusing on the assessment of areas including the physical fabric and layout of wards, the safety of fixtures and fittings and the provision of same-sex accommodation and single bedrooms with an en suite bathroom. CQC will expect Trust boards to be aware of the quality of the inpatient estate and to have taken action to obtain funding for improvements. The NHS recognises the importance of co-design and co-production with people of relevant lived experience. This is emphasised in existing guidance on Adult Acute Mental Health Units. This guidance states that the planning of new in-patient mental health services should consider the needs of all relevant stakeholders and that the needs of each group of stakeholders should be identified at an early stage during service planning. Service users in existing services, particularly those who may be transferring into a new service building, should have an early and continuing opportunity to contribute to the new service design and participate in the planning process. Trusts using national capital and non-foundation Trusts are required to follow Health Building Notices (HBNs) or explain why they have moved away from this guidance. The CQC use HBNs as the basis for their Key Lines of Enquiry when assessing Trusts and expect adherence to them.

Subject to funding, we will explore whether a review of the guidelines could be undertaken. The basis for this review will be informed by the co-production approach established by the Sexual Safety Collaborative, work led by Royal College of Psychiatrists, the CQC, and NHSEI.

86. 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.

We accept this recommendation. Ward culture is a vital consideration of how to achieve therapeutic social environments that help people get well. Risk assessments should consider unintended psychosocial effects.

The COVID-19 pandemic has however shown the vital importance of getting infection control right on wards. The safety and the lives of patients must always be the paramount concern of all health services.

88. The backlog of maintenance and repairs needs to be addressed so that mental health facilities are brought up to standard.

89. 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.

90. All existing dormitory accommodation should be updated without delay to allow patients the privacy of their own room.

91. The definition of single sex accommodation should be tightened up to ensure a genuinely single sex environment with separate access to any shared daytime space.

We agree with these recommendations. The need to improve the physical ward environment has been echoed in the NHS Long Term Plan and the Government has responded with a major programme of new investment in psychiatric hospitals. This is a major contribution to our commitment to pursue the most ambitious transformation of mental health care England has ever known.

We have already taken steps to introduce significant new investment to transform the mental health estate so that inpatients can have the privacy and dignity of their own rooms. We are investing over £400 million to rid the estate of dormitory provision and will look to replace 1,200 dormitory beds with new en suite single rooms for patients.

We will build new mental health hospitals. Two new two schemes were approved in October 2020, one in St Ann's in Poole, Dorset, and another in Northgate in Morpeth,

Northumberland. There will be more announced in the future. The Government has announced investment of over £400 million in improving mental health estate since July 2017, and as set out in the Health infrastructure Plan on 30 September 2019, the Government is committed to making further strategic investments to modernise mental health facilities.

Examples of funded projects include:

- £72.3 million for Greater Manchester Mental Health NHS Foundation Trust to develop a new adult mental health inpatient unit.
- £33 million to Mersey Care NHS Foundation Trust for a 40-bed low secure unit for people with learning disabilities.

Both were included in the £850 million capital funding for 20 hospital upgrades announced by the Prime Minister in August 2019.

The Government will also tackle the maintenance work that the estate needs.

NHSEI will work with stakeholders from across the sector, including experts by experience, to review whether the guidance and data collection on mixed sex accommodation is adequate for mental health settings. This process will enable us to determine whether the existing guidance needs to be revised, better communicated or measured differently.

Person centred care

93. Reasonable adjustments should be made to enable people to participate fully in their care, including in relation to communication abilities.

95. The CQC should pay particular regard to obtaining patient (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, children and young people.

We accept this recommendation and [the CQC already focuses on this area under its caring domain](#).^[35]

The CQC also looks at the empowerment and involvement principle in detail on their monitoring visits. Over the next year the CQC will be working with people who use services, families, providers, frontline staff and other stakeholders on improving the way that they regulate services where there is a closed culture, or high risk of this developing. This will include making reasonable adjustments for people with communication difficulties.

In addition to the commitments in this White Paper to improve care and treatment, as part of the CQC's work on closed cultures, over the next year it will be working with people who use services, families, providers, frontline staff and other stakeholders to improve the way that they regulate services where there is a closed culture, or a high risk of a closed culture developing.

The [CQC's Equality Objective 2](#)^[36] sets out the importance of accessible information and communication.

The CQC is also working to establish ways to strengthen the involvement of patients and carers in inspection assessment frameworks. This includes their inspection and Mental Health Act monitoring methodology.

We are considering the following options for strengthening this and to inform a new coproduction strategy for the Act:

- Greater involvement and scoping new roles for service users and carers in Act monitoring and inspection processes.
- New roles for Experts by Experience to monitor services outside of inspections, by using local community groups to feed information back on local health and care services.
- Inviting patients and carers to be members of the CQC's internal governance activities to shape our assessment frameworks
- Expanding current digital methods to engage with service users and carers more frequently.

The CQC renewed their Experts by Experience contract in April 2020 which has increased flexibility and scope to use Experts by Experience in inspections, Mental Health Act monitoring visits and in methodology development. The CQC continues to work with their Experts by Experience team to consider how to improve the use of Experts by Experience in their work.

94. A patient's physical health should be monitored, so that physical illness and conditions (e.g. diabetes and asthma) can be identified and treated.

We accept this recommendation. As part of the NHS Long Term Plan, the NHS has committed to ensuring that 390,000 people with severe mental illness receive a comprehensive physical health check and follow-up intervention annually in line with NICE guidance. CCGs have increased baseline funding over the course of the NHS Long Term Plan to support systems to commission physical health checks and follow up intervention

services which span primary and secondary care and the voluntary, community and social enterprise (VCSE) sector where relevant.

Following the success of the secondary care CQUIN (Commissioning for Quality and Innovation framework) in 2014/15 which incentivised the completion of comprehensive assessment and follow-up interventions in line with the Lester Tool, the requirement to deliver physical health monitoring is now included in the NHS Standard Contract, which states, “The provider must monitor the cardiovascular and metabolic health of Service Users with severe mental illness, in accordance with: NICE clinical guidance CG178 and the Lester Tool and if a need for further treatment or care is indicated, take appropriate action in accordance with Service Condition 8”.

Recognition of patient individuality at the Tribunal

96. Training should be developed for panel members in specialisms including children and young people, forensic, learning disability, autism, and older people.

We accept this recommendation in principle. The individual needs of the patient should be recognised. Training is currently available to tribunal panel members in a number of specialist areas: autism, risk (including forensic risk), and mental health services for children and young people. From 2020 there will be on training on LGBT issues relevant to the tribunal.

Over the next three years, the mandatory training for all judicial office holders will also include modules relating to transcultural psychiatry and the specific issues arising from mental disorders in older people. Any decisions relating to this recommendation are for the judiciary to take forward, through the Judicial College, which is responsible for setting and developing the training for panel members.

97. Statistics should be collected on the protected characteristics of those applying for a Tribunal hearing, and their discharge rates.

We accept this recommendation in principle and it is already being considered as part of the wider HMCTS Reform Program.

HMCTS have committed to collect data on the protected characteristics of people accessing reformed services. This will support the evaluation of reform and help HMCTS meet the public sector equality duty. Work to enable the collection of this data is underway and is taking place in consultation with the Office for National Statistics and other Government departments such as the Race Disparity Unit and Government Equalities Office.

The experiences of people from ethnic minority communities

98. An Organisational Competence Framework and Patient and Carer (Service User) Experience Tool should be implemented across health and care services. This should build upon ongoing work by NHS England to develop the Patient and Carer Race Equality Framework (PCREF).

We accept this recommendation. The Government set out our commitment to introduce a new Patient and Carer Race Equality Framework (PCREF) in summer 2019. This will support NHS mental healthcare providers to work with their local communities to improve the ways in which patients access and experience treatment. Key to this is monitoring data on equality at board level to facilitate appropriate action.

The PCREF is under development and is being co-produced as a tool to facilitate culture-change within mental health services. Patients, carers and front-line staff will be instrumental in shaping the PCREF to ensure it can be applied across a number of mental healthcare settings, and supports measurable improvements in black, Asian and minority ethnic patient and carer experience.

The PCREF is expected to identify core competencies for culturally aware services and opportunities to advance them. At a local level it will also support services to engage with people from black, Asian and minority ethnic backgrounds to identify which competencies should be prioritised, and whether there are additional localised competencies local services wish to develop and measure.

NHSEI has mobilised a steering group consisting of experts by experience and Trust representatives to develop the PCREF. Engagement with patients, carers, NHS staff and other stakeholders will continue into 2021 to ensure the PCREF supports improvements in care. Ahead of national roll-out, and in line with the recommendations of the Review, the PCREF will be tested in different mental health services and settings to ensure the final framework delivers the results we should rightly expect.

92. The CQC should review and update their inspection and monitoring of individual treatment and care to provide assurance that it meets the needs of people in different equality groups.

99. Regulatory bodies such as the CQC should use their powers to support improvement in equality of access and outcomes. The EHRC should make use of their existing legal powers to ensure that organisations are fulfilling their Public Sector Equality Duty.

We accept these recommendations and the CQC are working to establish ways to strengthen the involvement of patients and carers in inspection assessment frameworks. This includes the inspection and Mental Health Act monitoring methodology. Through their new equality objective, 'Equal access to care and equity of outcomes in local areas', they aim to focus on the longstanding issue of lack of access to preventative and appropriate mental health services for some BAME people, which may contribute to higher rates of compulsory detention under the Mental Health Act.

CQC has also set out that they will work with EHRC to consider how they can use their regulatory powers to better support improvement in equality of access and outcomes.

EHRC is an independent body and will respond in their own capacity to this recommendation.

100. 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.

We accept this recommendation and we have committed to launching a pilot programme of culturally-sensitive advocates in partnership with Local Authorities and others, to identify how best to represent the mental health needs of ethnic minority groups. The scoping work concluded in summer 2020 and a full pilot programme will follow.

101. Safeguards should be created so that patients are able to continue religious or spiritual practices while detained in hospital. These should prevent the use of restrictive practices that limit a person's access to religious observance.

We accept this recommendation, and staff awareness of religious and spiritual practices is expected to be embedded in the PCREF, as a means of improving the cultural responsiveness of mental health services.

CQC will also take action, if this is not taken into account, as part of its review and inspection process.

102. In line with the NHS Workforce Race Equality Standard programme, greater representation of people of Black African and Caribbean heritage should be sought in all professions, in particular psychology and occupational therapy.

103. 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.

We accept these recommendations. The Government fully supports the need to improve the diversity of the workforce and has a number of programmes to address this.

The Preparation for Work scheme across the NHS aims to improve the representation of people from black, Asian and minority ethnic backgrounds through employability programmes, supported internships and traditional work experience programmes. The NHS Leadership Academy has also developed a programme, Ready Now, to support leaders from ethnic minorities to rise to senior levels within the NHS.

To understand whether these programmes and other similar work is having an impact, it is crucial that we have high quality ethnicity data on the workforce. Health Education England collates ethnicity data on students currently completing HEE's commissioned pre-registration Healthcare programmes and NHS Digital publishes data on the ethnicity of the NHS workforce, highlighting equality and diversity issues within the NHS.

While current work provides a good starting point for improving the diversity of our workforce, we know there is further to go to meet our ambitions, particularly in ensuring more people of black African and Caribbean descent are recruited into the skilled workforce and supported to rise to senior positions. The Interim NHS People Plan, published in July 2019, and the subsequent 2020/21 People Plan both emphasise that the NHS must do more to advance equality and diversity and to develop leaders who have the knowledge, skills and behaviours to create and sustain cultures of compassion and inclusion.

The 2020/21 People Plan, along with the NHS COVID-19 phase three recovery guidance, set out the urgency required to intensify efforts across teams and organisations. They require all local areas to take action to identify a named executive board-level lead for tackling inequalities and to publish action plans to set out how its board and senior staff will at least match in proportion the BAME composition of its overall workforce or community, whichever is higher.

The Mental Health Workforce Equalities Subgroup, set up by HEE in 2019, aims to address the issues raised by the Review. The Subgroup, in collaboration with NHSEI's Advancing Mental Health Equalities Taskforce, is working to address the workforce priorities outlined in the NHS Long Term Plan, to develop and implement strategies to enable a more diverse and inclusive mental health workforce that is reflective of the population it serves. This includes workstreams to increase fairness of access to, and inclusion in, mental health training programmes.

HEE is taking steps to improve representation and inclusion in mental health professions, starting with clinical psychology. From 2021, training in clinical psychology will be commissioned so that courses are held to account on targeted improvements in representation, such as the introduction of contextual recruitment processes and positive action initiatives.

The Chief Social Worker, Social Work England, the British Association of Social Workers, the association of Directors and Social Services and the Local Government Association

are also committed to supporting the implementation of the recommendations relating to race equality and diversity that affect social work and AMHPs. Scoping work is being undertaken by Skills for Care on workforce race equality to improve the oversight and leadership of this area in social work and social care. The AMHP workforce plan, new AMHP service standards and draft race equality guidelines, which have also been produced, outline how these ambitions can be met by Local Authorities and Principal Social Workers.

104. Behavioural interventions to combat implicit bias in decision-making should be piloted and evaluated.

106. Funding should be made available to support research into i) the issues that lead to mental disorder in people of a wider range of ethnic minority communities, in particular African and Caribbean individuals; and ii) interventions which improve outcomes.

107. A call for research should be made into tailored early interventions for African and Caribbean children and young people, particularly those at risk of exclusion from school.

In December 2019, the National Institute for Health Research launched an open call for research proposals to take forward these recommendations. Proposals have been reviewed and an announcement on those projects that will be funded under this programme will be made in due course.

105. Data and research on ethnicity and use of the MHA should be improved, with all decisions being recorded and reviewed consistently by organisations involved in the process – in particular criminal justice system organisations and Tribunals.

We agree in principle with this recommendation and the Race Disparity Unit (RDU) is willing to support others in fulfilling this recommendation by facilitating and assisting research, working with DHSC and delivery organisations in conducting better research and data collection. Further discussions between the RDU and these organisations will take place to see what actions are required in each case.

Children and young people

108. Legislation and guidance should make clear that the only test that applies in relation to those aged 16/17 to determine their ability to make decisions in relation to admission and treatment is that contained in the Mental Capacity Act.

The Mental Health Act's Code of Practice's existing guidance allows for the test contained in the MCA as well as for other considerations, but we will look to make improvements to

the guidance in future. We are actively considering this recommendation as part of current work to review and update the Mental Capacity Act's Code of Practice.

109. In young people under 16, competence should be understood in this context as the functional test under the Mental Capacity Act, although without the presumption of capacity that applies in relation to those over 16.

For children aged under 16, in all matters of clinical decision making, practitioners need to assess whether a child has “Gillick competence”, which involves considering whether the child has sufficient understanding, maturity and intelligence to enable him or her to fully understand what is proposed and to make a decision about consent.

The Review took the view that this professional judgement would benefit from a formal test. It recommended that, although the MCA does not apply to children aged under 16, its functional test, as set out in section 3 of the MCA, could be used as a framework to assess capacity. This would have the advantage of bringing together the same test for all children and young people and would provide a clearer basis of evidence for decisions made on their capacity.

As the Review noted, the Code of Practice already takes the principles contained within the section 3 MCA test and recommends that practitioners use them. The Government appreciates that there are different opinions about matters to do with children and young people's rights, and for under 16s on the best approach to assess their capacity and competence. These matters are ultimately for the Code of Practice rather than the Act itself and will form a particular focus for consultation when we come to review the Code.

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

111. Government should consult on the ability of parents to consent to admission and treatment for those under 16.

The Government agrees with the Review's recommendation that young people aged 16 and 17 should not be admitted on the basis of parental consent. Recently, in [the case of *Re D*](#)^[37] the Supreme Court held that a parent should not be able to consent to a deprivation of liberty on behalf of their 16 or 17 year old child.

For those under 16 who lack competence or capacity, parental consent to admit is possible, but is a complex matter about which the courts have ruled that there are limits to the types of decisions that can be made by those with parental responsibility on behalf of their child, and the circumstances in which these decisions can be made. The Government is not minded to consult on this complex matter, which it believes is best left to the courts. The Code of Practice currently does not rule out relying on parental consent, but states

that it is not advisable. The Government will return to this issue in future when it consults on the Code.

112. Every inpatient child or young person should have access to an IMHA who is trained to work with young people and their families.

Patients are eligible for support from an IMHA, irrespective of their age. The commitment to expand advocacy provision to all patients, including informal patients, will likewise apply to all ages. We will explore IMHA training needs as part of the wider commitments to improve advocacy.

113. 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. The Government should consider whether there should be a statutory duty for such a plan where the child or young person does not already have either a statutory care plan or a Care and Treatment plan under the MHA.

114. Initial Reviews should take place within five days of emergency admission (or three days if it is to an adult facility) and at a minimum of four-to-six weekly intervals after that.

The Government and NHSEI agree with these recommendations. Both relate to service specifications which are already requirements of contracts for the provision of tier 4 children and young people's mental health services. We will legislate to put these on a statutory footing as compulsory elements of such contracts, though this will be taken forward through an alternative legislative route, rather than through the Act.

115. For children/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.

118. The local authority for the area in which the child or young person ordinarily lives should be notified if a child or young person is placed out of area or in an adult ward or if admission lasts more than 28 days. For 'looked after children', paragraph 14.97 of the Code of Practice will continue to apply.

The Government agrees that the local authority should be notified when a child or young person is placed in an adult ward or out of area or if an admission lasts more than 28 days. This will be made clear in the Code of Practice.

Where providers are required to notify the CQC, e.g. where a child/young person is placed in an adult unit, we believe that the current requirement of 48 hours is sufficient.

CQC inspectors, when these notifications are received, contact the provider and/or the CCG to find out more about the care plan including how the patient will be protected and kept safe in an adult environment, how regularly the placement will be reviewed and what plans are in place to make sure the patient is moved on to an appropriate placement as swiftly as possible.

This information is also recorded by NHS Digital. NHSEI, NHS Digital and CQC will keep this issue under review to ensure the most effective process for recording such instances and to ensure that appropriate steps are taken as soon as possible to end such placements.

NHSEI is working to minimise the number of children and young people requiring inpatient care, using new intensive resources more effectively to increase access to services in the community.

Following extensive engagement, NHSEI has identified a need to improve the national distribution of inpatient beds, address urgent gaps as well as a need to provide more effective integrated treatment pathways. Its regional specialised commissioning teams are delivering the Accelerated Bed Programme, which provides a national overview of planned changes to inpatient beds across the seven regions. The programme aims to improve patient outcomes and experience by eliminating inappropriate out of area placements; improving local bed availability aligned with community services; and eliminate inappropriate under-18 placements in adult beds.

116. Government should consider making it a requirement that the parents and families of young people placed out of area are supported to maintain contact.

We agree parents and families should be supported to maintain contact, and the Code of Practice sets out that families should let commissioners know if they are struggling to do so. When next revising the Code of Practice, we will seek to improve guidance in regard to supporting families to maintain contact.

For children who are considered to be accommodated within the meaning of section 85 of the Children Act 1989, that is those who have been placed in hospital for three months or longer, 8A of Schedule 2 of the Act places a duty on Local Authorities to make provision for such services as they consider appropriate, including (at para. 8A(4)(b)) services necessary to enable the child to visit, or to be visited by, members of the family.

117. Section 17 of the Children Act 1989 should be amended to clarify that any child or young person admitted to a mental health facility is regarded as a 'child in need' so that parents can ask for services from their local authority.

The Government does not accept this recommendation. Section 17 of the Children's Act already covers children or young people who are in need due to mental health needs or

related issues. Working Together to Safeguard Children (the statutory guidance for all agencies) is clear that health services should refer cases to children's services where they believe there is a risk to that child's health or development, and that Local Authorities are responsible for safeguarding and promoting the welfare of children in their area, regardless of where they are educated or resident.

However, local authority children's services are responsible for setting a local threshold at which individual cases will meet S17 and for assessing cases against that threshold to be deemed a 'child in need'. Disabled children are currently the only group of children in S17 who are deemed to be 'in need' (that is, they are automatically classified as "in need" by virtue of their disability). The definition of disability includes children suffering from a mental disorder of any kind. For any child, being 'in need' under S17 does not bring any guarantee of services – the LA decides what any services will be. There is only a general legal duty to provide appropriate services, rather than an obligation to deliver services of a particular nature.

The Government therefore believes that the proposed change would not meet the stated goal. Firstly, this is because a child admitted to a mental health facility will by definition be suffering from a mental disorder and should therefore already be considered to be "in need". Secondly, as the duty owed to children in need under section 17 is a general one, Local Authorities would not be obliged to provide specific services requested by parents. It may put increased pressure on children's services which are already stretched. Nevertheless, the Department for Education has reviewed the language in Working Together to Safeguard Children to ensure it is clear that hospitals which are responsible for children in this situation should consider whether a referral to children's social care is necessary, and to reinforce Local Authorities' existing duties to safeguard all children, including those in mental health inpatient settings. Also, this revision will seek to reinforce Local Authorities' existing duties to safeguard all children, including those in mental health inpatient settings.

119. Where data is recorded it should be split into age groups.

We agree with this recommendation. The Mental Health Services Data Set (MHSDS) already collects data on the use of the Act by age group, and publishes this data annually.

People with learning disabilities and autistic people

120. 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.

We agree with this recommendation and will consult on new duties to make sure Local Authority and Clinical Commissioning Group (CCG) commissioners ensure an adequate supply of community services for people with a learning disability and autistic people. To give this additional impact, we will also consult on a duty on commissioners to monitor those who are most at risk of admission through the use of dynamic 'risk' or 'support' registers.

In addition, there may be more that can be done specifically in relation to pooling budgets for services for people with a learning disability and autistic people. This consultation will provide an opportunity to explore the challenges around their use and reporting spend on services for people with a learning disability and autistic people.

121. Amend the MHA Code of Practice to clarify best practice when the MHA is used for people with autism, learning disability or both.

We agree with this recommendation and are consulting on proposals to limit the scope to detain people with a learning disability or autistic people under the Act.

We want to ensure that people receive high quality and safe care that is the most appropriate for them, recognising that learning disability and autism cannot be removed through treatment while some people with a learning disability and autistic people may require treatment for a mental illness. We propose that the Mental Health Act be revised to make clearer that for the purposes of the Act autism or a learning disability are not considered to be mental disorders warranting compulsory treatment under section 3 of the Act.

The revisions would allow for people with learning disability and autistic people to be detained for assessment under section 2 of the Mental Health Act where their behaviour is so distressed that there is a substantial likelihood of significant harm to self or others (as for all detentions) and there is probable mental health cause to that behaviour that warrants assessment in hospital.

We envisage that the process of admission for assessment of people with learning disabilities and autistic people should be very different in future reflecting its use only when other options have been tested and with a presumption that detention should be avoided wherever possible. Detention for assessment should only be considered after all alternatives to de-escalate have been exhausted. The assessment should be reasonably adjusted to accommodate the sensory and specific needs of people with a learning disability and autistic people.

We propose to introduce these changes only for civil patients under Part II of the Act. This is to ensure that accused people and offenders whom the courts or the Secretary of State might currently divert to an inpatient mental health setting are not forced into the criminal justice system which is not able, or indeed intended, to cater for their needs.

Assessment under section 2 should seek to identify the driver of this behaviour. If it is identified that a mental health condition is the driver, there may be continued justification for detention under section 3 of the MHA. Where the driver of this behaviour is not considered to be a mental health condition, for example due to an unmet support need, unmet social or emotional need, or an unmet physical health need grounds for a detention under the MHA would no longer be justified and the detention should cease.

We would expect that a community Care, (Education) and Treatment Review (CETR) is carried out in advance of a detention and that evidence from such a CETR is considered as part of any decision to admit.

122. Care and Treatment Reviews should be given statutory force in the MHA.

We agree that Care and Treatment Reviews (CTRs) should be given statutory force. The Responsible Clinician will be required to take into account the findings and recommendations made as part of CTRs in the patient's statutory Care and Treatment Plan, including any explanation as to why the CTR recommendations have not been followed.

123. 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.

We agree that we should continue to improve the MHSDS in this respect. There is a single flag for learning disabilities and autism in the MHSDS data. The quality of this data will continue to improve over time, as NHS Digital continues to make wider data quality improvements to the MHSDS, as well as improvements to the methodology of tagging of learning disabilities and autism data. We will work towards splitting of learning disabilities and autism so that both are separately identifiable in the data. We will continue discussions on this matter as part of wider conversations on future MHSDS work packages. We will also consider how activity related to recommendation 146 might be able to support these ambitions in the longer term.

Policing

124. 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 in place.

The Government accepted this recommendation in June 2019 and committed to take further steps to end the use of police cells and remove them from the definition of a 'place of safety' under the Act by 2023/24.

Before we can do this, we want to ensure that the health system is ready. This may require new capital funding to be available to provide the estate needed, including additional health-based places of safety in areas that need it.

125. Ambulance services should establish formal standards for responses to section 136 conveyances and all other mental health crisis calls and ambulance commissioners and ambulance trusts should improve the ambulance fleet, including commissioning bespoke mental health vehicles.

We agree with this recommendation. A national programme to develop standards and specifications where required, and to provide implementation support, is under way as new funding became available in CCG baselines from 2020/21. There is a specific focus on defining and sharing good practice and ensuring that the improvements made to ambulance response align with the overarching Long Term Plan vision for integrated urgent care and a universal single point of access.

The NHS Long Term Plan has committed to a dedicated national investment programme to improve the capacity and capability of the ambulance service to meet mental health demand. This will see £70m additional revenue investment by 2023/24 for additional mental health professionals to deliver mental health specific initiatives and extra capacity in ambulance services, such as having mental health staff based in NHS 111/999 (Integrated urgent care) control rooms to improve telephone triage and support, as well as a national programme to increase mental health training and education of ambulance staff.

The Long Term Plan also outlines its commitment to introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E, subject to future decisions on capital investment.

126. The responsibilities of NHS commissioners under section 140 of the Act must be discharged more consistently and more effectively, so that emergency beds are available.

We agree with this recommendation. The Chief Social Worker's office has written to all Directors of Social Services to ask them to work with their colleagues in the local CCG or Integrated Care System (ICS) to ask them to develop local guidelines in relation to the availability of inpatient beds in cases of special urgency. We will be reviewing progress on this issue.

127. NHS England should take over the commissioning of health services in police custody.

Each police force is legally responsible for procuring their own healthcare provision for people in police custody. Following Dame Elish Angiolini's report on serious incidents and deaths in custody, which originally recommended this, we are currently exploring various options for raising the healthcare standards in all police custody suites so that they are in-keeping with national NHS standards and are appropriately monitored.

Work in respect of the future of healthcare commissioning is being taken forward as part of the programme being overseen by the Ministerial Deaths in Custody Board. We are considering two options; transfer to NHSEI, or adding health specialist support to the police commissioning process. These options have also been consulted on with the National Police Chiefs Council, and the Association of Police and Crime Commissioners.

This is also subject to wider decisions around police budgets and funding.

128. 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.

The police currently employ a range of mechanisms and monitoring to ensure effective engagement with people from black, Asian and minority ethnic backgrounds. The Home Office and police will await the development and implementation of the new NHS Patient and Carer Race Equality Framework and consider whether this provides a model for helpful enhancements to police systems.

Patients in the criminal justice system

129. Magistrates' courts should have the following powers, to bring them in line with Crown Courts: remand for assessment without conviction under section 35 of the Mental Health Act (MHA); remand for treatment under section 36 of the MHA; the power to commit a case to the Crown Court for consideration of a restriction order following an 'actus reus' finding; the power to hand down a supervision order following an 'actus reus' finding (where a person is not fit to enter a plea, but has been found to have committed the offence) under S1a of the Criminal Procedure (Insanity) Act.

We recognise that the powers available in the magistrates' court to divert defendants towards appropriate support are currently limited. We will consider the proposed changes alongside the wider reforms suggested by the Law Commission in their 'Unfitness to Plead' report. This recommended greater alignment between the Crown Court and magistrates' courts in managing defendants who lack capacity to participate effectively in a criminal trial. We need to consider both sets of recommendations together, as such, we will defer our final decision on this to a later date.

130. Prison should never be used as ‘a place of safety’ for individuals who meet the criteria for detention under the Mental Health Act.

The Government agrees with the Review that prisons should not be used as a place of safety in cases where courts divert defendants requiring care and treatment in an inpatient setting to prison, because there is no hospital bed available. However, further work is needed before we can take this forward.

We will work with sentencers, health service commissioners and clinicians to ensure that there is a clear, timely pathway in which sentencers have confidence to transfer people directly from court to a healthcare setting where a mental health assessment and treatment can be provided, under the relevant section of the Act. Before moving to amend the legislation to embed these changes we will need to ensure that viable alternatives are properly established and commissioned. We will consider introducing guidance for the courts and will ensure that the necessary adaptations and investment are in place before legislative changes are commenced as a final step to delivering this objective.

131. A new statutory, independent role should be created to manage transfers from prisons and immigration removal centres.

We agree with the objectives of this recommendation and are consulting on how best to take this forward. The Government believes that work in response to recommendation 22, on the extension of rights to IMHAs, is relevant here. The role could also address recommendation 140, which could help ensure that the least restrictive option for immigration detainees was considered. The Government is consulting on whether the AMHP role, a role within NHSEI or across NHSEI and HMPPS or another option would be suitable to support people in transfers from prisons and immigration removal centres.

132. The time from referral for a first assessment to transfer should have a statutory time limit of 28 days. We suggest that this could be split into two new, sequential, statutory time limits of 14 days each: i) from the point of initial referral to the first psychiatric assessment; ii) from the first psychiatric assessment until the transfer takes place (this incorporates the time between the first and second psychiatric assessment and the time to transfer).

We accept the time limit set out by the Review (28 days), and agree that this should be statutory, but do not plan to legislate in relation to this immediately, to allow time for the new NHSEI guidance on secure transfer and remission to be properly embedded. We are consulting on what other safeguards need to be in place before we can implement this.

We will also develop a stronger monitoring system to enable us to better understand and provide greater transparency on how the transfer process is working.

133. Decisions concerning leave and transfer of restricted patients should be categorised by the Ministry of Justice according to risk and complexity. Straightforward and / or low risk decisions should be taken by the responsible clinician. The Ministry of Justice would have 14 days to override this decision.

We accept the goals of this recommendation to speed up decisions on leave and transfer of restricted patients, but we think that this is best achieved through work that is already underway and is delivering significant progress. Whilst the Independent Review of the MHA was in progress, the MHCS in HMPPS took significant steps to reduce the length of time it takes to consider applications for consent from responsible clinicians.

The backlog which existed during the early stages of the Review was eradicated by May 2018 through additional resource and process improvements.

In July 2019 MHCS published, for the first time, targets for timeliness of decisions and during their first year in place nine out of thirteen targets were met. MHCS were clear from the outset that these were challenging targets and continue to work with partners and stakeholders to make further improvements to performance.

134. The new statutory Care and Treatment Plan should include a plan for readmission and consider what factors should be taken into account concerning use of informal admission, section 2 and recall.

We agree and propose including this in Care and Treatment Plans. We are consulting on the proposed content.

135. The powers of the Tribunal should be expanded so that they are able, when deciding not to grant an application for discharge, to direct leave or transfer.

This recommendation was made in regard to restricted patients only. We do not believe that it is in line with principles of the Restricted Patient regime to empower the Tribunal to direct leave or transfer. The Justice Secretary's role is to oversee the safe management of mentally disordered offenders diverted into hospital for treatment and ensure the right balance is struck between public protection and the patient's right to treatment. However, we do consider that it would be appropriate to empower the Tribunal, to make a statutory recommendation in relation to community leave or transfer to a different hospital, which the Justice Secretary must consider when taking such decisions

136. The Government should legislate to give the Tribunal the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

Further work is needed to identify the best way to take this forward and we are using the consultation to inform our approach. We are seeking views on the introduction of a new

power to discharge a specific group of restricted patients (who are no longer therapeutically benefitting from detention in hospital, but whose risk could only be managed safely in the community with constant supervision), with conditions amounting to a deprivation of liberty, in order to adequately and appropriately manage the risk they pose.

137. There should be an automatic referral for people on conditional discharge to the tribunal after 12 months and at regular intervals after that for patients who have not applied directly.

We think that an automatic referral at 12 months after receiving the conditional discharge, as recommended by the Review, is too soon. We propose instead automatic referral at 2 years following receipt of the conditional discharge would be more reasonable. We also propose that 4 years would be a reasonable 'regular interval' for conditional discharge patients to be automatically referred to the Tribunal. We are consulting on whether these timelines are appropriate.

138. The Government should consider giving the Parole Board Tribunal status and combining hearings where appropriate. At the very least the Government should streamline processes so that hearings could be convened back to back.

Consideration of the Parole Board's status and whether it should be part of the unified tribunals system will now be fully addressed in the Government's 'root and branch' review of the parole system.

The Government accepts the second part of the recommendation and cross-agency work is underway to test options to streamline processes where an individual is subject to both a Tribunal and a Parole Board hearing.

139. There should be a common framework for assessment of risk across criminal courts, clinicians and the Justice Secretary. The assessment needs to be regularly reviewed (at least annually and before every Tribunal hearing). Every patient should have written into the Care and Treatment Plan what their risk levels are.

The Government does not believe that a common framework for risk is appropriate across courts, clinicians and the Justice Secretary, as we think that the different approach they take is legitimate. The primary concern of the Criminal Courts and the Secretary of State for Justice is the protection of the public from serious harm. Clinical assessments are primarily concerned with the best interests of the patient and their recovery and consider both harm to self as well as harm to others.

It is the design and purpose of the restriction order that recognises the possibility that the Secretary of State will come to a different conclusion than the responsible clinician as to whether the likelihood of the risk of harm can be safely managed, or indeed the

seriousness of the harm that could be caused. We do not therefore consider it appropriate to harmonise the approach to risk.

Immigration Detention

140. The new statutory, independent role for prison transfers should be extended to consider the least restrictive option for immigration detainees, including treatment in the community, informal admission and civil sections of the MHA.

We agree that any role created to oversee prison transfers should also apply to Immigration Removal Centres. We are considering how we take this recommendation forward, along with recommendations 22b) and 131, which are closely related.

Victims

141. In accordance with the Review, we wish to ensure victims of serious offences committed by offenders suffering from a mental disorder receive the information to which they are entitled. This should deliver equity of rights for victims of mentally disordered offenders (MDOs) comparable to those of victims of offenders in the prison system.

The UK Government's Victims' Strategy committed to reviewing and improving the processes by which victims of mentally disordered offenders (MDOs) are given information. We are aware that there is currently inconsistent provision of information to victims of those offenders who become subject to the Act without a restriction order (unrestricted patients) whom courts do not consider to represent a serious risk of harm to the public (and so need not be subject to a restriction order)., This is true both in the level of information and the way it is provided. Informed by responses to the public consultation in 2019 and 2020 on a revised Victims' Code, Government considers it appropriate to offer the services of VLOs to victims of unrestricted patients. This is reflected in [the new Victims' Code published on 18 November](#)^[38] and which comes into force on 1 April 2021.

Victims in England and Wales are currently unable to submit a VPS to the Tribunal. The Government is continuing to engage with key stakeholders on whether it would be appropriate to give victims this right. We are continuing to engage with key stakeholders on options that would enable policy change to allow victims to submit a VPS to the Tribunal.

System-wide enablers

Data

142. An agreed, accurate national baseline of use of the MHA should be established following a pilot programme to develop robust methodology.

We and delivery partners agree and fully support the idea of developing a baseline of Act data. This must cover both overall use of the Act and issues of equality. The key indicators that should be baselined and the data required to report that, will be informed by the consultation.

A programme of work to identify and address data quality and completeness issues in the MHSDS, linking with and addressing any relevant issues with other key data sources, will be taken forward. This should link with and build on the existing NHSEI led MHSDS data quality cross ALB action plan, wider equality agenda and work stemming from the NHS Long Term Plan and PHE and NHSEI collaborative work programme. It will also involve engagement with ALBs and the health system to understand the issues with data quality. Insight from this will be used to establish a programme of work to address those issues and establish an accurate baseline through the national datasets.

143. A new official national dataset of AMHP activity should be created and integrated into the NHS Digital Mental Health Services Data Set.

A comprehensive review of AMHP and assessment activity under the Act was recommended by the Review and by the All-Party Parliamentary Group on Mental Health Social Work in 2018.

Skills for Care have updated their AMHP data collection process and are due to publish a more comprehensive annual picture of the AMHP workforce than was previously available.

However, there is no annual national data on the number of Mental Health Act assessments, the details of MHA activity and the outcomes of these assessments. Much of the data is available locally but is collected and maintained in a variety of settings and formats.

We will seek to commission work, to be developed in partnership with the sector, NHSX, NHSD and other stakeholders, on an appropriate data collection. This work needs to include (but not be limited to), defining a data specification, collection mechanism, exploration of synergies with existing collections and technology, appraisal of technical and governance challenges to flowing data across traditional domain boundaries and an assessment of the wider strategic fit with the evolving national data strategy within social care and beyond.

144. Key data from the NHS Digital Mental Health Services Data Set should be published monthly, as close to real time as possible.

The Government has acted on this recommendation. NHS Digital now publishes, as of October 2020, monthly data on the uses of the Act. This includes new measures on the number of detentions, number of short term orders, number of uses of section 136 and number of CTOs.

Data on people subject to the Act is published monthly via the [Mental Health Services Data Set](#) ^[39].

145. Data on police use of detention powers under the MHA (sections 135 and 136) should be published on a quarterly basis as close to real time as possible and include new data on delays.

While recognising the potential value of being able to obtain current data to inform service development, this would entail significant additional bureaucratic burdens on police forces and the quality assurance and auditing processes associated with the current annual publication. The Home Office therefore considers that the disadvantages of the administrative efforts involved would outweigh any potential benefits of a more frequent collection, and does not propose, routinely, to increase the current frequency of police data reporting.

However, to assist health partners, where there is a specific need for s135 or s136 data to inform upcoming health services policy or operational decisions, police forces will, to the best of their ability, collate and share from their data bases, available data to assist with this.

146. 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.

While we are supportive of the ambition to do more to bring together and link different datasets, given the complexity of the Act's data landscape (with a number of different sources held by different delivery partners) further consideration is required to decide how best to do this. Options could include a dedicated data hub as recommended, expanding an existing data tool to incorporate data on use of the Act, or lighter touch options such as a cross-data sharing model drawing on the powers from the Digital Economy Act or indirect linking of information through overlapping of data. The type of data that should be included will influence and shape which option might be most appropriate.

Delivery partners are fully engaged and committed to exploring the options and working collaboratively to improve collective understanding of the MHA user data.

147. The NHS, Home Office / policing and Local Authorities should work towards standardising ethnicity categories. This could be extended to all public sector reports including ethnicity.

We agree in principle with this recommendation. As part of wider work on harmonising ethnicity classifications, the Race Disparity Unit (RDU) is working with the Office for National Statistics (ONS) to align the Government's approach to collecting ethnicity data with the proposed classification to be used in the 2021 Census.

The RDU and the ONS are engaging with departments and agencies so that those responsible for administrative systems that record ethnicity can set out their commitment to use the 2021 Census classification. This will include supporting the NHS, police, criminal justice systems and Tribunals to work towards their respective ethnicity reporting systems reflecting the 2021 Census classifications (e.g. the NHS Data Dictionary).

The RDU and the ONS are engaging with departments and agencies so that once the Census Order is approved, those responsible for administrative systems that record ethnicity can set out their commitment to use the 2021 Census classification. This will include supporting the NHS, police, criminal justice systems and Tribunals to work towards their respective ethnicity reporting systems reflecting the 2021 Census classifications (e.g. the NHS Data Dictionary).

Digital

148. NHS England should build on the work of the Mental Health Trust Global Digital Exemplars and other trusts to test, evaluate and roll-out a fully digitised, consistent approach to the MHA.

149. Work should be carried out to streamline activity undertaken between NHSE, NHSD, NHSI, CQC, Tribunals and providers, to include improved digitisation of notifications such as early discharge to avoid late cancellation of tribunal hearings.

Digital transformation is at the heart of the NHS Long Term Plan and is a key enabler for high quality personalised, mental health care. This includes the delivery of a modern Mental Health Act. The changes we have made in legislation to allow for the digitisation of statutory forms under the MHA, pave the way for the significant transformation committed to in the Long Term Plan. It is through the wider digital transformation agenda that all mental health providers are expected to progress to core levels of digitisation by 2024.

Whilst digital change typically flourishes under local leadership, it is clear a consistent, standard approach is required to the Mental Health Act pathway. Delivery partners across DHSC, NHSX and NHSEI are fully committed to progressing this recommendation. Guidance to support this is in development, but our expectation is that this will include:

- Supporting real time information sharing across the mental health act pathway. This will ensure staff can easily access, update and share the information that they require, at the point of need to support decisions on care. Service users will also be able to access and contribute to their health care record (including advance choice documents). In the future, linked data will support our services to more proactively understand and respond to emerging need.
- Decision support, ranging from clinical monitoring to bed management, will be routinely used to help improve outcomes and reduce unwarranted variation in care
- Digital options for accessing care which aim to improve choice, self-management and patient experience. This will adopt a user-centred and inclusive approach and build on the lessons learnt during the pandemic period regarding remote access to mental health assessments, advocacy and peer support.

In addition, we are also piloting a digital solution to improve communication between MH wards and MHA tribunals in a local area. If successful, innovation will be shared with other Trusts.

Quality Improvement (QI)

150. NHS Improvement and NHS England should fund the establishment of a national Quality Improvement (QI) programme relating specifically to the Mental Health Act.

The Government agrees with this recommendation, subject to securing funding. NHSEI recognises that while legislation is important, for some of the Review's recommendations there is a strong case for the development of a comprehensive implementation support plan, which will be developed in partnership with NHSEI and HEE. This will include a National Quality Improvement (QI) programme led by NHSEI, which will look specifically at care under the Act to enable and support this system-wide drive for change.

The scoping phase will identify the specific Act reforms which are most likely to benefit from a QI approach, but areas of focus may include improved care planning, reducing inequalities, improved partnership working, improved assessment processes, greater levels of safety, and the dignity and respect experienced by service users.

The QI programme will seek to empower clinicians, ward staff and people with lived experience to take ownership of, and benefit from positive change, through improving people's experiences of assessment and detentions under the Act.

Once developed and tested, subject to future funding, the programme will be rolled out to support all mental health providers and local systems, nationally.

151. The role of the CQC in monitoring the use of the MHA should be extended to cover all organisations that commission or provide services under the Act with due consideration given to the roles of other national bodies

We support this recommendation in principle and would like to explore how extending the monitoring role of the CQC to cover how the Act and Code is working could improve the quality (including safety) of care delivered, with due consideration given to the roles of other national bodies.

This proposal will increase CQC's oversight in how it monitors the Act in local areas and allow for the increased identification of issues in the detained patient pathway as well as monitoring the effectiveness of joint working between organisations. However, this proposal is only in respect of monitoring powers derived under section 120 of the Act, not regulatory powers under the Health and Social Care Act. The proposal is not a suggestion that the CQC regulate or take enforcement action against CCGs, Local Authorities or any other partner organisation in the exercise of the Act's powers. This is instead about considering extending CQC's current Act monitoring role in mental health inpatient units and building on its lived-in experience role to help establish a local picture of the current position, for example looking into reasons for delayed admissions and discharge and using this information to highlight issues and to support improvements locally. The monitoring power under section 120 of the Act is a broad power, however, consideration will need to be given to what, if any, changes in legislation might be needed to make sure CQC can discharge an extended monitoring power co-operatively with system partners.

We propose to look at how any expansion of the CQC monitoring role could make a positive impact and aid the quality and safety of care. We will work with the CQC and national bodies including NHSEI and Local Authorities to consider how best to extend these powers, and then publish proposals for consultation at a later stage.

We expect the recommendations to complement the wider work being taken forward to improve the quality (including safety) of patient care.

Staffing

152. The factors that affect the timely availability of section 12-approved doctors and AMHPs should be reviewed and addressed.

Research has also been commissioned to explore the factors promoting and inhibiting the accessibility of S12 Approved Doctors to participate in Act assessments in England and Wales.

The National AMHP workforce plan outlines in detail the pressures on the AMHP service, how to support AMHP services and develop national AMHP standards together with

improved recruitment and retention for AMHPs. This makes a clear recommendation for a whole system approach that includes resolving the availability of s12 Doctors and AMHPs that affect this issue.

HEE has commissioned NHS Benchmarking to undertake a review of the mental health social work workforce (including AMHPs) across NHS MH Trusts, CCGs and Local Authorities. The findings have been published and are available via [the HEE website](#)^[40].

153. The Government should consider introducing a minimum waiting time standard for the commencement of an MHA assessment.

The NHS Long Term Plan set out that field testing of appropriate waiting time standards for urgent and emergency mental health will inform publication of national standards.

As highlighted in the response to recommendation 46, field testing of access and waiting time standards for urgent and emergency mental health care, with 11 sites as part of the clinical review of standards began in October 2019, much of the work paused by COVID-19. Standards for people with mental health needs in A&E are expected to be included in any new roll out of new A&E access standards. Testing and engagement on new access standards for community crisis services will continue through 2020/21, with an intention to carry out sector engagement on potential new standards during 2021/22.

154. 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 Government and NHSEI agree that improving staff experience can have a significant impact on the quality of patient care, as well as boosting staff morale and retention. This is why the NHS is striving to be a beacon of good practice in helping staff maintain and improve their physical and mental health and wellbeing through the Improving Health and Wellbeing programme. This programme embeds NHSEI's evidence-based NHS staff health and wellbeing framework which provides Trusts with diagnostic tools and suggested interventions to help them improve access to services for those staff who need this support.

The programme is being rolled out across 22 NHS Trusts delivering mental health services and aims to have a positive impact on staff morale, thereby potentially improving the experience of all patients including those who are detained. We are planning to roll out this programme across the remainder mental health Trusts over the next three years.

Further, the COVID-19 pandemic presents a unique and unprecedented challenge for many health and social care staff, who are caring for people in unfamiliar and challenging clinical and support roles. It is therefore essential that staff can get rapid access to mental

health support when required. NHSEI has developed a specific national support offer which is available at people.nhs.uk^[26] for NHS staff which includes the following:

- A dedicated health and care staff support service including confidential support via phone and text message;
- A specialist bereavement support helpline for those who have sadly lost friends and family – whether from COVID-19 or otherwise;
- Online resources, guidance and webinars;
- Piloting a specialist relationship counselling service with the charity Relate;
- Partnered with MaPS to launch a financial well-being offer.

A comprehensive mental health offer is also in development, following investment from NHSEI to strengthen mental health support for healthcare staff in all local areas, and ensure rapid access to evidence based mental health services, this includes the following:

- Centrally commissioned service for people with complex needs: a national support service particularly for critical care staff who research suggests are most vulnerable to severe trauma;
- Mental health and wellbeing hubs: nationwide outreach and assessment services, ensuring staff receive rapid access to evidence based mental health services; developing [wellbeing and psychological training](#)^[27], set to be rolled out this winter.

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