Government response to the Joint Committee on the draft Mental Health Bill

Presented to Parliament

by the Secretary of State for Health and Social Care

by Command of His Majesty

March 2024

CP 1036

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Introduction

The Mental Health Act 1983 governs the compulsory detention and medical treatment of people with severe mental illness, people with a learning disability and autistic people for their own safety or for the protection of others. In 2018, a landmark independent review, chaired by Professor Sir Simon Wessely, found that the act could be reformed 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.

The draft Mental Health Bill contains proposals to reform the Mental Health Act (MHA) and provide a stronger system updated for the 21st century. These proposals would: provide for enhanced protections and support for people with severe mental health needs; strengthen their voice, choice and rights; and support work underway to address the racial disparities that have too long been part of the way the act has been used.

The draft bill contains provisions to:

- tighten the criteria which govern when someone can be detained ('sectioned') under the act – to ensure detention only happens where strictly necessary, and where there is a clear therapeutic benefit
- further limit the extent to which people with a learning disability and/or autistic people can be detained and treated under the act and support such individuals to live fulfilling lives in their community
- give patients, where possible, greater involvement in decisions concerning their own care and treatment, and rights to appeal their detentions more frequently
- strengthen and improve the statutory roles which protect and support those who are detained, by increasing legal rights to access independent mental health advocates, and by allowing patients to choose their own 'nominated person' rather than just be assigned a 'nearest relative'
- support offenders with serious mental health problems to access the care they need as quickly and early as possible, and improve the management of those patients subject to a restriction order (for the purposes of public protection)

Pre-legislative scrutiny process

The draft Mental Health Bill was published on 27 June 2022. The joint committee on the draft Mental Health Bill was appointed on 19 July 2022, chaired by Baroness Buscombe, and reported on its pre-legislative scrutiny of the bill on 19 January 2023. The committee made 55 recommendations, not just in terms of amending the bill itself, but also to help secure its successful implementation.

The government would like to thank the committee, its chair, members and staff, for its careful and considered work scrutinising the draft bill. We are also grateful to all the stakeholders who gave or provided oral or written evidence.

The safety and care of mental health patients is of paramount importance, and people receiving inpatient care should expect high quality services. The Department of Health and Social Care commissioned an independent rapid review to explore how government can improve the way data and evidence is used to identify risks to patient safety in mental health inpatient settings. The review was published on 28 June and the government will be issuing a response. In addition, the Health Services Safety Investigations Body (HSSIB) has launched a national investigation into mental health inpatient settings as one of its first priorities. The investigation will identify risks to the safety of patients and the HSSIB will seek to address those risks by making recommendations to facilitate the improvement of systems and practices in the provision of mental health care in England. The aims of the investigation include learning from inpatient mental health deaths to improve patient safety.

We have carefully considered our responses to each of the recommendations made by the committee. These are set out in the subsequent response. In taking forward the committee's recommendations, there as some areas where changes will need to be made to the draft Bill prior to introduction. We have also set out in our response areas which require further consideration and policy development prior to being ready to introduce the Bill. We will seek to introduce a revised bill when Parliamentary time allows.

Although the committee did not number its recommendations, we have chosen to number them in the order they appeared in its report. This is intended to be helpful, and to provide clarity in those instances where we have responded to recommendations out of their original order.

Recommendation 1

To facilitate early engagement with future pre-legislative scrutiny, we recommend that the Cabinet Office’s Guide to Making Legislation include wording for bill teams to include in press notices announcing future draft bills. This should advise readers on the upcoming scrutiny process and direct them to where further information can be found. This wording should be agreed with officials in the Scrutiny Unit in both Houses of Parliament.

Government Response

The government accepts this recommendation and is grateful to the House Authorities for engaging on the wording that will be included in the next revision of the Guide to Making Legislation.

Recommendation 2

We recommend that there should be an ongoing process of mental health legislation reform, leading in the direction of more “fused” and rights-based legislation and learning from developments elsewhere in the UK and overseas. In advance of this work, the government should look for opportunities to amend the code of practice to improve the justification required for clinical decisions to use the MHA where a patient has decision making capacity and is refusing admission and treatment.

Government Response

We welcome the committee's support for reform to mental health legislation. Under the reforms provided for in the draft bill, people will have more choice and influence over their treatment, and detention will only take place when it is absolutely necessary. We will also make legislation and guidance clearer to ensure that people continue to get the protections provided by the MHA when needed. In addition to legislative reform, we will update the code of practice.

These reforms will take time to implement and form part of a system-wide programme to improve mental health services. We will continue to review implementation of the reforms within the bill and will commission independent evaluation of the reforms. The government accepts that we should keep mental health legislation under review, including the matter of fusion and a rights-based approach.

Recommendation 3

Effective handling of complaints is an important part of ensuring patients feel their voices are heard and services improve from a service user perspective. We recommend that the government adopt the Parliamentary and Health Service Ombudsman's (PHSO) recommendations on streamlining and signposting complaints processes.

The PHSO's recommendations taken from their written evidence:

- The bill should consider proposing that a complaint does not have to be made in writing and instead can be made through other means, such as over the phone or via a video call, to give complainants options in the way they communicate their complaint and experience.
- The bill should be updated to state clearly what exactly each organisation can and cannot look at in relation to MHA complaints.
- The bill should introduce mandatory signposting. This would require providers of care under the MHA to provide information about the four routes of redress: tribunal, Care Quality Commission (CQC), Local Government and Social Care Ombudsman (LGSCO) and PHSO and what each organisation can specifically look at.

Government Response

The government agrees with the committee about the importance of the complaints process being accessible and responsive. We will work with the CQC and the PHSO to establish what steps need to be taken to improve the complaints process.

The draft bill already contains proposed amendments to section 132, and 132A of the MHA and inserts a new section 132B, which will place a statutory duty on hospital managers to supply complaints information to both the patient and their nominated person on a more regular basis. We will provide further guidance on what information should be provided in the code of practice, including information on which is the right body to complain to in respect of particular issues.

Although we are sympathetic to the PHSO's recommendations, the government does not think that legislation is necessary as there are alternative ways of signposting and clarifying the complaints process. We will provide further guidance in the next revision of the code of practice.

Recommendations 4, 10 and 40

Recommendation 4

We recommend that the post of a statutory mental health commissioner should be created, with the support of an office. Their role should include:

a. Being a voice at the national level promoting the interests of those who are detained, or are likely to be detained, under the MHA, and of their families and carers, raising awareness of their needs, and challenging stigma and stereotypes;

b. Working in conjunction with the CQC and other bodies to make recommendations on reforming mental health law in the direction of more rights-led and "fused" legislation;

c. Tracking the implementation of the reforms in and associated with this bill, including the provision of data;

d. Providing advice and support to service users, their families and carers on their rights and how to navigate complaints processes; working with NHS bodies, the CQC and PHSO to promote best practice in handling complaints.

Recommendation 10

We recommend that one of the roles of the commissioner proposed in Chapter 2 will be to be a national figure overseeing, standardising, and promoting the work of the 'responsible people' proposed above and already in the Mental Health (Use of Force) Act. They should also work with NHS and independent services, the CQC, Equality and Human Rights Commission (EHRC) and the Office of the National Data Guardian, to produce proposals aimed at reducing inequalities in, and improving data on, the provision of services and use of powers under the MHA.

Recommendation 40

There will be benefits for service users and professionals if as many people as possible nominate their nominated persons in advance of a crisis situation. Earlier in this report we recommended a statutory right to request an advance choice document. We recommend that the choice of nominated person is included in such documents. We also envisage that as part of the mental health commissioner’s advocacy and support function, they may wish to promote the value of specifying a nominated person at or soon after the point of diagnosis.

Government Response

As recognised by the committee, there previously was an MHA commissioner, whose functions were absorbed into the CQC and Healthcare Inspectorate Wales in 2009. While we appreciate that some of the proposed responsibilities of the new commissioner would be unique, we are nevertheless concerned that where a role already exists, it would be better for it to continue to be carried out by the organisation that is currently responsible for it. For example, supporting individuals to raise complaints is the role of the CQC and the PHSO, the CQC is also responsible for monitoring the operation of the act and the government is responsible for reviewing the impact of the legislative reforms it makes.

The committee suggested that the CQC’s wide remit, and its regulatory role, might detract from its functions in respect of the rights of mental health patients, resulting in the need for a dedicated advocate or ‘consumer champion’. On the contrary, firstly we believe that the wide remit allows it to take a holistic view of the health and social care sector, making it uniquely placed to identify and investigate potential issues. We also feel that its role as a regulator means that it is well positioned to directly follow-up on any issues it might find with the powers to intervene where necessary.

Secondly, we feel that, at a ‘consumer’ level, there are already statutory mechanisms in place to champion the voices of service users, such as independent mental health advocacy (IMHA) services and Healthwatch England, which is an independent statutory body that is responsible for gathering feedback from service users to improve health and care standards.

Taking all these considerations into account, the government does not believe that a statutory mental health commissioner would add significant value within the framework currently provided by existing bodies, therefore we do not intend to take this recommendation forward.

Recommendations 5, 6 and 7

Recommendation 5

We recognise the government's concerns about putting entirely new principles into the MHA and are wary of making complex legislation yet more complex. We believe that there already exists a mechanism to put the principles into the act that meets those concerns. We recommend that section 118 be replaced with a new section, requiring the Secretary of State to draw up the code of practice having regard to and including the principles set out in the independent review: choice and autonomy, least restriction, therapeutic benefit and the person as an individual. The new section should also specify that the principles should inform decisions taken under the act, mirroring the current wording in section 118. This would ensure that the principles endure, inform the operation of the amended act and would require the government to ensure they are reflected in the practical guidance given to professionals on all aspects of how the act operates in practice.

Recommendation 6

We recommend that the replacement for section 118 be placed at the beginning of the amended act. This would reflect the central role of the principles and code of practice in the operation of the MHA in practice. It would make the legislation more accessible and better tell the story of what the amended act is trying to achieve. Placing principles relating to patient choice and least restriction in the legislation before the powers to detain is logical and would send a message to help drive that cultural change ahead of more fundamental reform.

Recommendation 7

The principles that the Secretary of State is required to draw up under section 118 of the MHA that "inform" decisions under the act do not explicitly include the need to respect racial equality. Whether or not they accept our earlier recommendation about re-writing section 118, the government should amend it so that the list of matters that the Secretary of State must address in the code of practice includes respect for racial equality.

Government Response

The government is firmly supportive of the 4 principles that were co-designed with service users during the independent review. These are choice and autonomy, least restriction, therapeutic benefit and the person as an individual.

We are grateful that the committee has recognised the complexities involved with putting new principles in existing legislation and at the same time we do recognise the strength of feeling on this issue.

We maintain the view that, with regard to the principles, the strongest and most effective approach to deliver the impact and change envisaged by the independent review, and to drive culture change in how the act is applied, is to embed them substantively in targeted, specific and practical measures in the act and to give full prominence to the principles in a revised code of practice. The principles have informed every decision we have made when developing new measures in the draft Mental Health Bill.

Given that the act already contains a statutory duty to include a statement of principles in the code, we will ensure that the new principles are clearly set out up front in the next revision of the code of practice, which informs the decisions of those performing functions under the act and will provide guidance as to how the amended act should be applied in practice. This will make it clear to practitioners that the recommended principles should inform all decisions made under the Act. We do not consider that replacing the current list of matters required to be addressed by the statement of principles in section 118(2B) with the 4 principles is the most effective means of driving cultural change and ensuring the principles are central in all decisions as to how the act is applied. The express inclusion of respect for racial equality in the list of matters that must be addressed in the statement of principles in the code of practice is also not necessary as this is already a requirement of the Equality Act 2010, to which those carrying out functions under the MHA must already adhere.

Recommendation 8 and 9

Recommendation 8

Improving data collection will be an important part of reducing inequalities, but it cannot be an excuse for a lack of urgent and comprehensive action. There should be a ‘responsible person’ for each health organisation whose role will be to collect and monitor data on the number, cause, and duration of detentions under the MHA broken down by ethnicity and other demographic information. The Secretary of State must ensure that these statistics are published at the end of each year.

Recommendation 9

The ‘responsible person’ should also oversee workforce training and policies designed to address bias and discrimination in decision making in the operation of the MHA on the basis of protected characteristics, including the implementation of the Patient and Carer Race Equality Framework (PCREF).

Government Response

Taking action to tackle the disparities currently seen in the application of the MHA is a priority for the government’s reform agenda. Indeed, concerns around disproportionate use of the MHA is one of the reasons the government first commissioned Sir Simon Wessely to undertake the independent review of the MHA.

The proposals for legislation contained within the draft bill itself reflect the government’s aims to improve the experience for everyone subject to the act, including people from ethnic minority groups, who the statistics show are currently subject to disproportionately higher rates of detention. Non-legislative action is already being taken forward to address disparities, including through the department’s culturally appropriate advocacy pilots and the roll-out of NHS England’s PCREF.

We thank the committee for their consideration of issues relating to inequality and where we might go further, and for their recommendation that a ‘responsible person’ be introduced across each health organisation. We envisage this being an additional duty on existing senior staff rather than a new role. We will consider the proposal further ahead of introduction of the Bill, including how this would align with existing duties, for example under the Equality Act and the public sector equalities duty.

Recommendations 11 and 16

Recommendation 11

The government should work with NHS England to produce an implementation plan for the NHS's non-legislative programmes to address inequalities in mental health care with clear milestones and reporting against them. Examples of milestones might include appointment of 'responsible people', take up and implementation of the PCREF, increased awareness of the public sector equality duty, reductions in disproportionate detention rates, improved diversity in the workforce and access to culturally appropriate advocacy, which is discussed later in this report.

Recommendation 16

The government should publish a comprehensive implementation and workforce plan alongside the bill. It should contain clear actions and key milestones detailing the implementation of the bill and how they link to milestones in the implementation of the 10 Year Plan and other relevant government policies. These should include milestones on workforce development, training, advocacy and community care capacity, as well as on numbers of detentions, length of stay and reducing racial and ethnic inequality. There should be a statutory duty to report annually to Parliament on the progress against these milestones during the implementation period.

Government Response

We thank the committee for their recommendations in relation to the publication of implementation plans, and for the accompanying suggestions for what these might include. We agree that the effective implementation of the planned legislative changes and accompanying non-legislative programmes will be critical in delivering the government’s MHA reform ambitions.

To this end, we will set out how we intend to deliver these reforms, both legislative and non-legislative, alongside the bill when it enters Parliament. We intend for this plan to include information in relation to the planned sequencing of the commencement of provisions, and also cover where possible actions to support necessary workforce development and to address disparities. We will work closely with our partners, including NHS England and other arm’s length bodies, to ensure these plans are deliverable, and align with the NHS Long Term Workforce plan published in June 2023, which identified the need to grow the overall mental health and learning disability workforce the fastest of all care settings, at 4.4% per year up to 2036 to 2037. We will also keep stakeholders informed on progress during the implementation period and keep the implementation of the provisions included in the draft bill under review.

A number of non-legislative plans are already being taken forward, for example including the department’s commissioning culturally appropriate advocacy pilots and NHS England’s work to implement the Advancing Mental Health Equalities strategy.

As part of the latter, NHS England launched the PCREF across all NHS mental health trusts in October 2023. NHS England is also taking forward a quality improvement programme in NHS mental health trusts across the country, which will improve the quality of care and experience for patients subject to the MHA.

Recommendations 12, 13 and 14

Recommendation 12

The evidence shows that community treatment orders (CTOs) are being used more than intended and, in many cases, as a more restrictive alternative to discharge. There is not enough evidence to demonstrate benefit for the use of CTOs for part II patients to justify their continued use, especially as they are used disproportionately for black and ethnic minority patients. We recommend that CTOs are abolished for patients under part II of the MHA.

Recommendation 13

We have received some evidence that suggests unrestricted part III patients may benefit from CTOs. However, that evidence is inconclusive, so we recommend that the government should amend the draft bill to include a statutory review of CTOs for part III patients, to report within 3 years of Royal Assent.

Recommendation 14

We also recommend that the bill contains a provision that abolishes CTOs for part III patients 6 months after the time for the statutory review recommended above expires (or earlier with the approval of both Houses of Parliament). This would give the government time to introduce legislation to stop the abolition of CTOs for part III patients if the statutory review demonstrated convincingly that they had value and were now being used in a non-discriminatory way. If that were not the case, they would be abolished automatically without need for further legislation.

Government Response

Although we recognise that this proposal would receive some support, this is a complex matter that was considered in some depth by Sir Simon Wessely's Independent Review of the act. We believe that it is right that we continue to reform CTOs as the Independent Review recommended and for which the draft Bill now provides.

The reforms we have set out in the draft Mental Health Bill seek to address the committee's concerns regarding longstanding issues, notably people being on a CTO for far too long, when it is no longer appropriate, and especially, black people being disproportionately made subject to CTOs.

Under the government's proposals, we will reform CTOs so that they can only be used where there is a strong justification and a genuine therapeutic benefit for the patient. Such patients include those with complex symptoms (for example, psychosis) and comorbidities or other risk factors (such as homelessness) who have insufficient insight into their illness so would be at risk of disengaging once in the community. These patients often require time and supervision to achieve stability of their symptoms which then allows them to engage with treatment on a voluntary basis. We will also introduce greater scrutiny of their use through the involvement of community clinicians in arrangements for care after discharge from hospital, and by providing greater oversight by the mental health tribunal. These measures should help to guard against CTOs being disproportionately used for black patients.

The government continues to uphold the principle that the community may be the most appropriate place for treatment for some patients under the act. Our approach is focused on how best to treat a patient and, where that might include community treatment, we do not consider that the availability of such treatment should depend on whether a person is subject to part II or to part III of the act.

For some patients, CTOs provide the least restrictive option that ensures patients receive the ongoing support they need - but in the community, rather than having to stay in hospital. It is important that we strike the right balance between the risks and benefits to patients, as well as considering any potential unintended consequences related to the abolition of CTOs. The government is concerned that one such risk would be an increase in delayed discharges if there is no appropriate framework to allow for discharge into the community for patients felt to be high risk. There is also a risk of a consequential over reliance on other areas of the act that are not designed for longer term cases such as continued detention and placement on leave of absence under section 17 of the MHA.

We believe that our reforms will improve practice around CTOs and therefore we do not agree with the recommendation to abolish CTOs for either part II or part III patients. These changes will need time to become embedded and we agree that we need to ensure that the changes we introduce will have the intended impact of reducing the use of CTOs where this is inappropriate. As we committed to in the white paper, we will monitor the impact of the new safeguards being addressed in CTO provisions. Monitoring the impact on racial disparities will form a key part of our assessment of the continued use of CTOs.

Recommendation 15

We recommend that the introduction of the final bill should be accompanied by a revised impact assessment to take account of changes in the workforce and the economy since the original was published. It should also be explicit about the extent of interdependencies with other government programmes and policies.

Government Response

The government agrees that an updated impact assessment should accompany the final bill. The final impact assessment will reflect changes to the proposals, workforce and economic indicators where relevant. The impact assessment will also consider interactions with non-legislative measures and existing programmes that fall within the scope of the reforms. We will continue to work with NHS England and CQC when developing the impact assessment.

Recommendation 17

We were disturbed by the evidence we received that the concept of 'capacity' has been misused to deny treatment to very ill and potentially suicidal patients when they have voluntarily sought it. We recommend that the government set out in the response to this report what it, the CQC and NHS Trusts are doing and will do to prevent this practice.

Government Response

The government agrees that denying treatment to patients in these circumstances not only goes against the spirit of both the MHA and the Mental Capacity Act (MCA) but may also fall short of professional standards. The government will consider amendments to the code to make guidance on this point clearer. We will also work with professional bodies to investigate whether we can improve the way that clinicians communicate and engage with patients about capacity and suicide. We note the committee’s findings that this issue often occurs in relation to people with complex emotional needs and/or a diagnosis of ‘personality disorder’ or eating disorders. Ongoing work set out in the NHS long term plan will also help improve the pathways for these patient groups and improve training for clinicians. CQC continues to monitor services to ensure they implement effective safeguards for all cohorts of patients.

Recommendation 18

We welcome the government's confirmation that there will be further guidance on applying the new detention criteria in the code of practice. We recommend that this particularly address the definition of 'serious' harm and give guidance on how the 'likelihood' of harm should be assessed. This should balance the need to ensure detention is a last resort with the potentially greater therapeutic benefits of an earlier intervention in some cases. It should be clear that the change in criteria should not be used to deny care to those who need it and would benefit from it, including where serious harm would arise from a breakdown in personal circumstances, health neglect or deterioration.

Government Response

The government agrees that it will be important to clarify the new detention criteria in the code of practice. This has always been our intention and we will take the committee’s recommendations into account. We will set out in guidance our clear view on how the terms ‘serious harm’ and ‘likelihood’ should be interpreted in practice by decision makers.

Recommendation 19

We recommend that the consideration of 'how soon' harm might occur should not be included in the draft bill itself. This was not in the independent review's recommendation and would be better handled in the code of practice. Whilst we recognise what the government is trying to achieve, it will be difficult for professionals to assess objectively. We are concerned that it might dissuade potentially beneficial and shorter interventions at an earlier stage that would be in keeping with the principles. We recognise that some witnesses saw this provision as tackling the very real issue of long-term detentions of questionable benefit, but believe that these are already, and more effectively, addressed under other provisions in the draft bill, such as increased reviews by tribunal.

Government Response

The government will review the wording on ‘how soon’ harm may occur. We included this wording in response to the independent review’s finding that detentions currently could be justified by concerns about harms that may only occur far in the future. There is no express requirement in the current detention criteria for clinicians to consider the time element of when harms will occur, and we sought to clarify this. We note the committee’s concerns about the potential unintended consequences of this wording and will work to see how best to address this matter.

Recommendation 20

We recommend that the code of practice also give guidance on how the definition of 'appropriate treatment' should be interpreted in cases with a relatively low chance of improvement, or where resourcing means treatment may not be immediately available. It should also make clear that 'appropriate treatment' includes non-drug-based treatment.

Government Response

The government agrees that it will be important to explain, including in relation to the new detention criteria, what is meant by 'appropriate medical treatment' in the code of practice. The government agrees, as we stated in the white paper, that therapeutic benefit is about more than just medication. We will set out in guidance our clear view on how the term ‘appropriate medical treatment’ should be interpreted in practice by decision makers.

Recommendation 21

At present the changes in the draft bill mean it may be easier to be detained under part III of the MHA, which deals with those who are in the criminal justice system, compared to part II, which covers the rest of the population. We have heard convincing evidence that this is difficult to justify on the grounds of risk and that it could result in an increase in black people, autistic people, and people with learning disabilities being detained under part III of the act. This would be contrary to the aims of the review and the draft bill. We recommend that the changes in detention criteria should be consistent for individuals under either part II or part III of the MHA.

Government Response

The government acknowledges the committee’s concerns over the potential consequences of our proposed reforms. However, leaving the detention criteria for part III patients as currently drafted will ensure that, for example, vulnerable neurodivergent offenders in the criminal justice system, who would otherwise go to prison, can continue to be diverted to hospital (where appropriate), where they are more likely to receive more therapeutic and specialist support. This view was informed by an expert group of clinicians, third sector organisations, and justice stakeholders.

Under the revised act, there will need to be consideration of the therapeutic benefit of all detentions of part III patients, as with civil patients. Where the proposed reforms to the detention criteria differ is the determination of the risk of 'serious harm'. For part III patients this has always been a matter for the courts or the Secretary of State for Justice, taking into account all relevant factors, and it would be inappropriate to rely on the new standard statutory risk test used for part II patients.

Recommendation 22

We recommend that the government conducts a review of the Building the Right Support Action plan in light of the proposals in the draft bill. It should identify which milestones in this plan must be met to ensure that people with learning disabilities and autistic people who would have been eligible for detention under section 3 can be supported to live in the community. This review process should include all relevant parties, including service providers and service users. The milestones outlined in this review must then be met before commencement of those parts of the bill that remove learning disabilities and autism as a condition for which people can be detained under section 3.

Government Response

We agree with the committee that there will need to be an appropriate level and range of community support available before commencing those parts of the bill which will remove the power to detain people with a learning disability and autistic people without a co-occurring mental health condition under section 3.

We will set out how we intend to deliver these reforms, both legislative and non-legislative, alongside the draft bill as it enters Parliament. This will include detail and milestones in relation to the planned sequencing of the commencement of provisions, including those relating to learning disabilities and autism. The Building the Right Support Action Plan will be an important source of evidence to help inform this work, as will insights from people with experience of using mental health services and providers.

Recommendation 23

The government monitors outcomes for people with learning disabilities and autistic people who are no longer eligible for detention under section 3. This monitoring should specifically focus on people detained under the MCA or in the criminal justice system, including people detained in long term segregation. The government should commit to act if detention by these routes rises.

Government Response

The government agrees that we need to monitor the outcomes of the proposed changes to the detention criteria in the MHA for people with a learning disability and autistic people. We remain committed to reducing the number of people with a learning disability and autistic people detained in hospital. We already collect some data in the Assuring Transformation dataset on detentions of people with a learning disability and autistic people in mental health hospitals under different legal arrangements.

The Department of Health and Social Care is seeking to commission evaluation research of the reforms we plan to commence first and will consider how to monitor whether the full set of reforms are being implemented as planned and early signs of their impact, including for those with a learning disability and autistic people.

Under our proposed reforms, Integrated Care Boards (ICBs) will be required to establish and maintain a register of people with a learning disability and autistic people at risk of detention under the act. These registers may contain information about detention under different powers of detention and could be a useful tool for monitoring outcomes.

Recommendation 24

We recommend there should be provision by which detention can be continued after the 28-days allowed under section 2 of the MHA for people with learning disabilities or autistic people in tightly defined exceptional circumstances. This should only be available if pre-authorised by a specialist tribunal comprising individuals with an understanding of learning disabilities or autism. The time-period should be determined in the tribunal and subject to regular review by the same tribunal. The conditions which constitute 'exceptional circumstances' should be defined in the code of practice; we envisage they might include particularly complex presentations where further assessment beyond 28 days is needed.

Government Response

We agree with the committee that it is important people with a learning disability and autistic people can be properly assessed within the 28-day detention period under section 2 to ensure the decision is made to either continue detention by placing the patient under section 3, where there is a co-occurring mental disorder, or to discharge the patient, where there is not. We recognise that in order to achieve this, assessments must be carried out in a timely manner.

However, we are concerned that this recommendation could lead to unintended consequences. As the committee has identified in its report, treatment in inpatient settings for people with a learning disability and autistic people can be distressing, leading to worse outcomes for a patient and potentially, perpetuated detention. Given that we are attempting to address the issue of lengthy detentions through our reforms we are not in favour of creating a mechanism by which section 2 detention can be extended beyond 28 days. We are concerned that this would risk creating an alternative route to longer term detention which we know is often inappropriate for people with a learning disability and autistic people.

We will instead focus on a range of non-legislative measures to ensure that individuals can have their needs assessed and be given the right support in a timely manner, such as improved training for clinicians. In addition, the appropriate use of risk registers and improved community support should result in individuals’ needs being properly understood before they are detained, should this be considered necessary, thus reducing the need for lengthy assessment processes.

Recommendation 26a

The government should follow through with existing plans to provide enhanced diagnosis, care and treatment for people with learning disabilities and autistic people in prisons.

Government Response

We agree with the committee that the prison environment should be as supportive as possible for autistic people and people with a learning disability. As set out in our cross-government neurodiversity action plan which was published in July 2022, the Ministry of Justice and our wider health and justice partners are committed to improving early identification of need and support for neurodivergent people in prison. This includes championing autism accreditation across the prison estate, rolling out neurodiversity support mangers in every prison in the adult estate by 2024 and piloting digital interventions to support neurodivergent prison leavers. Significant progress continues to be made against all of the commitments made in the Action Plan as demonstrated by our 6-month and 12-month updates, which were published in January 2023 and September 2023 respectively.

To improve access to healthcare, NHS England's health and justice team is undertaking a number of actions to improve the experience of accessing healthcare for neurodivergent people in the criminal justice system. These actions include developing a network of learning disability and autism prison healthcare champions and developing neurodiversity pathways and guidance materials for the services it commissions.

Recommendation 26b

If the government continues with the provisions as they are in the draft bill, with learning disabilities or autism removed as grounds for detention under part II but not part III of the MHA, it will be imperative that the government develops safeguards to prevent further inappropriate use of part III for this group.

Government Response

We are committed to improving the support available, and reducing the need for mental health inpatient care, for all people with a learning disability and autistic people, including those who may come into contact with the criminal justice system. By making the appropriate support available to individuals we intend to prevent their needs escalating to a point where they may come into contact with the criminal justice system.

NHS England will provide national funding to local systems in 2023 to 2024 for investment in community infrastructure, which is in line with the Building the Right Support service model, which includes community forensic teams for people with a learning disability and autistic people.

The draft bill will help ensure that commissioners understand the risk of crisis at an individual level in their local area, through introducing a duty to establish risk registers, and ensure an adequate supply of community services for those at risk of admission under part II of the act. These duties will help people avoid reaching a crisis point which could lead to them coming into contact with the criminal justice system.

We will consider whether additional non-legislative safeguards are required to prevent people being detained inappropriately under part III of the act.

Recommendation 27

The government should strengthen the wording of the duty for integrated care boards and local authorities, which currently only requires that they 'have regard to' recommendations in the care (education) and treatment review reports, to ensure that the outcome of each review is actioned effectively. This could be done either by requiring that integrated care boards and local authorities must 'follow' recommendations in the reports or by placing an additional requirement that the integrated care boards and local authority must provide a 'good reason' for not following recommendations in the reports. For example, that the recommendations are not in the best interests of the individual.

Government Response

The government welcomes the committee’s recommendation and agrees it is important that recommendations from care (education) and treatment reviews (C(E)TRs) for people with a learning disability and autistic people are followed unless there is a good reason not to.

The 'have regard to’ duty is a common duty that clinicians and ICBs, like other public bodies, are used to applying. Indeed, it is a duty that already exists in the act. Further, a duty framed in these terms requires serious consideration to be given to the recommendations made. Such recommendations would ordinarily be followed except where there are clear, cogent and convincing reasons not to do so.

We do recognise the committee’s concern that some ICBs do not currently fully engage with the C(E)TR process. Our reforms will mean ICBs, as a responsible commissioner, are under a statutory duty to make arrangements to ensure a C(E)TR takes places and they must have regard to recommendations from a review – currently C(E)TRs are held only pursuant to guidance from NHS England.

Recommendation 28

The maximum time period between care (education) and treatment reviews is too long, especially when recognising the detrimental effects that inpatient environments can have on people with learning disabilities and autistic people, particularly those who are under 18. The maximum time period between reviews should be shortened from 12 to 6 months.

Government Response

C(E)TRs are important in helping to ensure that when people with a learning disability and autistic people are detained under the act their individual needs are identified and met, and steps are taken to support them towards discharge. That is why we are placing them on a statutory footing under our proposed reforms. We agree with the committee that some people with a learning disability and autistic people, particularly those under 18, should receive C(E)TRs more frequently than every 12 months, as set out in current NHS England policy.

The 12-month interval set out in the draft bill is intended to be a maximum time limit between reviews, based on the maximum C(E)TR interval in current NHS England policy. This does not preclude C(E)TRs from happening more frequently than this. Section 125F sets out that the Secretary of State must publish statutory guidance on C(E)TRs, and we would use this to specify when C(E)TRs should happen at shorter intervals than 12 months, in line with current NHS England policy. We designed this approach in the bill in order to allow different C(E)TR frequencies to be set for different circumstances. However, we do recognise there is a risk that C(E)TRs will be carried out to the maximum timings set out in the legislation (12 months), as opposed to those specified in guidance.

We welcome the committee’s recommendation and are considering the best way of ensuring that individuals receive C(E)TRs at the appropriate intervals. This could include, for example, ensuring that responsible commissioners have the capability to meet any new legislative requirement for more frequent C(E)TRs.

Recommendation 29a

We recommend that the 'risk register' is renamed 'dynamic support register' in the draft bill to better reflect its purpose.

Government Response

We thank the committee for their drafting suggestion and will consider this further.

Recommendation 29b

The government should also consult with people with learning disabilities and autistic people to see how they can build trust in this dynamic support register mechanism.

Government Response

We welcome the committee’s recommendation and will consider the views of people with a learning disability and autistic people when developing statutory guidance on risk registers, to help ensure ICBs are using registers in a way that individuals feel able to trust.

NHS England has already undertaken work to build trust in risk registers. It has published guidance on dynamic support registers (DSRs) which it co-produced with people with a learning disability, autistic people and their families. This guidance sets out the expectation that local areas will make information about DSRs available, to support people and their families to find out more about the process.

Recommendation 30

We recommend that the government should strengthen the duties on integrated care boards and local authorities to impose a firm duty to ensure the adequate supply of community services for people with learning disabilities and autistic people, using information gathered from the dynamic support register.

Government Response

We believe that the provisions contained within the draft bill will be sufficient to ensure adequate supply of community services, and we agree with the committee that this support will be vital. Under the proposed section 125E, both ICBs and local authorities will be required to have regard to information made available through the risk registers and commissioners will be under a duty to seek to ensure that the needs of people with a learning disability and autistic people are met in the community, so that they may avoid detention under part II of the act.

Recommendation 31

The duty on integrated care boards to 'establish and maintain' a register should be strengthened to include more proactive language, for example, using the 'develop and maintain' duty in existing NHS policy for dynamic registers. We also recommend that the factors to be set out by the Secretary of State to indicate that an individual is at risk of admission have sufficient clarity to avoid the misinterpretation of risky behaviour as risk of admission, and to give clarity to individuals on the register and their families.

Government Response

We agree that it is important that ICBs are proactive in identifying people with a learning disability and autistic people to be included on a risk register and will consider whether this drafting suggestion helps to achieve this.

We agree with the committee’s recommendation that risk of admission factors need to be clear and will seek to achieve this when drafting the regulations setting these out. We intend that this will provide clarity for individuals and their families and will support health and social care professionals to correctly identify individuals who should be on the register. This will also help to ensure that sufficient services are commissioned locally and provide an additional tool for understanding the person’s needs to help prevent them reaching a crisis point.

Recommendation 32

Section 117 aftercare, proportionate to need, should also be extended to patients who are admitted under the 'exceptional circumstances' route recommended above (recommendation 24)

Government Response

We recognise the importance of people with a learning disability and autistic people being properly supported in the community upon discharge. However, as we are addressing the concerns which led to recommendation 24 through non-legislative means, rather than introducing a mechanism for extending section 2 detention under ‘exceptional circumstances’, this recommendation will not be taken forward.

We are introducing measures in the bill, through new duties on commissioners, that will help to ensure people with a learning disability and autistic people who are discharged from an inpatient setting receive the right support in the community to meet their individual needs.

Recommendation 33

The government should commission research into the likely costs and benefits of extending aftercare, proportionate to need, to patients who are detained in mental health settings under provisions other than section 3 of the MHA, including those admitted for more than 28 days or detained under the liberty protection safeguards of the MCA. Informed by this research, the government should consider extending section 117 aftercare, or an equivalent aftercare provision, where appropriate.

Government Response

Aftercare under section 117 of the MHA is already available to people who have been detained under sections other than section 3 - sections 37, 45A, 47 and 48 of the act are all qualifying sections for people who then cease to be detained and leave hospital. Although we appreciate there is a demand for entitlement to be extended, it is the government’s view that the existing position generally serves to ensure that it is those patients who have the greatest need who benefit from the support.

Recommendation 34

The government should consult on the introduction of a statutory test for competency, or 'child capacity', for children under 16. This consultation should be wide ranging and consider the wider implications of this reform on other areas of law affecting children.

Government Response

The government appreciates that there are different opinions about matters to do with children and young people’s rights, and on the best approach to assess their capacity and competence. But these considerations are relevant to people in all settings, not just to those detained under the MHA. The MHA is not the appropriate forum for setting a statutory test for child competence in wider settings. Gillick competence remains the accepted competence test for under 16s across all settings.

We have heard that some stakeholders would like a statutory test for competence for under 16s in the act. The government is concerned, however, that setting out a statutory test for competence in the MHA could potentially put under 16s in a more complicated position, particularly those assessed as having competence to consent to decisions under the MHA definition but who would be considered not to have competence using the existing test of Gillick of competence, or vice versa. We think that the best place to set out how practitioners should assess children and young people’s competence and capacity under the act is in the code of practice, and we will consult with stakeholders when we come to review this.

Recommendation 35

The government must take the opportunity of this legislation to strengthen the protections in the MHA against children and young people being placed in inappropriate settings, such as adult wards or placements out of area. For example, the draft bill must amend duties on hospital managers to ensure that there are sufficient services for children and young people, and there must be stronger procedural requirements where inappropriate placements are considered, including that such a placement is demonstrably in the child’s best interests. It is imperative that these reforms coincide with developments in the provision of specialist services for children and young people to address the core driver of this problem.

Government Response

The government agrees that children and young people should not be placed in inappropriate settings and will explore what more can be done, outside of legislative changes, to reduce the instances where this occurs.

Section 131A of the act already places a duty on hospital managers to ensure that the patient’s environment in the hospital is suitable having regard to their age, whilst section 140 requires ICBs to inform local authorities when accommodation suitable for children becomes available. NHS England’s regional specialised commissioning teams are delivering an accelerated bed programme which aims to improve patient outcomes and experience by eliminating inappropriate out of area placements, improving local bed availability aligned with community services, and eliminating inappropriate under-18 placements in adult beds.

In 2021 to2022, we provided an additional £79 million to expand children’s mental health services which allowed around 22,500 more children and young people to access community health services. We are also investing £150 million of capital funding in NHS urgent and emergency mental health infrastructure to support people to receive care in more appropriate settings outside of A&E. This includes settings that will specifically support children and young people.

Recommendation 36

We recommend that there should be a statutory right for patients who have been detained under the MHA to request an advance choice document be drawn up. These should also be offered to everyone who has previously been detained, as recommended by the independent review. This provision should extend to people with learning disabilities or autistic people who have been detained under the MHA, including section 2, section 3 prior to the commencement of the changes in the draft bill, and the 'exceptional circumstances' route outlined in paragraph 180 of the committee's report. They should be recorded in a way that is accessible digitally, linked to a patients' GP records, and usable quickly in crisis settings, including by first responders such as the police and paramedics.

Government Response

The government agrees with the aim of the committee's recommendation, which seeks to strengthen the offer of advance choice documents (ACDs) for people who are likely to benefit from them. However, we think that this is best achieved by placing a duty on services to carry out activity in relation to ACDs as opposed to introducing new rights for individuals to request an ACD. We think that this approach is likely to be more effective as, rather than the onus being on individuals to 'request' to create an ACD, it will be on services to take action. We will be exploring how best to take this forward.

We agree that a mechanism to store ACD information digitally is the best means of ensuring that they can be shared easily and readily accessed by the relevant professionals at the point of need. We continue to explore how best to achieve this in a way that supports take up and accessibility, in both the short and longer term, alongside NHS England and external stakeholders.

Recommendation 37

We heard evidence that when the patient is meaningfully involved in the creation of their ACD this helps build trust. Therefore, we recommend that to facilitate such involvement this should be done with the support of a trained person who is independent of the service users' treatment team.

Government Response

We agree that the person should be at the centre of their ACD and therefore it is critical that they are meaningfully involved in its creation. To facilitate this, we agree that the support of a person who is independent of the individual’s treatment team can be important, whether for instance that be a loved one, a peer support worker or a clinician. However, we think that the person should also be able to rely on the input of their treatment team, who will be well positioned to advise on what options might be available to the individual should they be detained under the act. Ultimately, we want to uphold the principle of patient choice and autonomy in this respect.

We are aware of various research studies that have explored this issue, and we are working closely with stakeholders to develop a model that works best.

Recommendation 38

We agree with the independent review that a slimmed down mental health tribunal should be able to consider whether a patient is entitled to challenge their treatment plans, if requested, following a Second Opinion Appointed Doctor (SOAD) review of their care and treatment plan or a major change in treatment. We recommend that the government amend the draft bill to allow for pilots in the first instance, to ensure that the additional workload is manageable and the tribunal and clinicians' roles are not compromised.

Government Response

We appreciate the committee’s thorough consideration of this policy proposal. However, we do not consider that it would be appropriate for the tribunal to be able to review each and every aspect of a patient’s treatment. In particular, we do not think the tribunal should be able to make determinations about whether an individual clinical judgement about treatment, made in good faith, is right or wrong in a particular case. Therefore, we do not see a rationale for taking forward the pilots proposed by the committee.

We also continue to be of the view that the new measures included in the draft bill already significantly improve the autonomy that patients have over their care and treatment. For example, those around advance decision making, the ‘clinical checklist’ and the new, stricter rules around when refusal of medication by a person with capacity can be overridden.

We agree, however, that the patient’s care and treatment should play a more central role in the tribunal’s consideration of whether their detention should continue to be upheld or not. We intend to achieve this through our proposed changes to the detention criteria, which place a greater emphasis on the principle of therapeutic benefit, and by working with His Majesty’s Courts and Tribunals Service and the judiciary to agree how the patient’s statutory care and treatment plan can be used in tribunal proceedings to help inform decision making.

Recommendation 39

The nominated persons provisions for adults are welcome, necessary and reflect the principle set out in the independent review to support patient choice and autonomy. We recommend that the government work with approved mental health professionals (AMHPs) to revise the proposals to address the practical concerns that have been raised with us and ensure the benefits of these reforms as envisaged by the independent review materialise.

Government Response

We appreciate that there are concerns that some aspects of the current process for appointing a nominated person on behalf of the patient may be challenging for AMHPs. We accept the recommendation to work with AMHPs to improve the practicalities around appointing a nominated person in the legislation.

The nominated person provisions provide patients with choice and the opportunity to exercise autonomy. It is important that the uptake of nominated persons is supported by a nomination process which is both robust enough to ensure that nominations are not subject to doubt whilst avoiding being overly complicated or inflexible for health and social care professionals. We have been working with AMHPs and intend to amend the bill in order to improve the final provisions which allows us to maintain our policy objectives without being overly burdensome on staff.

Recommendation 41

The government should consult specifically on how nominated person provisions will apply to under 18s in regard to potential conflicts with other legislation affecting children, such as the Children Act 1989. It should come forward with new proposals on how the nominated person provisions will apply to under 18s at an early stage in the bill’s progress.

Government Response

We appreciate stakeholders are keen to ensure that the interface between the bill and existing legislation concerning children is clear. We will work closely with stakeholders to ensure that any potential points of confusion are addressed, and that children and young people are appropriately safeguarded. In terms of the right to appoint an NP with respect to under 18-year-olds, we aim to take forward the provisions already included in the draft bill which will allow young people aged 16 or 17 the same right to choose an NP as an adult, and allow under 16s this choice as long as they are Gillick competent. We originally proposed this in the white paper and consulted on whether under 16s in particular should have this right and the majority of respondents agreed with our proposal. We will continue to work with stakeholders to ensure that the appropriate safeguards are in place to enable greater autonomy for children and young people.

If the child does not nominate their parent, the parent will maintain all their existing legal rights, including to be consulted on certain decisions and to receive information about the child's care and treatment (subject to the child's confidentiality rights and safeguarding concerns). In our view, the child should be informed that the parent maintains these rights and we will make this clear in the code of practice. Similarly, where a child is under a care order and parental responsibility sits with the local authority, the local authority will retain their parental responsibilities to the child even if the child chooses an NP who is not the local authority. We intend to clearly describe the respective roles and decision-making powers of the NP and the body or person with parental responsibility in the code of practice.

Recommendation 42

We welcome the 'opt-out' advocacy scheme for detained patients. Once capacity has been built up in the advocacy sector, as measured against the annual independent mental health advocate (IMHA) workforce modelling targets in the impact assessment, it should be extended to include informal (voluntary) patients as well. This would bring particular benefits to children and young people, most of whom are informal patients. The bill should include the powers to do this, to be commenced only once capacity exists to support informal patients on top of those who have been detained.

Government Response

We recognise the important role the IMHA service can play in supporting informal (voluntary) patients, particularly children and young people. That is why we are seeking to extend the right to an IMHA to informal patients in the draft Mental Health Bill. We have prioritised the 'opt out' scheme for formal patients, who are subject to greater restrictions and are potentially more vulnerable compared to informal patients.

Although the opt out scheme will not apply to informal patients, the draft bill places a duty on hospital managers to make informal patients aware of their right to an IMHA, so that they can access the support and advice available through the advocacy service.

Our reforms aim to offer a greater level of support and representation to all patients, including children and young people.

Recommendation 43

There are shortages of advocates with the specialist knowledge of learning disabilities and autism, relevant language skills or cultural knowledge to support patients with specific needs. The government should examine the case for a central advocacy service, to meet the needs of specific groups who may otherwise go unsupported in some areas.

Government Response

We agree that it is important that advocacy services appropriately support people with specific needs and people from different groups. We have taken forward discussions with delivery partners regarding the introduction of a centralised advocacy service, including to consider potential policy and implementation requirements, and are minded not to pursue such a model at this stage. We think there is a particular value associated with the commissioning of advocacy at a local level, where independent advocates know and are able to effectively navigate local systems with their clients. We also expect all advocacy services to make reasonable adjustments to meet the varying needs of the people they are representing and supporting, including as required under the Public Sector Equality Duty. The creation of a national service would risk creating confusion and potential gaps, including in relation to differing respective roles of local and any nationally commissioned service provision. Our preferred approach is therefore to work with the advocacy sector to improve and upskill existing provision, including through staff training, to ensure that all local services are able to meet specific needs.

Recommendation 44

The bill should include a statutory right to request culturally appropriate advocacy, as defined in the existing pilots. The government should consider the workforce requirements needed for this change and the impact assessment and implementation plan should ensure adequate timing to develop services. The second round of pilots should be evaluated before commencing this right so that lessons can be learnt in its implementation.

Government Response

Culturally appropriate advocacy has the potential to play a significant role in helping address the racial disparities currently seen in the application of the MHA.

We are not in favour of introducing a statutory right to access such services in the legislation at this stage, however. Rather, we intend to consider the findings from the pilots before deciding if legislation would be the correct mechanism for implementation of such a policy and, if so, what any statutory right could look like. This will allow us to further build our understanding of what such services might entail, how they may be delivered, and the improvements in outcomes that they might support. When commissioning advocacy services, local authorities are already required under section 149 of the Equality Act 2010 to eliminate discrimination and advance equality of opportunity, including in respect of taking steps to meet specific needs based on race as well as religion or belief and other protected characteristics.

Recommendation 45

We recommend that there be a statutory duty to collect and publish data on the use of supervised discharges, including duration, cause and demographic profile. We recommend that there be a statutory review after 3 years from the commencement of this clause and that the provision will expire following that review, unless renewed through approval of both Houses of Parliament.

Government Response

The government agrees there should be transparency and scrutiny over the use of supervised discharge, but we intend to take this forward through non-statutory means.

Data on conditional discharge, including demographic data, is already published through the annual restricted patient's statistical bulletin and the use of supervised discharge will be included in this. While all the information recommended by the committee will be collected, it may not always be possible to publish demographic data if patient numbers are low as this could lead to individuals becoming identifiable. It would also be inappropriate to publish the reasons an individual requires deprivation of liberty conditions for the same reason.

As recognised by the independent review, these provisions are necessary to fill a legal gap preventing patients from continuing their care in a less restrictive setting. The government will work with stakeholders to closely monitor the impact of these reforms to ensure the powers are being used proportionately and appropriately and in line with the policy intent.

Recommendation 46

Despite the government's preference for consistency with the approach for other forms of conditional discharge, we consider that extra safeguards are necessary given that this form of discharge involves the deprivation of liberty. We recommend that the tribunal must be involved in the decision to place someone on a supervised discharge, as recommended by the independent review, to ensure that therapeutic benefit is being considered in this process.

Government Response

The government agrees that therapeutic benefit should be considered in supervised discharge decisions, but this can be achieved without compromising the Justice Secretary's public protection duties in respect of these patients.

Restriction orders are given by the independent judiciary to ensure the Secretary of State for Justice has oversight of dangerous patients. It would be inconsistent for the tribunal to have more powers than the Secretary of State for Justice over supervised discharge, given these patients will present a higher public protection risk than those suitable for ordinary conditional discharge.

The Secretary of State for Justice applies a slightly different test to that of the tribunal in order to preserve their discretion in the interests of public protection, but conditions for patients must still be appropriate and proportionate. We will publish operational guidance as part of the implementation process to make clear that the Secretary of State for Justice should have regard to the principle of therapeutic benefit and only use this type of discharge when the evidence indicates it is in the best interests of the patient. Explicit safeguards are present in the draft bill, providing these patients with regular access to the tribunal once a decision has been made to ensure the arrangements remain therapeutically beneficial. We will work with stakeholders to consider whether further safeguards would be appropriate.

Recommendation 47

The government should consult with the CQC and set out in their response to this report how community care homes or other establishments in which individuals may be residing under supervised discharge can be appropriately regulated and inspected, relative to hospitals, considering the deprivation of liberty patients will be under.

Government Response

We agree with the committee that regulatory oversight would provide an enhanced safeguard for individuals subject to supervised discharge, given that these individuals will be deprived of their liberty.

We will continue to consult with the relevant regulatory authorities in England and Wales to cover all patients subject to a supervised discharge in the community.

Suitable placements for these patients may be found in care homes in the community or other premises which are equipped to provide the right level of care and support, in order to protect the public whilst also giving patients greater independence than is available in a hospital setting. We are exploring what level of regulatory powers would be appropriate, given the different nature of these settings relative to hospitals.

Recommendation 48

For the 28-day transfer deadline to be meaningful we recommend that 'seek to' be removed, so that the duty is to ensure that the deadline is met. We appreciate transfers involve multiple authorities and bodies with some lenience being needed, but if included in legislation it should be a meaningful deadline that can be applied to services who should be expected and are supported to meet it.

Government Response

The government remains committed to reducing delays for those prisoners who meet the threshold for detention under the MHA to access in-patient treatment. The current wording in the draft Mental Health Bill, to 'seek to ensure' a transfer occurs within 28 days of initial referral, is sufficiently robust to provide accountability for a breach of the time limit, while recognising that multiple agencies are involved in the transfer process. We consider that 'seek to ensure' would likely be construed by courts as parties making every reasonable effort to ensure the timeline is met. We will ensure that the explanatory memorandum published alongside the bill emphasises the statutory duty upon responsible parties to make every reasonable effort to ensure the transfer occurs within 28 days.

Recommendation 49

The government should set out an action plan alongside the bill that has a clear timeline and process for how all services will achieve this deadline.

Government Response

As referenced earlier, the effective implementation of the planned legislative changes and the accompanying non-legislative programmes is critical for delivering the government’s MHA reform ambitions. To this end, we plan to publish an action plan for how services will achieve the statutory 28-day deadline for transfers from prisons and immigration removal centres to hospital, which will be set out alongside the introduction of these provisions in Parliament.

Recommendation 50

The government should include the newly developed statutory independent role to monitor and manage prison transfers in the bill when it is presented to Parliament, as stated by the minister.

Government Response

The government welcomes the committee’s assertion that independent oversight of the transfer process would be valuable to protect patients’ interests. To ensure flexibility in the design of the role, we believe we can pursue these agreed objectives through a non-statutory role. As stated by Minister Hinds during the joint committee’s evidence session on 23 November 2022, we are continuing to explore the best way to do this and will share details of this non-statutory role before the bill is presented to Parliament.

Recommendation 51

We recommend that the government should consult further on a short-term emergency detention power, and whether this would provide greater legal clarity to clinicians and accountability for what is happening in A&E services.

Government Response

The government recognises that there are pressures in A&E which can prevent people in a mental health crisis from timely access to mental health crisis care. The delivery plan for recovering urgent and emergency care services, published in January 2023 sets out action to increase capacity, grow the workforce, improve discharge, expand and better join up health and care outside hospital, and improve access to the right care.

DHSC, NHSE, Home Office, the National Police Chiefs’ Council, the Association of Police and Crime Commissioners and the College of Policing have published a national partnership agreement (NPA) to work together towards reducing inappropriate involvement of police in responding to mental health related incidents, and support individuals experiencing acute mental health distress and in need of medical help to get the right care at the right time.

Alongside the draft bill, we announced £150m of capital funding for crisis services. This funding will provide additional alternatives to emergency departments, including crisis houses and health-based places of safety, and help people to receive support in more suitable environments. The funding also included £7 million for mental health ambulances, to help reduce pressure on general ambulances and avoid police conveyance of people in mental health crisis.

The government accepts that there may be a need to provide greater legal clarity to clinicians in A&E. We will continue to engage with stakeholders to understand how the current legal framework is being applied and what, if any, legislative changes may be required.

Recommendations 25, 52 and 53

Recommendation 25

The government should urgently review the operation of the MCA in this context with a view to amending the deprivation of liberty safeguards (soon to be liberty protection safeguards) so they cannot be used as an alternative route to the MHA to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units for lengthy periods of time and thereby undermine the intention of this bill. We reflect that this would be a specific disorder exclusion from the liberty protection safeguards (LPS), which have not yet been put into practice. We also recommend that the government re-examine the inclusion of other specific disorders under the LPS in this context in future, for example, dementia.

Government Response

The government does not believe that it is always inappropriate for the MCA to be used to authorise a deprivation of liberty for the treatment of mental health conditions. In certain circumstances, where a person lacks the relevant capacity but is not objecting to admission to hospital or treatment, it may be the most appropriate option.

We think it is right in these circumstances that clinicians are able to make a choice between using the MCA or the MHA, based on the specific individual needs of the patient. We will work to improve and clarify the interface between the two legal frameworks in the code of practice.

The government notes the concern of the committee that deprivation of liberty safeguards (DoLS) will continue to be available to apply to some people with a learning disability and autistic people when the bill is implemented.

The government’s objective is to minimise length of detention and secure the reduction of the number of people with a learning disability and autistic people who are compulsorily admitted to hospital by supporting them to live fulfilling lives in their community. In order to support this ambition, through the bill we are aiming to reduce the scope of the MHA to detain people with a learning disability and autistic people without a co-existing psychiatric illness. This ambition is also reflected in our proposed reforms that help to ensure that commissioners understand the risk of crisis at an individual level, through the duty to establish risk registers, in their local area and ensure an adequate supply of community services.

There may, however, still be cases where a person who has a learning disability and/or is autistic, and who lacks the relevant capacity, needs care and treatment arrangements that require a deprivation of liberty. The government will review the impact of changes to the detention criteria with regard to people with a learning disability and autistic people, with the aim to ensure detention in hospital is only used where there is a direct therapeutic benefit to the person, and not simply a displacement from the MHA to the DoLS.

Recommendation 52

The government should look to resolve the 3 gaps or ambiguities in the law regarding the interface of the MHA and the MCA identified in this subsection, through amendment of the MCA if necessary. Such relatively minor changes could make a significant difference to simplifying decision-making in difficult circumstances, without prejudicing the rights of the patients concerned.

Recommendation 53

Our inquiry has highlighted the complexity and unintended consequences of the interface between the MHA and MCA. This issue needs to be addressed. We recommend that the government review the interaction between the two pieces of legislation as part of the process of ongoing reform recommended earlier in this report. In particular, it should review the use of the MCA to authorise admission to, and treatment in, mental health units.

Government Response

We recognise that the MHA is, at times, being used in cases where it may be preferable to use the DoLS. We note the concerns raised by the committee regarding the complex nature of the interface between the MHA and the MCA and recognise that this may present challenges for decision makers. We will continue to consider the interface between the MHA and the MCA as we implement our mental health reforms. We will also continue to engage with stakeholders to understand what support and guidance could help improve application of the interface.

The 3 specific ambiguities identified by the committee in recommendation 52 relate to the LPS. The government has decided to delay LPS beyond the lifetime of this Parliament, and therefore we will not be considering these specific issues at this point in time.

Recommendation 54

We recommend that all people known to a mental health service with a known learning disability and/or autism should have the reasonable adjustment flag attached to their record, with an option for individualised adjustments of preferred communication and the name of their advocate.

Government Response

The government agrees with the committee’s recommendation.

NHS England is working to implement a reasonable adjustments digital flag within patient records to enable health and social care staff to recognise that someone has a learning disability or is autistic, at the point of contact. The flag will also allow health and social care staff to record, share and view details of a person’s needs for reasonable adjustments, allowing services to tailor support appropriately.

Recommendation 55

The provision of appropriate places of safety will be crucial to reducing detentions and reducing the pressures on A&E and police services, especially following the welcome removal of prisons and police custody as places of safety. We recommend that the government increases the provision of appropriate health-based places of safety, and include plans for this within the implementation plan recommended in chapter 2.

Government Response

The government agrees with the committee about the importance of health-based places of safety. We continue to invest in additional health-based places of safety, as well as a range of other crisis services, as part of the £150 million capital investment programme for mental health announced by the government in January 2023. This funding will assist with the removal of police stations as a place of safety in all circumstances, as well as building capacity in preventative services so that people do not reach the crisis point in the first place.

Annex A: drafting points

This table contains the government's responses to the points made in Appendix 3 of the Joint Committee's report on aspects of drafting.

Clause	Text	Committee comments	Government response
4(3)	In section 20A (community treatment period)— … (c) for subsection (7) substitute— “(7) Subsection (6) of section 17A applies for the purposes of subsection (4)(b) of this section as it applies for the purposes of subsection (4)(a) of that section.”	Clause 4(3) makes changes to section 20A of the act that require the reader to cross-reference section 17A, which means going backwards and forwards between the two sections. The change made by clause 4(3)(c) in particular is difficult to apply because it requires the reader to envisage a provision of section 17A applying for the purposes of section 20A. It would be preferable to make the amended section easier to understand, for example by adopting the wording of section 17A(6) and putting it directly into section 20A. (See similar comments on clauses 26(5) and 39(3).	At the time when section 20A(4) is being applied in relation to a patient, the patient will be subject to a community treatment order under section 17A (unless there has been a previous extension) and, in effect, what is happening under section 20A is that the responsible clinician is deciding whether the criteria in section 17A continue to be satisfied. However, in the act as it stands, the criteria are written out in both places. The thinking behind the drafting was that (a) now that the criteria are longer, the approach of writing them out in both places is less appropriate, and (b) it would make sense (as well as abbreviating things) for the wording of section 20A to highlight the link with section 17A by cross-referring to it.

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			However, we note the committee's specific point about the way in which subsection (6) of section 17A is applied and will consider whether there is a more straightforward way of achieving the same result in relation to that subsection.
6(2)	…(i) has a reasonable prospect of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations…	The definition of “appropriate medical treatment” in the new section 1A includes the condition that treatment has a reasonable prospect of alleviating, or preventing the worsening of, “manifestations” of the disorder concerned. This definition is potentially wide. It appears to cover self-harm and harm to others. So, it may go beyond what might otherwise be considered “therapeutic benefit”, which appears to be the intention of the provision. If it is intended to be narrower in scope (to avoid detaining	The intention of the provision is to introduce the concept of likelihood of the treatment ameliorating the patient’s condition when considering whether a treatment is “appropriate medical treatment” (i.e., whether it provides therapeutic benefit), rather than, as currently, the focus being on the purpose of the treatment when considering appropriateness. The reference to medical treatment in the new definition of “appropriate medical treatment” is not intended to be any narrower in scope than the existing definition of medical

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		people on the basis only of propensity to commit harm), it would be preferable for the drafting to be amended to make this clearer.	treatment in section 145(4) of the act, and for that reason the drafting approach has been to mirror the wording of section 145(4), including use of the term “manifestations”. When section 145(4) was inserted into the act in 2007, the government explained that “symptoms” covers things that the patient can identify and “manifestations” covers things that other people notice (Hansard, HoL 693:835). However, we note the committee’s concern and will reflect on whether the drafting needs to be amended to clarify this.
8(5)	For section 64 (supplementary provisions for part 4), for subsection (1) substitute…	It appears that this should read “**In** section 64…” (the provision is substituting the subsection, not the whole section). (As with the other sub-clauses.)	We agree, are grateful, and will make the correction.
11(2)	This section applies to the forms of medical treatment for relevant disorder	It isn’t immediately clear from the wording “relevant disorder” – without a	The committee is correct that the intention in inserted section 57A(1) is

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	mentioned in subsection (2)…	preceding word that might be expected grammatically, such as “a”, “the”, or “any” – whether only one such disorder is being referred to, or potentially more than one disorder that any patient might have. It is understood that in fact more than one disorder is intended to be captured. In which case, it would be preferable for all references to “relevant disorder” be amended to read “any relevant disorder” (except where only one such disorder is intended), so this is made clear to the reader.	that the term “medical treatment for relevant disorder” is intended to capture treatment for the totality of the patient’s disorder, which may include multiple diagnoses. “Relevant disorder” is defined in the bill in paragraphs 8 and 12(b) of schedule 1 and is substituted for the term “mental disorder” in various provisions relating to part III patients as a result of the amendments made by the bill to the application of the act to patients with a learning disability or autism. Whilst we can see that on the face of section 57A(1) one might expect a preceding word grammatically, the drafting approach mirrors the current approach in the act to use of the term “medical treatment for mental disorder” where it appears and is intended to have equivalent meaning in terms of being capable of capturing more than one disorder. See in particular existing section 57(1) which

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			the new section 57(1) is mirroring. We will, however, review usage of the term “relevant disorder” in the bill and consider whether any amendments to the drafting are needed to aid interpretation.
11(8)(a)	…(ii) the administration of medicine to the patient by any means (not being a form of treatment specified under section 57, section 58(1)(a) or section 58A(1)(b)) if a period equal to or longer than the section 58 period has elapsed since the first occasion, during the relevant period, when medicine was administered to the patient by any means for relevant disorder…	It is assumed that “the administration of medicine” at the start of this provision refers to the same medicine as “when medicine was administered” at the end. Read literally, different medicines could be being referred to. To resolve any ambiguity, it would be preferable to qualify the second reference to “medicine” (for example “that medicine”).	The drafting mirrors the wording of section 58(1), which it cross-refers to, and is intended to include different medicines so we think the drafting approach here reflects the policy intention. However, we will continue to consider whether this can be more clearly expressed to resolve any ambiguity.
22(2) (New section 114C)	Where a nominated person objects under subsection (4B) to the making of an application, the application may be made only if it is accompanied by a report certifying that, in the opinion of the approved mental	The word “likely” here is ambiguous. Does it mean more probable than not (i.e., more than a 50% chance), or a reasonable chance or real possibility (i.e., not necessarily more than a 50% chance)?	The use of the word “likely” in new section 11(4C) was intended to mirror the current wording in, and have the same meaning as use of that word in, section 25 of the act. The concept of “likely” in section 25

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	health professional, the patient, if not admitted for treatment or received into guardianship, would be likely to act in a manner that is dangerous to other persons or to the patient.”	It is understood that the intention is to follow the code of practice, which in turn takes into account the approach in the case of Re JR [2011] NIQB 17. However, it is still not obvious what the relevant meaning would be (the code refers only to “probability” in general terms, rather than the level of probability, and the case refers to a test of “real probability”, which is itself potentially confusing). It would be clearer for the legislation itself to set out precisely what the test is: i.e., is it more probable than not, or something else?	is well established and the intention was not to change that. However, we will reflect on whether the wording should be clarified.
22(3)	…in subsection (5)— (i) the words from “one” to the end become paragraph (a), and (ii) after that paragraph insert— “(b) if the patient appears to have a nominated person, the nominated	The effect of this amendment would be that the responsible clinician must consult “(a) one or more other persons who have been professionally concerned with the patient’s medical treatment, (b) if the patient appears to	We agree, are grateful, and will make the correction.

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	person".	have a nominated person, the nominated person." There is no conjunction between (a) and (b). It is assumed that both persons in a) and b) need to be consulted, rather than either one or the other. But it would be preferable to confirm (for example, by adding "and" between them).	
26(5), inserting new para 2ZA to Sch. 1	"2ZA (1) Section 20 is to apply with the modifications specified in paragraph 5B if— (a)… (b)… (2) Otherwise, section 20 is to apply with the modifications set out in paragraph 6."	The provision inserted into schedule 1 requires the reader to go backwards and forwards between the schedule and section 20, trying to mentally hold information from the one to apply it to the other. The drafting approach here appears to follow that elsewhere in schedule 1, but it would be easier for the reader if a modified version of section 20 could be set out in full. (See similar comments on clauses 4(3) and 39(3).)	As the committee notes, the drafting approach here is consistent with the existing approach in schedule 1 to the act. The thinking when drafting the clause was that, despite the disadvantages of that existing approach, it would be better to be consistent with it. We will consider the approach again in light of the committee's comments, but we note that the length of section 20 and the fact that it is modified differently for different purposes means

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			that an alternative approach might give rise to additional length and repetition. These factors will need to be considered, as well as the point about consistency with the existing drafting.
39(3)	"(3A) In applying subsection (3) for the purpose of determining the local social services authority in relation to a person— (a) section 105(6) of the Children Act 1989… (b) the following provisions apply for the purpose of determining the person's ordinary residence at any time when they were aged 18 or over…"	The insertion of section 117(3A) achieves its effects by applying modified provisions of other legislation. This requires the reader having to go back and forth between different pieces of legislation, and mentally reconstructing provisions that apply in this mental health context. It would be easier for the reader if the modified provisions themselves could be set out in one place. (See similar comments on clauses 4(3) and 26(5).)	We recognise the difficulty that the committee mentions here. However, the provisions cross-referred to are already in operation and have to be applied by local social services for determining ordinary residence for other purposes. The policy is that those established ordinary residence rules should now apply for the purposes of section 118 of the act as they already do for the other purposes. The approach therefore reflects the policy intention. Writing the rules out again would produce a lengthy and complex provision in which it would be unlikely to be possible to preserve the wording of the

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			existing rules verbatim. Writing things out twice in slightly different ways may be unhelpful if the reader has to satisfy themselves of whether any difference of meaning was intended. However, we will continue to consider whether there is a way to minimise the extent of cross-referencing in this provision.

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