



Reforming the Mental Health Act

Government response to consultation

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

July 2021



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Ministerial Foreword

This report represents a significant milestone on the road to reform of the Mental Health Act. It summarises the invaluable and constructive responses we have heard from the public and stakeholders during our consultation on the White Paper *Reforming the Mental Health Act*. We are pleased to see that there is a broad support for our proposed reforms. We thank all those who contributed – these are once in a generation reforms and we will continue to collaborate in developing and refining them.

We have consulted with people who use services, their families and carers, and with professionals involved in the Act. We have heard, too, from the stakeholder organisations that represent service providers, professionals, and service users. Our consultation work has been extensive – including a close review and evaluation of written responses, in parallel, we have held policy development workshops with experts that have explored proposals in depth, and high quality work led by Rethink Mental Illness and the British Institute of Learning Disability (BILD) with service users on what they think about the proposals. This report summarises this activity, and reports on what you have been telling us.

The scale of this work is a testament to the importance of getting these reforms right, and to the commitment shown by thousands of people to engage and to find solutions and improvements to mental health legislation.

This activity has all taken place while the NHS is still responding to the challenges of the pandemic, and we recognise that the sector has given significant time and effort to engage during difficult circumstances. Our COVID-19 Mental Health and Wellbeing Recovery Plan, backed with £500 million of new funding, is expanding services for people with mental health needs, to respond to the impacts of the pandemic.

Our job is now to continue to develop a new Bill to reform the Mental Health Act.

We have listened, we will continue to listen, and we will deliver on enacting mental health legislation fit for the 21st Century – legislation which will provide for the protections and support for people with severe mental health needs, which will strengthen their voice, choice and rights, support the increased use of community alternatives to hospital, will limit the use of the Act for people with learning difficulties or autistic people, will improve support for offenders with acute mental disorders, and which will aim to address the racial disparities that have too long been part of the way the Act has been used.



**The Rt Hon SAJID JAVID MP Secretary
of State for Health and Social Care**



**The Rt Hon ROBERT BUCKLAND MP
Secretary of State for Justice**

Executive Summary

The Government and NHS England and Improvement (NHSEI) are delivering the most ambitious programme to transform mental health care that England has ever known.

We are committed to legislate so that patients suffering from mental health conditions, who may require care under the Mental Health Act, have greater control over their treatment and receive the dignity and respect they deserve.

The Independent Review of the Mental Health Act, chaired by Professor Sir Simon Wessely, which reported in December 2018, concluded that the Act does not always work as well as it should for patients, nor for their families and carers. It proposed recommendations for change.

In response to the Independent Review, the Government published a White Paper, which accepted the vast majority of the Review's recommendations and sought views on the impact of these recommendations and how best to implement them in practice. This report sets out what respondents have said.

Public consultation

We ran a 14-week public consultation, receiving more than 1,700 responses. In parallel, to the consultation, we held 19 policy development workshops to get richer insights from service users, clinicians, and those with lived experience of detention under the Act, on the details of the proposals.

Overall, there has been an overwhelmingly positive response to the proposals. Respondents generally approved of the guiding aims behind the reform agenda, and agreed with key proposals for change including changes to the detention criteria, replacing the Nearest Relative role with the Nominated Person role, and considering A&E holding powers. Some of the proposals put forward in the White Paper are complex, and we are grateful for the constructive input we have had from stakeholders.

Some respondents raised particular concerns around how the reforms to the Act will apply to children and young people. We are committed to ensuring that children and young people benefit from the reforms we plan to introduce and that their rights are protected and upheld. We are aware that there are particular considerations and sensitivities involved in caring for children and young people. We will work closely with stakeholders to develop our proposals so that, where appropriate, adjustments are made in recognition of the particular needs and vulnerabilities of this patient group, and that the reforms fit with existing legislation that applies to children and young people.

We have also heard useful insights on how we can ensure the effective implementation of some of our proposals. We will continue to work through these considerations with stakeholders, and refine proposals accordingly, over the coming months and years. For example, following stakeholder feedback, we will draw on feedback as we take forward Advance Choice Documents and statutory Care and Treatment Plans and the role of the Tribunal in challenging treatment, to ensure that these proposals have the desired impact and produce meaningful results in terms of improving patient experience and strengthening choice and autonomy.

In a small number of areas, the consultation response did not support the direction of travel set out in the White Paper. For example, our engagement has made clear there is very limited support for the proposal to change the interface between the Mental Health Act and the Mental Capacity Act in the context of detention. In light of the feedback received, we do not intend to take forward the reform for the interface, as set out in the White Paper, at this time. We will seek to build the evidence base on this issue through robust data collection, to better understand the application of the interface. In addition, we will continue to engage with stakeholders to understand what support and guidance could help improve application of the current interface.

Next steps

The proposals made in the White Paper represent once in a generation reforms to the Mental Health Act, which will see that patients have greater rights under the Act and more choice and autonomy when it comes to their care and treatment. These changes, in parallel with the work being undertaken by NHSEI to transform mental health services, will see that people receive earlier support and better mental health services in the community and, where admission to hospital is the best option, improvements to patient experience and faster discharge when detention is no longer appropriate. The consultation response is a critical milestone in taking forward these planned improvements.

The positive response we have received to the proposed reforms at consultation has served to underline the importance of the reform agenda and the need to modernise the Mental Health Act. We will now work closely with stakeholders to build on what we have learnt at consultation, and to test and develop our policy proposals to make sure that our approach is right and that everyone benefits from the reforms. This will include continued engagement with service users, carers, individuals with lived experience of detention, and groups disproportionately subject to the Act.

As set out in the White Paper, the proposals that require additional funding, continue to be subject to future funding decisions, including at Spending Review 2021. We will continue to work on a Bill to reform the Act, taking into consideration the valuable feedback we have received at consultation. We intend to bring forward a Mental Health Bill, which will give effect to many of the changes we wish to make, when Parliamentary time allows.

The consultation also served to highlight that, of course, legislative reform is only part of the solution. In order to meet the aims set out in the White Paper, we must prepare and expand the mental health and social care workforces, build the necessary infrastructure to support the roll out of these reforms, and work to promote practical and cultural change across the system, through such initiatives as the Quality Improvement Programme and the Patient and Carer Race Equality Framework. We will work closely with our partners to take forward this work, which in tandem with implementation of the NHS Long Term Plan, is a critical part of delivering on all aspects of the reform agenda.

Introduction

The Government and NHS England and Improvement (NHSEI) are delivering the most ambitious programme to transform mental health care that England has ever known.

We remain committed to legislate so that patients suffering from mental health conditions, who may require care under the Mental Health Act, have greater control over their treatment and receive the dignity and respect they deserve.

Following the Independent Review conducted by Simon Wessely and published in December 2018, the Government published a White Paper in January 2021. This White Paper set out the Government's response to reform mental health legislation, responding to the Independent Review. We proposed substantial changes to the Act, based on four principles:

- choice and autonomy – ensuring service users' views and choices are respected
- least restriction – ensuring the Act's powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- the person as an individual – ensuring patients are viewed and treated as individuals

Following the publication of this White Paper, we consulted widely to understand the views of service users, clinicians, carers, and people with lived experience of treatment under the Act. Our consultation was broad-reaching in its scope, seeking to gather views on 35 questions. We consulted on key principles, technical changes, and specific measures to improve the experiences of service users.

This document sets out what we heard from the consultation on the White Paper, our response to the points raised, and how we plan to take forward our proposals.

How we consulted on proposals

This section sets out how we consulted on the White Paper, who responded and what people thought about the White Paper overall. The public consultation ran for 14 weeks.

It comprised of:

- An online consultation, open to anyone of any age.
- An easy read version of the consultation, open to anyone of any age.
- A series of service user and carer engagement events, run by Rethink Mental Illness and British Institute of Learning Disabilities (BILD) including with people with learning difficulties and autistic people and detained patients.

We would like to thank everyone who participated in the consultation for their time and thoughtful input. We are particularly grateful to Rethink Mental Illness and British Institute of Learning Disabilities (BILD) for organising bespoke online consultation events with patients, professionals, young people, service users, and carers.

Additionally, in parallel to our consultation activity, the Department of Health and Social Care and the Ministry of Justice have held a number of policy development workshops with experts from a wide range of sectors, including professionals and individuals with lived experience of the Act. These events took place online due to Covid-19 restrictions.

Who responded?

We received an excellent response to the online consultation from individuals and organisations, totalling 1,710 responses overall. This was made up of 1,378 responses received through the main online consultation, 114 responses to the easy read consultation and 218 emails directly responding to the consultation. In parallel to the consultation, we have also had over 300 people from different organisations attending 19 policy development workshops, to date.

Of the 1,710 responses we received to this consultation, 1,449 responses fed into our quantitative analysis (1,378 from the main consultation, 71 via email following similar format to the online system). The other 261 responses received (147 via email, 114 from via easy read response) have been used to inform the qualitative analysis in addition to the qualitative responses from the main consultation (where only free text responses were provided rather than selecting multiple choice option).

Consultation Activity	Number of responses
Main online consultation	1,378 responses
Easy read consultation	114 responses
Email responses and letters	218 responses
Total	1,710 responses

Who did we consult?

The consultation was published on GOV.UK. We drew the consultation to the attention of individuals, organisations and groups that we expected would have an interest in the proposals.

We received 1,119 online responses from individuals. The majority of online individual respondents were women (61% of individual responses). Nearly a tenth of the responses were from ethnic minority groups and a similar proportion of responses were from lesbian, gay, bisexual people. Of the online responses received, 31% of respondents consider themselves to be disabled and nearly a fifth were from people who currently are or were previously subject to the Mental Health Act.

We also received 330 online responses from various organisations. These organisations spanned a wide range of sectors including charity and non-Government, education, health, local authority, social and academic. More information on the breakdown of respondents is included in the annex of this report.

What you said

Overview

The following sections provide a summary of how people responded to the Mental Health Act White Paper consultation questions. We have grouped the comments we received from people who responded to our consultation and we have presented these as broad themes for each consultation question. This section will largely follow the structure of:

- Our proposals in the White Paper
- How people responded to the consultation questions
- Comments received in response to each consultation question
- Next steps

For the majority of questions in this consultation, the overall response was the same whether responding as an individual or organisation. Where there are differences between responses received from individuals compared to organisations, we have presented this. We have not assigned a weighting where a response might reflect multiple individuals or organisations. Please note that percentages reported in this section will not always add up to 100% due to rounding.

1. Guiding Principles

Proposals:

As set out in both the Independent Review and in the White Paper, we will introduce four new guiding principles to drive a more person-centred system, in which the choices made by patients have weight and influence, where care must have a therapeutic benefit for the patient, and where the powers of the Act are only used when absolutely necessary.

We set out in the White Paper our intention to embed the principles in the Act and its Code of Practice. We therefore asked for views on:

Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?

What you told us in this consultation

Responses to this question were broad ranging. This included specific suggestions on how to embed the principles within the mental health system. Some responses went further and recommended the principles could apply beyond the Act. In addition, respondents used this as an opportunity to express support, or concerns about the principles themselves. Where they did this, there was substantially more support for the principles, and for embedding them in the Act and Code of Practice. Of those who responded negatively to the proposals, some were concerned around the new principles themselves (for example, the removal of one of the existing principles), while others were more specifically concerned with the proposal to include the principles in the Act itself rather than just in the Code of Practice.

Points raised from those who commented include:

Applying Principles in the Mental Health System

Many responses suggested the principles should be applied throughout the mental health system to ensure they are embedded in practice. This included proposals to make them more prominent to practitioners, service users and carers.

Areas identified from responses were:

- Practitioner training
- Practitioner guidance documents
- In the commissioning of mental health services
- In the review of mental health services (including through the CQC)
- Documentation and paperwork associated with the application of the Mental Health Act
- Being promoted and visible to patients in mental health settings, for example, through posters and leaflets provided to service users and carers

“We agree with the guiding principles suggested by the Independent Review of the MHA (2018): choice and autonomy, least restriction, therapeutic benefit, the person as an individual. These should be embedded in the Act, Code of Practice, and throughout all paperwork and processes surrounding use of the Act. They should be clearly and transparently communicated to people who are subject to the Act, their advocates, Nominated Persons, families and friends.”

- **The Centre for Mental Health**

Applying the Principles in the Wider Health System

Some respondents suggested applying the new principles of the Mental Health Act outside of areas affected by the Act itself, in the wider health and care system.

These responses suggested wider application to see the principles informing care provided either prior to coming under the Act, or as a form of early intervention. Some responses recommended this could be done by requiring consideration of them in other Government legislation, however the majority of these responses cited other areas of health and care system where the principles should be made clear, such as in A&E (where people with severe mental health issues can often present at crisis point), or in GP surgeries. Respondents also drew attention to social care (and the local authorities that oversee it), as an area where the principles could also be relevant.

“It is important that these principles of choice & autonomy, least restriction, therapeutic benefit, the person as an individual are embedded in all guidance and legislation relevant to support for people with health and social care needs. [...] It is important that [Local Authority] and NHS commissioners are required to follow these principles, and that they also have duty to follow the MHA Code.”

- **Challenging Behaviour Foundation (CBF) and Mencap**

Applying the Principles beyond the Act

There were also suggestions to apply the principles beyond the Act, including in other parts of Government and wider public services, beyond health.

This included policing, where responses emphasised the need for the police to be trained and aware of the new principles and to be considerate of them when dealing with people with mental health issues. Responses also mentioned the justice system, including the Mental Health Tribunal and prison environments. Some respondents recommended that the Mental Health Tribunal could play a role in reviewing and enforcing the principles or suggested that that prison staff should consider the principles of the Mental Health Act when dealing with service users affected by mental health issues. Some responses even spoke about potential application in education, work and welfare settings.

Next steps

We will continue to work to take forward the principles. We will seek to incorporate the feedback received from the consultation as we consider the how the principles are embedded in everyday practice and application of the Act.

2. Detention Criteria

Proposals

The current wording of the Act states that detention should be “necessary for the health or safety of the patient or the protection of other persons” and that “appropriate medical treatment is available.” The White Paper proposed changing the detention criteria to make it clear that detention must involve the provision of a therapeutic benefit to the individual. It also proposed requiring that an individual can only be detained if detention is necessary to deliver care and treatment.

The White Paper also proposed changing the wording around risk to make it more explicit that a person may only be detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. This proposal was designed to ensure that detention is only permitted when there is a genuine need to prevent harm to the individual or to others.

Given the potential impacts of changes to detention criteria we sought views on both proposed changes.

We asked whether you agree or disagree to change the detention criteria so that detention must provide a therapeutic benefit to the individual, and to provide an explanation for your view

What you told us in this consultation

There were 1355 responses to this question. Overall, 82% of responses agreed/strongly agreed with the proposal; while 8% disagreed/strongly disagreed and 10% were not sure.

Respondents overwhelmingly supported changing the detention criteria to require that the individual receives therapeutic benefit. They agreed with the principle that people must benefit from detention and felt that amending the criteria to reflect the need for ‘therapeutic benefit’ would improve on the Act’s current requirement that ‘appropriate medical treatment is available’.

Points raised from those who commented include:

Defining ‘therapeutic benefit’

There were a range of concerns about potential unintended consequences resulting from this change, with some respondents arguing that ‘therapeutic benefit’ needed to be carefully defined. On the one hand, some respondents argued that the term should be defined broadly, to encourage the use of a range of therapies and ensure that people received the help they needed. Other respondents, however, felt that a broad definition might lead to people being detained on unnecessary grounds, and so advocated a narrower definition.

A broad definition – a holistic approach

Advocates of a broad definition of 'therapeutic benefit' felt the term would prompt a more holistic approach to patient care that considered a range of therapeutic options and the wider environment. Some respondents who had previously been detained shared their experiences of an over-reliance on medication, saying they would have preferred other therapies. They stated that a broader focus on therapeutic benefit might have mitigated these experiences and helped them to recover better. Nonetheless, some respondents emphasised that there needed to be common standards for therapies, which must remain well-evidenced, effective and personalised.

A narrow definition - balancing risks

Other respondents proposed a narrower definition of 'therapeutic benefit', arguing that if the definition was too broad, the 'therapeutic benefit' test risked being too easily satisfied and people would be detained unnecessarily. Respondents highlighted that the provision of therapeutic benefit would need to be balanced with the need to prevent risks. Where there is a substantial risk of serious harm to the individual or others, these respondents argued that it was important that individuals were detained, even if it was not clear whether therapeutic benefit could be provided. Other respondents emphasised that detention in itself could be harmful to people's mental health, and so this should be taken into account as a risk.

Considering the treatability of conditions

Respondents raised concerns about some conditions where it is not clear that they can be 'treated'. In particular, there was a prevailing view amongst those respondents who mentioned autism that detaining people with autism under the Mental Health Act was not appropriate. These comments fit with our intention elsewhere in the White Paper to revise the Act to be clearer that for the purposes of the Act we do not consider autism or a learning disability to be mental disorders warranting compulsory treatment under Section 3. Responses to other consultation questions on this theme are explored later in this document.

We also asked whether you agree or disagree to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person, and to provide an explanation for your view.

There were 1352 responses to this question. Overall, 74% of responses agreed/strongly agreed with the proposal; while 14% disagreed/strongly disagreed and 12% were not sure.

Respondents were strongly supportive that the requirement for a 'substantial likelihood of significant harm' was a good proposal, agreeing that risk ought to be significant to justify depriving someone's liberty. Some respondents also requested clarity around the definition of some of the terms, particularly 'substantial' and 'significant'.

Points raised from those who commented include:

General agreement with proposals

Most respondents agreed with the proposal to adjust the criteria in this way. They wrote that detention can be a stressful experience, is resource-intensive and should be avoided unless absolutely necessary. Some people reported that detention could make mental health conditions worse, and it was therefore important not to detain people at too low a threshold. These respondents therefore argued that the conditions for detention should therefore be set at a high bar, to limit the deprivation of people's liberty wherever possible. Other respondents felt that detention, if focused on the health and safety of the individual and others, could have a more positive impact than at present.

Requests for clarity

There were other comments that raised complications about the wording and requested clarifications. Respondents stated that assessing risk could be difficult, and considering the health and safety of the person, and the safety of any other person presented significant challenges. They felt that the number of conditions for consideration in the new criteria could potentially lead to abuse of detention powers.

Moreover, there were concerns about the criteria being open to interpretation, in particular with the terms 'substantial' and 'significant' needing to be clearly defined to avoid ambiguity. Respondents identified the subjectivity of these terms, particularly when making predictions about the future. They requested that clarifications be made in the Code of Practice.

Practical implications

Some respondents were concerned that the change in the criteria could make the threshold too high for people who needed help. These respondents argued that early interventions were better than later ones, and so staff should not have to wait until risks are very high before detaining someone.

Other respondents shared poor experiences of services, arguing that improving their quality would be crucial to ensuring that any new wording was effective. They argued that if fewer people are detained as a result of a higher risk threshold, better services in the community would be required to manage those people who might otherwise have been detained.

Considering individual needs

There were also a few specific requests to ensure the Act worked for specific groups. For example, respondents requested that the needs of people with learning disabilities or autistic people were considered, noting that the behaviour of some people with these conditions might be mis-diagnosed as risky. Other respondents requested that families and carers should have their views taken into account, because they might better understand and contextualise people's behaviour and past experience.

Disagreement with proposals

Some respondents disagreed with the proposals, for various reasons. Some considered the current criteria to be sufficient, others believed detention should never be an option, and others thought that the criteria would lead to more people being detained unnecessarily.

“The Law Society strongly agrees with this proposal [on therapeutic benefit], as this would better reflect human rights standards. Detention must be necessary and proportionate, used as a measure of last resort and with care provided in the least restrictive setting.

[On risk, the] Law Society considers that the inclusion of ‘imminent harm’ would lead to a much clearer test, through which risk of harm necessitating detention could be more accurately demonstrated.”

- **The Law Society**

Next steps

There is wide support for reforming the detention criteria as set out in the White Paper. The proposals on introducing the tests of therapeutic benefit and ‘a substantial likelihood of significant harm’ were well received. Respondents have also raised some important considerations, which we will bear in mind as we develop the draft Bill.

3. Giving patients more rights to challenge detention - Increasing the frequency of automatic referrals to the Tribunal

Proposals:

We want to increase the frequency of automatic referrals to the Mental Health Tribunal, as recommended by the Independent Review, to ensure that detentions under the Act are more regularly scrutinised. Automatic referrals to the Tribunal are an important safeguard, ensuring that all detentions are reviewed independently from the detaining authority on a regular basis, rather than relying on the patient or their representative to request one.

We proposed that:

- For **patients subject to a Section 3**, referral would instead take place 4 months after the detention started, if the Tribunal has not considered the case in the first 4 months. Thereafter, referral would take place 12 months after the detention started, if the Tribunal has not considered the case in the intervening months. After the first 12 months of detention, referral would take place annually.
- For **patients on a CTO**, referral would take place 6 months after the patient was put on the CTO, if the Tribunal has not considered the case in the first 6 months. However, thereafter, referral would take place 12 months after the patient was put on the CTO, if the Tribunal has not considered the case in the intervening months. After the first 12 months of detention, referral would take place annually.
- For **patients subject to Part 3**, referrals would take place every 12 months.
- For **patients on a conditional discharge** (Part 3, restricted), referral would take place 24 months following receipt of the conditional discharge by the patient. Thereafter, referral would take place every 4 years.

We asked you whether you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal, and to provide an explanation for your view for:

- A. Patients subject to Section 3**
- B. Patients on a Community Treatment Order (CTO)**
- C. Patients subject to Part 3**
- D. Patients on a Conditional Discharge**

What you told us in this consultation

- A. Patients on Section 3** - There were 1236 responses to this question. Overall, 62% of responses agreed/strongly agreed with the proposal; while 11% disagreed/strongly disagreed and 27% were not sure.
- B. Patients on a Community Treatment Order (CTO)** - There were 1224 responses to this question. Overall, 60% of responses agreed/strongly agreed with the proposal; while 12% disagreed/strongly disagreed and 28% were not sure.

C. Patients subject to Part 3 - There were 1216 responses to this question. Overall, 59% of responses agreed/strongly agreed with the proposal; while 9% disagree/strongly disagreed and 32% were not sure.

D. Patients on a Conditional Discharge - There were 1215 responses to this question. Overall, 57% of responses agreed/strongly agreed with the proposal; while 11% disagreed/strongly disagreed and 33% were not sure.

The majority of respondents agreed that the proposals for automatic referrals to Tribunals were sensible, and that their frequency should be increased to provide more robust scrutiny to ensure patients' rights are protected. However, some responses voiced specific concerns on the timings for each group of patients, in addition to comments on practical implications for the Tribunal, the role of the Tribunal, and the experience of patients.

Points raised from those who commented include:

Timelines for different groups of patients

Where respondents disagreed with the proposals, a key theme was that automatic referrals to Tribunals should be more frequent. For patients subject to Section 3, there was general agreement with the proposal of referral at 4 months rather than 6. However, some felt that 3 months would be better than 4 months.

For patients under Part 3, some respondents commented on the inconsistency between Part 2 and Part 3, and argued that the discrepancy should be justified. Some responses also mentioned that individuals who identify as BAME are more likely to be detained under Part 3 than under Part 2, which could lead to more unequal treatment if timelines vary.

For patients on a CTO, there was general agreement for the proposal, although some suggest referral should be more frequent and pointed to inappropriate use of CTOs.

For patients on Conditional Discharge, some respondents argued that 4 years for an automatic referral (following the initial referral after 24 months) is too long, and that there needs to be justification as to why timescales are different for CTOs and Conditional Discharge. More generally, some responses pointed to concerns around both public and personal safety if an individual was released too early.

“It is vitally important that people who are deprived of their liberty can access the courts to challenge the lawfulness of the decision made to detain them. We therefore agree with the proposed timetables for automatic referrals for the categories of patients outlined in this question.”

- The Law Society

The impacts of automatic referrals on the Mental Health Tribunal

Many respondents were supportive of the proposals but were concerned about the increased resource that more frequent automatic referrals would require and how that could negatively impact the quality of justice being delivered to Tribunal users. Some felt

that the proposed automatic Tribunal periods were unrealistic due to the increased resource required for both the Tribunal and the medical profession. Specific concerns were raised as to judicial capacity and the increased administrative burden on clinicians which could make it more difficult for them to fulfil their statutory duties. Respondents noted that these proposals will require significant funding for the Tribunal, including access to legal representatives and advocacy, if the proposals are to be delivered effectively.

“The increase in workload that would inevitably arise from the proposed reforms is recognised in the White Paper as an important factor to bear in mind. The ability of the Tribunal to manage that increase in workload requires careful consideration to be given to the financial and administrative resources the jurisdiction would require to implement the proposed changes.”

- **First-tier Tribunal (Mental Health Tribunal)**

The role of the Tribunal and patient experience

A number of respondents argued that more frequent automatic Tribunals are unnecessary given current provision, including that Tribunals can be requested by hospital managers at any time therefore making the referrals unnecessary. Similarly, respondents felt that if a Tribunal is not requested then it may not be useful or necessary. By contrast, some respondents argued there should be more flexibility to look at individual circumstances on a case-by-case basis.

Some respondents were concerned with the nature of the Tribunal itself, including that Tribunals can be traumatising and uncomfortable for service users, and the formality of the process can put people in a state of unease and may not always be in the patient's best interest. To combat this, some suggested that there should be a right to reject an automatic referral to the Tribunal.

Some responses commented that there should be special consideration for individuals with learning disabilities and autistic people. There was general agreement that automatic referrals to the Tribunal are beneficial for people with these conditions as they may not have the ability to challenge their detentions and evidence shows that they are less likely to request a Tribunal. More generally, many responses said that information on patients' rights should be made clear, especially if a patient lacks the relevant capacity or is physically unable to communicate.

Next steps

It is our intention to take forward the proposals to increase the frequency of automatic referrals to the Tribunal and ensure that detentions under the Act are more regularly scrutinised. They are an important safeguard, ensuring that many detentions are reviewed independently from the detaining authority on a regular basis, rather than relying on the patient or their representative to request a review.

We acknowledge some of the concerns with the proposed frequency of automatic referrals and the impact these could have on patients and the Tribunal system. However, we believe that the proposed timings are broadly appropriate. We will consider further with the judiciary how best to manage these referrals to ensure they can be administered in the least intrusive and effective way.

The implementation of the proposed more frequent automatic referrals will need to be carefully planned to ensure that access to justice is maintained effectively. We will work closely with MHT and Her Majesty's Courts & Tribunals Service (HMCTS) to do this. We will consider phasing in any changes over time so we can carefully assess resource and capacity constraints for the Tribunals services relating to reforms to the Act and ensure sufficient capacity and funding to enable the Tribunal to deliver on the reforms to the Act.

4. Giving patients more rights to challenge detention - Removing automatic referrals to the Tribunal following a revocation of a Community Treatment Order

Proposals

While overall we want to increase the scrutiny of detention, including by the Tribunal, we also want to ensure that the process for reviewing an individual's detention works effectively. Currently, there is an automatic referral to the Tribunal when someone's CTO is revoked. The Independent Review made the case that this is an ineffective safeguard, as often by the time the Tribunal sits, the patient is back in the community, on another CTO, or where the CTO has been revoked, they have reverted to a Section 3 patient. This makes the automatic referral to the Tribunal redundant, as the outcome of the Tribunal will not have a material impact on the patient. In our White Paper, we proposed to remove the automatic referral to a Tribunal received by service users when their CTO is revoked. This will also help create capacity in the Tribunal system, to take on other reforms for the more frequent automatic referrals we are proposing in relation to other detained patients.

We asked you whether you agree or disagree to remove the automatic referral to a Tribunal received by service users when their community treatment order is revoked, and to provide an explanation for your view.

There were 1,246 responses to this question. Overall, 41% of responses agreed/strongly agreed with the proposal; while 23% disagreed/strongly disagreed and 36% were not sure.

The biggest share of respondents agreed with the proposal, although among individuals there was an equal split between agree (38%) and those unsure (38%).

Respondents were generally supportive of the proposal citing that automatic referral to a Tribunal when a CTO is revoked is an ineffective safeguard. However, many respondents raised concerns about removing patients' access to independent legal scrutiny.

Points raised from those who commented include:

An automatic referral is an ineffective safeguard

In line with the White Paper, the majority of respondents who agreed with our proposals felt that automatic referrals following the revocation of a CTO are not effective safeguards, with respondents highlighting that by the time an automatic referral is heard by the Tribunal, a patient is either on a fresh CTO or the patient has reverted to a Section 3 patient and been detained in hospital. Additionally, many respondents who agreed with proposals stated that patients do not want to engage with unnecessary Tribunals as they can cause unwanted stress.

Alternative routes for safeguarding patient rights

A large proportion of respondents highlighted that patients will still have the right to challenge their detention by applying to appeal to the Tribunal or hospital managers panel. Moreover, many respondents recognised that the proposed changes to the frequency of automatic referrals to the Tribunal offers increased access to scrutiny and increases

safeguards for patients. Some respondents who agreed with the proposals stressed that mental health professionals undergo extensive safeguarding training and confidence should be placed in their decisions.

“We agree with the proposal to remove the automatic referral to a Tribunal which is triggered when a community treatment order is revoked, as by the time the hearing is held the patient is often back on a CTO. The right to appeal also of course remains. If the referral remains, the hearing should be held as soon as possible so the hearing is held as close to the revocation decision as possible; this would be more meaningful than the current situation which can appear to be a ‘tick-box’ exercise.”

- **South London and Maudsley NHS Foundation Trust (SLaM)**

Proposal removes patient safeguards

The most prominent concern that respondents raised was that the proposal removed a patient's right to independent legal scrutiny and therefore diminished patient safeguards. Some respondents expressed concerns that some patients may not understand or exercise their right to appeal, therefore the automatic referral was essential. Additionally, a portion of respondents expressed concerns that some patients may never have access to a Tribunal hearing if automatic referrals are removed. For example, some respondents were concerned about short stay patients “falling through the cracks.” Moreover, many respondents highlighted that there should be an alternative check, balance or safeguard introduced if patients access to an automatic referral is removed following revocation of a CTO.

“Bipolar UK has a concern that this constitutes a removal of a safeguard: ability to apply to the Tribunal is not the same as an automatic referral.”

- **Bipolar UK**

Considerations around patient choice and autonomy

Respondents who disagreed with the proposals expressed concerns that they could lead to a reduction in patient choice and autonomy. Moreover, some respondents stated they thought that referrals should be given on a case by case basis rather than as an automatic safeguard.

Considerations about Tribunal resources

Many respondents who agreed with the proposals highlighted that automatic referrals to the Tribunal when a Community Treatment Order is revoked are a waste of resources and the White Paper proposals will save resources including staffing time and cost. Additionally, some respondents who disagreed with the proposals pointed out that they thought the system requires more resources to provide a functioning automatic referral system that works for those after a CTO is revoked. Lastly, a small number of respondents

expressed concerns that automatic referrals should not be removed and should happen more quickly.

Next steps

Whilst we acknowledge concerns around the removal of a safeguard for those whose CTO has been revoked, we believe that our White Paper proposals to increase the frequency of automatic referrals to the Tribunal system including those on CTOs, provides more regular access to the Tribunal to scrutinise detention. Additionally, it is important to recognise that patients who are detained for assessment under Section 2 or for treatment under Section 3 following a revocation of a CTO, would still have the right to appeal to the Tribunal.

We agree with the views of stakeholders that revocation decisions should still be subject to scrutiny. The Government is committed to working with stakeholders to discuss how best to achieve this, but we feel this is for the Code of Practice and not the statute book.

The removal of an automatic referral to the Tribunal following a revocation of a CTO will need to be carefully implemented to ensure that a patient's ability to challenge their detention is not negatively impacted. We believe a phased approach is the best route to implementing this policy. As we increase the frequency of automatic referrals to the Tribunal over time, we must fully assess resource constraints and ensure sufficient capacity in the system before removing other safeguards. We will closely work with MHT and HMCTS to achieve this.

5. Giving patients more rights to challenge detention - Giving the Tribunal powers to make directions

Proposals:

Under Section 72 of the Act, the Tribunal can already make recommendations relating to a patient's leave or transfer, but such recommendations are not binding. We proposed to extend the role of the Tribunal so it is able to grant leave and transfer, and to direct services in the community. We propose that there should be an obligation in legislation on health and local authorities to take all reasonable steps to follow the Tribunal's decision. If the authority is not able to give effect to the Tribunal's decision, it must provide an explanation to the Tribunal, setting out the steps it took and why it was not possible to follow the decision. Additionally, we proposed that healthcare bodies and local authorities should be given a period of five weeks to take reasonable steps to deliver the Tribunal's direction.

We asked you whether you agree or disagree that health and local authorities should be given five weeks to deliver on directions made by the Mental Health Tribunal and whether that is an appropriate amount of time, and to provide an explanation for your view.

There were 1275 responses to this question. Overall, 53% of responses agreed/strongly agreed with the proposal; while 25% disagreed/strongly disagreed and 22% were not sure.

Respondents were broadly supportive of the proposal to direct leave, transfer and community service and recognised the potential positive benefit of imposing a timeframe on the delivery of directions by the Tribunal in order to improve patients' care; however the majority of these respondents caveated this by raising a number of concerns and implications. From the respondents who disagreed and commented on this question, there appeared to be no consensus on the proposed timeframe to implement decisions. Additional concerns and considerations included the enforcement of such proposals, the undermining of clinical decision-making, Tribunals making decisions when they do not know the service picture of the local area, and resource and funding concerns.

Points raised from those who commented include:

Proposed timeframes

Respondents had many conflicting views on the proposed timeframes to comply with directions. There was a substantial portion of respondents that felt that the five-week timeframe was an appropriate amount of time to deliver on directions but the majority of these responses were caveated by raising wider issues. Some of the respondents who generally supported the proposals also raised concerns that the five-week timeframe may not be sufficient for those patients who require a complex care package and they suggested that this could lead to those groups being disadvantaged. A large proportion of respondents who disagreed felt that the proposals were a good start but thought that the proposed five-week timeframe was too long and that directions could be complied with much more quickly. Additionally, some respondents highlighted that the timescale should be the maximum, with the expectation that directions are implemented as quickly as possible. Some respondents highlighted concerns and thought the proposed timeframe

was unrealistic and were doubtful that directions could be complied with in time. Additionally, a large number of respondents thought the timeframe to deliver on directions should be flexible, judged on a case by case basis with an option for extensions. Lastly, many respondents felt that the timeframe given to implement such directions should depend on the co-creation of plans with patients, families, carers, professionals as well as with health and local authorities.

“We would agree with the above, however resources need to be available. It also needs to be acknowledged that this will increase pressure on already stretched resources [...] We are concerned that it is not realistic to give LA 5 weeks to deliver all directions made by the MH Tribunal. An example being if specific accommodation and staffing are needed to enable safe discharge. LA may be dependent on organisations that they have no control over. What will the penalties be if this is not met, could potentially result in unsafe discharges and further detention under the MHA. Would there be an escalation process if MHRT require unrealistic services?”

- **Bournemouth, Christchurch and Poole (BCP) Council**

Enforcement and accountability of directions

Several respondents expressed concern and confusion over who would be responsible and accountable for directions issued by the Tribunal. For example, many respondents pointed out that if the Tribunal had power to give directions then it should be the Tribunal which is accountable for patient welfare and any failed directions. Many respondents thought that the proposal would ensure that health and local authorities would be held accountable for the delivery of directions set by the Tribunal. However, many respondents also thought the proposals would allow the Tribunal to make health and local authorities aware of their obligations, but that the Tribunal lacked the power to do anything about non-compliance and that the proposal did not go far enough. For example, some respondents thought that the proposals needed to go further, for example with fines and further meetings with the Tribunal to aid enforcement of directions.

“The White Paper qualifies the proposal in the 2018 Report that the Tribunal be granted a ‘limited’ power to direct the provision of community services to unrestricted patients. The Tribunal is currently able to adjourn and direct professionals to appear before it in relation to funding issues, a step which frequently resolves matters. The White Paper appears to accept that a local authority may not be able to comply with a direction to provide services. It appears to follow that the proposed power for the Tribunal is a power to recommend, and perhaps should be drafted as such.”

- **First-tier Tribunal (Mental Health Tribunal)**

Concerns about patient safety

A substantial number of respondents highlighted concerns that the proposal undermines clinical decision making and stated that the Tribunal should not be making clinical decisions in relation to patients with whom they are not familiar. Many respondents stated that a patient's mental health conditions can fluctuate, and directions given by the Tribunal may not be appropriate by the time of implementation. For example, a patient may no longer have capacity by the time their directions are due to be implemented. A number of respondents thought that there should be a safeguard mechanism introduced to check Tribunal directions to ensure that they remain appropriate for the patient. Lastly, many respondents thought that by proposing a five-week timeframe to deliver on a direction, that many directions would be rushed and inappropriate arrangements would be in place for patients.

Consideration of available community services, resources, funding and training.

A substantial number of respondents felt that the proposal could only be successful if the necessary funding and training is available to enable compliance by health and local authorities. Additionally, a large proportion of respondents felt that the success of the proposal depended on sufficient community services being available. Moreover, a great number of respondents highlighted that the Tribunal lacks understanding of the local service picture and that the services it may require by direction may not be available locally.

“Given the need to ensure therapeutic benefits of detention and ensure it is for the shortest period of time required it seems a supportive measure to introduce a time frame for implementation of directions made by the Tribunal. However, as already acknowledged in response to a number of questions, the availability of resources in the community will have a significant impact on the feasibility to support directions given within the time frames. It will be important to ensure that the timeframes do not adversely impact on decision making and planning of transfers and community care as a result of the need to implement direction at pace.”

- **Gloucestershire Health and Care NHS Foundation Trust**

Next steps:

The balance of responses was in favour of the proposal. However, contributions highlighted a number of issues which we will need to work through. These include reviewing our position on the proposed time requirement for health and local authorities to deliver on directions made by the MHT, considering further the relationship between a Tribunal direction and independent clinical decision making, and how obligations and duties should be discharged and monitored. We will continue to consider matters with stakeholders. The most important aspect of these considerations must be that all agencies, including the Tribunal, work together to ensure that patients get plans for care and discharge which work for them.

6. Giving patients more rights to challenge detention – associate hospital managers' panel hearings

Proposals:

The White Paper recommended removing the role of the associate hospital managers' panel in discharging patients from detention, a power delegated from hospital managers to associate hospital managers, as a result of stakeholder concern about the effectiveness of this safeguard. The White Paper proposed that the Mental Health Tribunal is better placed to assess whether a patient continues to meet the criteria for detention under the Act, and that the better policy is for an increase in access to the Tribunal which would allow for the removal of associate hospital managers' panel hearings.

We asked you whether you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order, and to provide an explanation for your view.

What you told us in this consultation

There were 1,270 responses to this question. Overall, 42% of responses agreed/strongly agreed with the proposal; while 23% disagreed/strongly disagreed and 35% were not sure.

Respondents who agreed with the proposal cited a range of reasons including the lack of discharges made following panel hearings, lack of consistency in quality of panels across trusts and similarity in role to that of the Mental Health Tribunal. Some who disagreed with the proposal felt that there was a lack of evidence to suggest that panel hearings were not working. This group tended to acknowledge that, while there was scope for hospital managers panels to be improved, overall, they were an important safeguard for patients that offered an informal, less intimidating and more accessible alternative to the Mental Health Tribunal for those wishing to challenge detention.

Points raised from those who commented include:

Panels rarely discharge patients

Respondents who agreed with the proposal often pointed to the reluctance of associate hospital managers to exercise their power of discharge, evidenced by the apparent low numbers of discharges following hearings. While data on discharges via this route is not collected centrally, there appeared to be a consensus amongst those that agreed with the proposal (and cited number of discharges as a reason) that the numbers are relatively low and that this may be indicative of ineffectiveness. However, respondents who disagreed or strongly disagreed with the proposal pointed to the similar levels of discharge by the Mental Health Tribunal.

Panel hearings are not truly independent and rarely challenge the Responsible Clinician's decision

Some respondents who agreed with the proposal suggested that the way in which panel members are appointed limits their independence. Some suggested that this may be impacting panel members' ability to adequately challenge the opinion of the Responsible

Clinician. Others suggested that bias, even if only perceived, impacted some patients' ability to have confidence in the process and outcomes of panel hearings.

Lack of evidence that panels are ineffective or fail to discharge

Some respondents who disagreed with the proposal pointed to the lack of evidence both in the Independent Review and White Paper that panel hearings are ineffective. Some argued that discharges are regularly made, and others pointed to the similar levels of discharges resulting from Mental Health Tribunal or the lack of robust comparison between the two.

Panels provide an important safeguard

Some respondents who disagreed with the proposal felt that panels were an important and accessible safeguard for patients wishing to challenge detention or Community Treatment Order decisions. Some within this group felt that the informality of a panel hearing was better tailored to the unique needs of patients, and that removing this channel may deter the most vulnerable from challenging their detention. Others within this group felt that the removal of this safeguard would lessen the impact of other reforms in the White Paper (such as increasing access to the Mental Health Tribunal) intended to 'give patients more rights to challenge detention' as, overall, there would be fewer opportunities to challenge.

Improve the quality of panels rather than remove them

Respondents across all groups pointed to potential improvements that could be made to panel hearings should they remain; however, this was most pronounced among respondents who disagreed or were 'not sure' about the proposal. Some within this group suggested that there should be greater consistency in the way that panel hearings are run across trusts. Others suggested strengthening the quality of membership and associated documentation, such as the final report. A small number of respondents suggested that the purpose and remit of panels be explicitly set out in legislation.

Proposal requires a more detailed articulation of what will replace panels

Some respondents, most notably those who said that they were 'not sure' about the proposal, recognised that there were clear positives and negatives for the proposal and suggested that further work is required to fully understand the implications of, and alternatives to, removing associate hospital managers panels' power to discharge. For example, some respondents, while broadly convinced by the proposal, worried that the Mental Health Tribunal would not adequately replace key aspects of panel hearings, such as the informal approach and engagement on a local level.

"If the Tribunal process is strengthened then, yes, [panels should be removed]. In our experience, the independent Tribunals tend to provide greater scrutiny of detentions and CTOs than Hospital Managers Hearings. In addition, Managers will be gaining a significant role in the LPS system, which in mental health trusts will be balanced out by the above change."

- **Association of Directors of Adult Social Services (ADASS)**

“DHSC should carefully assess the capacity of the Tribunal system, and take necessary steps to increase capacity as required, before removing the power of a hospital managers' panel to discharge a patient from detention.”

- **Equality and Human Rights Commission (EHRC)**

Next steps

The response to this question was far more mixed than the Government anticipated, with a lot of support in favour of keeping the panels in place. The Government understands this view. We have committed to extend patient rights and opportunities to access the Mental Health Tribunal. It may be that increased pressure on clinical time, to service a greater number of Tribunal hearings, will become reason enough for panels to be removed or phased out. The Government will consider this matter further.

7. Strengthening the patient's right to choose and refuse treatment - Advance Choice Documents

Proposal:

We are committed to introducing Advance Choice Documents as a means of providing people with the opportunity to set out in advance the care and treatment they would prefer, the name of their chosen nominated person, and any treatments they wish to refuse, in the event they are detained under the Act and lack the relevant capacity.

In the White Paper, we proposed that the Advance Choice Document should adhere to a standard format and approach, and it should include the following information about the individual's preferences, as well as any other information deemed relevant by the individual:

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

We asked if you have any other suggestions on what should be included in a person's advance choice document.

The majority of respondents supported the scope of the Advance Choice Document, as proposed in the White Paper. Where respondents provided further detail on the proposed contents or provided some new additions to what else could be included in a person's Advance Choice Document this ranged from information on the preferred location of the

hospital to information that might help support the patient's wellbeing during their stay in hospital.

Points raised from those who commented include:

Information about the person as an individual

Some respondents felt that Advance Choice Documents should be used to communicate wider information about the person as an individual, to help support clinical decision making and inform broader aspects of their care while in hospital. For example, what pronouns the person prefers staff to use, details of their hobbies and interests and what sorts of things might help support their general wellbeing.

“We feel that advance choice documents and care and treatment plans should record the non-clinical factors which are important to the individual patient and should inform decisions about their care including psychological, social, faith-based and cultural factors.”

- **The General Medical Council (GMC)**

Respondents felt that this could, in part, be achieved by linking the Advance Choice Document to the patient's historic care record, their 'This is Me' document or patient passport (where relevant). In a similar vein, respondents felt that, to build a richer picture of the individual and their wishes and preferences, that it would be valuable if the patient's family or carer were invited to input into the Advance Choice Document.

Other suggested additions to the contents of the Advance Choice Document

Some respondents felt that people should be able to express in their Advance Choice Document not only who they wanted to be involved in their care and treatment, but also who they wanted to exclude from their care and treatment.

Other respondents said that people should be able to express a preference in terms of the location in which they would prefer to be treated, particularly to assist crisis planning arrangements. For example, there might be reasons why an 'out of area' placement is particularly detrimental to the person's recovery and should be avoided. Of the respondents that made this suggestion, some commented that, while they recognised that it might not always be achievable to fulfil this request, that it would support the building of a more positive and trusting relationship with the clinical team if the patient was made aware of how their request had been factored into decision making. Rethink Mental Illness further indicated that this could help support further conversations about managing past trauma.

Concerns regarding implementation

Some respondents felt that the Government should not seek to limit the contents of Advance Choice Documents by introducing a standard format or pro forma, as this could discourage the individual from identifying issues that matter most to them with respect to their care and treatment.

To prevent a person's Advance Choice Document from being used when it is outdated and no longer reflects their wishes and preferences, some respondents felt that the Advance Choice Document should, at a minimum, be dated to indicate the time at which it was written. Respondents felt that this would allow the clinician to establish if a significant amount of time has elapsed, if the person later presents to mental health services, and therefore whether the contents were likely still to be applicable. Furthermore, some respondents felt that individuals should be able to attach an expiry date to their Advance Choice Document to reduce the risk of it being used inappropriately.

While we did not consult on this directly, some respondents raised broader concerns regarding the introduction of Advance Choice Documents. For example, some felt it would be difficult or unrealistic to deliver on the sorts of wishes and preferences included in an individual's Advance Choice Document. Some respondents worried that this could potentially expose clinicians to legal challenge, and others felt that it unfairly raised the expectations of service users, and that any failure to deliver on the service user's advance wishes could be extremely damaging to their relationship with the clinical team.

Next steps

While we think there is value in Advance Choice Documents following a basic structure, we recognise the value of not limiting what can be included in an Advance Choice Document, as highlighted in responses, and that it should be led by what the service user feels is most important to facilitating their recovery. We recognise that this needs to be balanced alongside ensuring that the service user is aware of the legal effect of the contents of their Advance Choice Document, that they understand any potential implications of what is included and what may or may not be deliverable, for example due to resource constraints. We will continue to work with stakeholders to establish what contents are critical to ensuring that Advance Choice Documents effectively inform patients' care and treatment.

Proposal

We said that the approach to the legal validity of an individual's Advance Choice Document should be similar to advance statements and decisions made under the Mental Capacity Act 2005: in particular that it must have been made by someone who had the relevant capacity and, in relation to advance treatment refusal, must apply to the treatment in question. We said that formal authentication of individual's relevant mental capacity at the time of writing the Advance Choice Document would not be necessary for the Advance Choice Document to be considered valid. Furthermore, we proposed that there should be a legal requirement on clinicians to show how the wishes and preferences made in a patient's Advance Choice Document have informed the patient's care and treatment.

We asked you whether you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act, and to provide an explanation for your view.

What you told us in this consultation

There were 1,278 responses to this question. Overall, 69% of responses agreed/strongly agreed with the proposal; while 10% disagreed/strongly disagreed and 21% were not sure.

Overall, the majority of respondents agreed with the proposed approach. Among those who agreed, some expressed the view that, while in theory they supported the approach, in practice they foresaw a number of practical barriers. Of the minority of people who disagreed with the approach, many were worried that the Advance Choice Document could too easily be dismissed by the clinician and ignored.

Points raised from those who commented include:

Problems with aligning the Mental Health Act with the Mental Capacity Act

While many respondents supported aligning advance decision making under the Mental Health Act with the Mental Capacity Act, some respondents cautioned that an individual's decision-making capacity is much more difficult to assess in a mental health context, particularly as it can be fluctuating.

“The MHA must recognise the fluctuating nature of capacity for those who have mental health problems. Better definition or more consideration of the terms ‘mental disorder’ and ‘capacity’, within the MHA, would help to support delineation.”

- **Royal College of Nursing (RCN)**

While the Royal College of Psychiatrists supported the proposed approach, it raised concerns that advance decisions under the MCA are too easily overruled. This might mean that Advance Choice Documents have little influence over the patient's care.

Particular concerns were raised by respondents in relation to under 16s. This is in part because of the different legal considerations at play in relation to children. For example, there is not the same presumption of capacity or competence in the case of under 16s, as there is under the MCA. In addition, some stakeholders argued that the clinician is always obliged to act in the best interests of the child, so they may be less inclined to follow an Advance Choice Document.

Further engagement with stakeholders on these issues indicated that, in the case of children, authentication of capacity at the time the Advance Choice Document was created may play a valuable role in ensuring that the child's Advance Choice Document delivers additional legal safeguards so that it has the same effect as that made by an adult. Stakeholders also felt that the process of authentication of capacity at the time of writing may help mitigate the risk of the child being subject to coercion or undue influence from others. In this scenario, if the child did not authenticate their Advance Choice Document, the clinician would still need to have regard to the statements made within it in order to decide what care and treatment to provide.

How mental capacity affects the validity of the Advance Choice Document

Some of the respondents who disagreed with the approach were concerned that the patient's relevant capacity at the time of writing the Advance Choice Document might be doubted subsequently by the treating clinician, invalidating the Advance Choice Document and causing it to be ignored. A small proportion of respondents felt that this could be

addressed through authentication of the individual's relevant capacity by a health or care professional at the time of writing.

"We recommend a requirement for advance choice documents to be authenticated by a health or social care professional to help ensure the patient understands their choices and the implications, and to prevent any disputes about whether the patient had the relevant capacity and information at the time they made the decision."

- **The Equality and Human Rights Commission (EHRC)**

However, others felt that making capacity a necessary precondition for a valid Advance Choice Document could prevent some people, such as people with a learning disability, or people with long-term delusional disorders, from benefiting from this safeguard. Some stakeholders raised a broader concern that our reform proposals will generally tend to favour and benefit people with the relevant capacity.

"We are concerned that the proposals in the White Paper may lead to a two-tier system, where those judged to have capacity and who have benefited from extended support and care will enjoy a significantly different level of autonomy to those who have not had such prior support."

- **National Survivors User Network (NSUN)**

Some respondents raised that additional factors, such as when the document was written or last updated, should be relied upon to determine the Document's validity.

When to apply a person's Advance Choice Document

In general, there was broad support from respondents for the introduction of Advance Choice Documents as a means of ensuring that an individual's wishes and preferences can inform their care and treatment, even when they lack the relevant capacity. However, a small number of respondents felt that life-threatening decisions should not be determined by a person's Advance Choice Document and that it should be possible to overrule the individual's advance decisions in these circumstances. This is in line with the proposals made in the White Paper.

Concerns over the effective implementation of Advance Choice Documents

While this was not directly consulted on, many respondents raised concerns around the effective implementation of Advance Choice Documents. For example, some felt that without a mechanism in place to store and locate someone's Advance Choice Document, the new safeguard would have very little impact. Respondents also felt that the provision of advice and support from appropriately trained professionals would be essential to ensuring that individuals were aware of the potential outcomes of the decisions they have made in their Advance Choice Document.

“Without robust mechanisms for implementation and enforcement, there is no guarantee that these important documents will enable decisions to be made which can be properly relied on in practice, rendering them largely ineffective.”

- **The Law Society**

Next steps

We will continue to work closely with stakeholders to establish how we can align advance choice decision making under the MHA with the MCA.

We value the feedback we have received from stakeholders with regard to the complexities associated with children. We will continue to develop our proposal to ensure that children benefit from using Advance Choice Documents as a tool to inform their care and treatment.

We recognise that the efficacy of Advance Choice Documents depends upon a number of practical considerations. As stated in the White Paper, we are seeking to ensure that these documents can be made and stored in a secure digital database so that they can be readily accessed by service users and health professionals. We also understand that training and guidance is needed to ensure that health and care professionals can support people to make Advance Choice Documents and so that they are equipped to use them in decision making.

8. Strengthening the patient's right to choose and refuse treatment - Care and Treatment Plans

Proposals:

In the White Paper we proposed to make Care and Treatment Plans statutory and we set out when and how the Plan should be developed and who should oversee the process.

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

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

We asked if you have any other suggestions for what should be included in a person's Care and Treatment Plan.

What you told us in this consultation

The majority of respondents expressed their support for the introduction of a statutory Care and Treatment Plan and had no further suggestions of what should be included, beyond the contents list proposed in the White Paper. Some respondents, however, were keen to see integration of the Care and Treatment Plan with other existing care planning requirements. Others felt that the new Plan should be more wide ranging, covering

housing and finance considerations, much like statutory care planning under the Mental Health (Wales) Measure 2010.¹

To ensure that the Plan truly informs the patient's care and treatment, some respondents emphasised the importance of ensuring that the Plan is measurable and achievable, with timebound objectives.

Points raised from those who commented include:

Comments on the proposed contents of the Plan

Some respondents elaborated on the contents proposed in the White Paper, underlining the importance of seeking the input of the family or carer in developing the Plan and ensuring that the patient's communication needs are accounted for. Other respondents did not feel that the contents went far enough. The CQC recommended that, instead of the clinician having to demonstrate 'how' the patient's Advance Choice Document has been incorporated, they should clearly indicate which parts of the Advance Choice Document apply to care and treatment and how the person's advance wishes and preferences have been built into the patient's Care and Treatment Plan.

In terms of discharge planning, many respondents agreed that this was important, but some respondents wanted to see that this aspect of the plan also captures multi-agency responsibilities, and other useful information that may support the patient's recovery in the community, such as their eligibility for entitlements and benefits, access to housing advice or specialist accommodation and the availability of extracurricular activities. Of these respondents, some felt that this could be achieved by more closely aligning Care and Treatment Plan requirements in England with statutory requirements already provided for by the Mental Health (Wales) Measure 2010.

Further engagement on the proposed contents of the Plan during the consultation period indicated that, for many of our stakeholders, the most critical elements of the Care and Treatment Plan were evidence of co-production with the patient and information on the purpose of admission, including how the patient will be supported to get better. Stakeholders recognised this may be more or less well-developed, depending on if the patient is already known to services.

Other respondents didn't have specific comments on the contents of the Plan but felt it was important that the deliverables are achievable, timebound and reviewed on a regular basis to ensure that the Plan genuinely reflects the patient's needs.

Expanding the scope of the statutory Care and Treatment Plan

Some respondents felt it critical that the patient's Care and Treatment Plan covers physical health care needs and that it is joined up with the patient's historic care records and other existing care planning requirements to ensure coordinated delivery, such as those under the Care Act 2014 and the Children's Act, in the case of patient aged under 18.

¹ The Mental Health (Wales) Measure 2010 is law made by the National Assembly for Wales, which aims to ensure that appropriate care is in place across Wales which focuses on people's mental health needs.

“This [the Care and Treatment Plan] must also include plans for a child’s education while they are in inpatient care, and how they will be supported with their transition to education in the community. While it is positive that Care, Education and Treatment reviews should inform Care and Treatment plans, it is also important that Care and Treatment plans are informed and complementary with other care plans in place such as Child in Need, Child Protection or Looked After Child plans, and Education, Health and Care Plans.”

- **Children’s Commissioner**

Some respondents felt that the scope of the Plan should not be limited, but instead led by co-production of the Plan by the clinical team with the patient. As with Advance Choice Documents, some respondents felt that the Plan should reflect the patient as an individual.

“This would include what the person has achieved in their life, what they like doing, where they live, who and what is important to them. Information about the person’s typical day or week would be extremely useful, their usual habits, role, routines, including employment [...] This type of information should be at the very beginning of the document to help frame an appropriate and humanising response throughout the person’s recovery journey.”

- **Royal College of Occupational Therapists (RCOT)**

Completion and quality control of the statutory Care and Treatment Plan

In the White Paper, we proposed that the Care and Treatment Plan should cover a required set of information about the patient’s care, that it should be completed by the Responsible Clinician by day 7 of the patient’s detention under the Act and that it should be signed off by the Clinical or Medical Director by day 14. While we did not consult on this directly, some respondents raised concerns that these requirements would place unrealistic expectations on staff, driving bad practice and risking the Plan simply becoming a tick-box exercise, as opposed to being genuinely patient-centred. Without additional resource and training in place, some respondents expressed doubt that the concept of a statutory Care and Treatment Plan would deliver any meaningful improvements to the patient’s care.

Other respondents felt that development of the Plan should be jointly led by a multidisciplinary team, as is now the case, as opposed to by the Responsible Clinician. Some felt that requiring the Clinical or Medical Director to review the Plan, once completed by the Responsible Clinician, would undermine the clinician’s role and discourage multidisciplinary working.

“Trusts have [also] raised concerns regarding the proposal for each Care and Treatment Plan to be subject to internal scrutiny and approval by the medical or clinical director, specifically: its practicability; purpose—given the role of the Tribunal; and potential implications on the funding of medical management posts in mental health trusts.”

- **NHS Providers**

“Without a substantial injection of resource, it [a detailed statutory Plan] would make far less time available for working with the patient. Furthermore, formally making the patient's care and treatment plan subject to scrutiny from the clinical or medical director would effectively undermine the independence and authority of the patient's RC and would result in the clinical or medical director being ultimately in charge of and responsible for the patient's treatment. This is neither workable nor beneficial for the patient.”

- **Royal College of Psychiatrists (RCPsych)**

Further engagement on the proposed role of the Clinical or Medical Director indicated that they may not be best placed to meaningfully appraise the Plan, as they may not always have sufficient clinical background or knowledge of the patient. That said, the stakeholders we engaged with recognised the value in the Plan being scrutinised by another member of staff, perhaps outside of the patient's immediate clinical team. Some felt that it would be advantageous if the Plan was appraised by someone with levers to address any areas of unmet need identified in the Plan, for example where the patient's preferred treatment is unavailable at the hospital.

Next steps

We will seek to ensure that the new statutory Plan takes into account existing requirements around care planning, that it encourages joint working, and that there is flexibility regarding the contents of the Plan so that it is truly patient led.

We think that the required contents, set out in the White Paper, are an essential part of the patient's Care and Treatment Plan. We appreciate that it may not always be feasible for clinicians to cover off all the required elements of the Plan by day 7 of an individual's detention. We also recognise that placing unrealistic deadlines on clinical staff, regarding its completion and sign off, may result in the Plan becoming a box-ticking exercise. We will work with stakeholders to review the proposed timelines and governance structure to ensure that any statutory requirements placed on staff are aimed at facilitating a culture of high quality, co-produced care and treatment planning for all patients detained under the Act.

9. Strengthening the patients right to choose and refuse treatment - Refusal of treatment for those with capacity

Proposals

We proposed to change the criteria² for administering urgent compulsory treatment under the Act so that it can no longer be given to patients with the relevant capacity, against their wishes, on the basis of the alleviation of serious suffering (as described in Section 62(1)(c)).

We asked you whether you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering, and to provide an explanation for your view.

What you told us in this consultation

There were 1,294 responses to this question. Overall, 56% of responses agreed/strongly agreed with the proposal; while 25% disagreed/strongly disagreed and 19% were not sure.

The majority of respondents agreed that patients with capacity should have the right to refuse treatment considered necessary to alleviate serious suffering. Some felt that was an important part of achieving parity of esteem in the treatment of mental and physical health. However, some respondents raised that this new safeguard may result in some negative unintended consequences that could compromise the human rights of the patient and their recovery. Others raised practical concerns, ranging from the ways in which mental illness can impede sound judgement, to the challenges associated with capacity assessments.

Points raised from those who commented include:

Introducing this element of choice will promote parity of esteem with physical health

Of the respondents who agreed with the proposal, a substantial proportion expressed the importance of this particular reform in promoting parity of esteem of mental health with physical health. Respondents emphasised the need to ensure that the individual has the relevant capacity to make the decision and that they are appropriately informed of the potential outcomes of their decision.

² Urgent criteria as set out in the Mental Health Act 1983, Section 62(1):

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

“This is a right afforded to patients in the physical health system and there is no justification for withholding this right within the mental health system.”

- Mind

Supports the guiding principles of choice and autonomy and the patient as an individual

Some respondents felt that, by giving the patient the power to refuse urgent treatment in these circumstances and respecting their wishes, that the White Paper's guiding principles of choice and autonomy and the patient as an individual, are supported. There was also a view amongst some respondents that such an approach would be more consistent with human rights legislation, particularly around the principles of self-determination.

In expressing their support for this proposal, some respondents highlighted the damage caused to the patient by the administration of compulsory treatment. Service users, who responded to the consultation, recounted distressing experiences of being forcibly restrained, which they found to be humiliating or traumatic. Some respondents felt that the negative side effects of treatment felt more pronounced when the treatment was not administered with their consent and that this negatively impacted their recovery.

Undermines principle of therapeutic benefit and raises ethical concerns

Conversely, some respondents raised that this proposal risked undermining the principle of 'therapeutic benefit', as the patient's refusal of urgent treatment could impinge upon their recovery, and the justification for detaining the individual under the Act. Some respondents felt that, failing to provide the patient with urgent treatment when they are undergoing serious suffering, raised ethical concerns, particularly as this could have long term implications for the person's health.

Concerns over the patient's mental capacity to refuse treatment and how this can be reliably established

Of the respondents who disagreed with the proposal, a substantial proportion expressed concern about the negative impact of mental illness on an individual's mental capacity or judgement. Respondents across the board felt that this could make it extremely challenging to ascertain whether an individual has the relevant mental capacity to make the decision in the first place, particularly where capacity is fluctuating. While some felt this could be addressed by establishing a robust and universally understood definition of capacity, which can be more easily applied in a mental health context, others expressed concern that this challenge would make it easy for a clinician to deny the patient their right to choose.

“Assessment of capacity in many circumstances can be unreliable and difficult. We are aware of a large disparity between the idea of capacity as often discussed and the way it is applied in everyday frontline practice. However, there is evidence that capacity can be assessed with a great degree of reliability and we would welcome a concerted effort to prioritise methods that allow this and ways in which this can be measured.”

- **The Royal College of Psychiatrists (RCPsych)**

“This [proposal] only gives the illusion of choice and autonomy. We are concerned that if the RC is determined to administer the treatment in question, there will be a tendency to either decide that the patient lacks capacity or use a different legal ground to administer the treatment within s62(1). In our experience of monitoring the use of the MHA, we have found repeatedly that s62 is used to authorise treatment without clear evidence that it was ‘immediately necessary’ as required by s62(1).”

- **The Care Quality Commission (CQC)**

Further engagement with stakeholders during the consultation period supported the concern raised by the CQC, that sometimes urgent treatment (Section 62) is used inappropriately or without a clear justification. Stakeholders felt that, in general, governance structures should be developed to ensure that urgent treatment is only used when the criteria stated under the Act are met. Furthermore, stakeholders recommended that, to address the challenges surrounding establishing an individual's mental capacity, the Responsible Clinician's assessment of the patient's capacity should be countersigned by another health professional, for example a nurse.

Next steps

While there was broad support for this proposal, many respondents raised potentially negative, unintended consequences, as well as practical considerations associated with implementing this new safeguard. Some of these concerns may be resolved through clearer guidance around assessing mental capacity, ensuring that mental health professionals are appropriately trained to carry out these assessments, and by strengthening governance structures around the use of urgent treatment, so that it is only used when absolutely appropriate. We will work closely with stakeholders to explore how we can develop our proposal to mitigate these concerns.

10. Strengthening the patients right to choose and refuse treatment - A new right to challenge a treatment decision at the Tribunal

Proposals:

In order to improve the rights of patients and give them greater choice and autonomy when it comes to their care and treatment, we proposed to give people detained under the Act the ability to appeal treatment decisions with the Mental Health Tribunal, if they are receiving treatment that they have not consented to. The challenge could also be brought by the patient's IMHA or nominated person (NP), if the patient lacks the relevant mental capacity but has an Advance Choice Document stating their treatment refusal.

There would be a permission to appeal stage and, if a hearing was granted, then a Tribunal judge (sitting alone) would consider the evidence and decide whether to uphold the responsible clinician's decision, order that they reconsider their decision or potentially order that the specific treatment is no longer administered to the patient.

We asked you whether you agree or disagree that, in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given, and to provide an explanation for your view.

What you told us in this consultation

There were 1255 responses to this question. Overall, 44% of responses agreed/strongly agreed with the proposal; while 33% disagreed/strongly disagreed and 24% were not sure.

A higher proportion of organisations disagreed (40%) than agreed (34%) with the proposal, while more individual respondents agreed (46%) than disagreed (31%).

Of the respondents who supported this proposal, many felt that this could vastly improve the patient's rights when it comes to appealing the administration of compulsory treatment. However, a substantial proportion of respondents raised concerns around the detail of the proposed approach and, while mostly respondents appeared to support the principles of the proposal, they expressed that this was contingent on other requirements such as the judge being clinically trained or having access to independent clinical advice.

Points raised from those who commented include:

Improves treatment safeguards

Those respondents in support of the proposal felt that expanding the powers of the Mental Health Tribunal would improve patient safeguards and ensure greater lines of accountability, with regard to clinical decision making. Others felt that it also provided a swifter and less expensive means of appeal for patients. More broadly, respondents felt that the proposal would help ensure that patient choice plays a more central role in the delivery of care and treatment.

“Overall, we feel that this will ensure that clinical staff are much more likely to engage with a patient on their wishes and preferences with regard to treatment, and to engage in care planning conversations rather than allowing treatment decisions to escalate to the level of the Tribunal.”

- **Rethink Mental Illness**

Some respondents felt that the patient should not only be able to appeal the use of compulsory medical treatments at the Tribunal, but also non-medical treatments like behavioural therapies. We tested this proposal with stakeholders during the consultation period and some felt that this might be challenging, both in terms of the complexities of making such decisions, but also from a resourcing perspective.

Concerns over expansion of the Mental Health Tribunal's powers

A large proportion of the respondents who disagreed with the proposal cited concerns around a member of the judiciary influencing clinical decision making. Some felt that it was wholly inappropriate as the Tribunal judge is unlikely to have the clinical expertise necessary to make such a decision, potentially putting the patient at risk. Further engagement with stakeholders indicated that the proposed expansion of the Tribunal's powers mirrored those already held by the High Court and therefore it would not necessarily be unusual for members of the Tribunal to make such decisions. Moreover, stakeholders cautioned against the judge's powers being limited to requiring that the responsible clinician only 'reconsiders' the patient's treatment, as they felt that this would significantly weaken the proposed safeguard. This position was supported by other stakeholders, including the CQC, who felt that this needs to be possible in order for the right to challenge to be meaningful for patients.

Other respondents who disagreed or were unsure about the proposal felt that the power to stop treatment should not fall to an individual member of the judiciary, but that it would be safer and more appropriate if the power was held by the Tribunal panel or a multidisciplinary team (MDT).

“This [decision] should ideally be a clinical decision made as a whole MDT, which is as collaborative as possible, but if the decision is highly contentious, it should be a matter for a higher court, for example the court of protection. A Tribunal judge is unlikely to have the clinical expertise to be able to weigh up the merits of one form of treatment over another, or to decide that no treatment at all should be given.”

- **The Royal College of Psychiatrists (RCPsych)**

Practical considerations

Many of the same concerns were cited by respondents who supported the proposal. They commented that, while they agreed with the broad objectives of the proposal, this safeguard would only be effective if the Tribunal judge received some form of clinical training or had the suitable experience to make such a decision. Others felt that the judge would require access to independent medical advice or any other evidence that they felt would be necessary in order to make a safe and properly informed judgement.

Some respondents were concerned that, unless properly resourced, this safeguard may be ineffective, particularly given existing resource constraints. The Mental Health Tribunal indicated that they supported replication of the single judge procedure typically found in judicial review, as proposed in the White Paper, as they felt this might minimise the impact on resources. They also felt that this might enable the Tribunal to decide more rapidly the issue and ensure that, if treatment is necessary, it is not delayed.

“This is a welcome proposal as we consider judicial review to be a ‘blunt instrument’ for essentially fact-specific issues. Clearly this will require significant resources for the Tribunal and for representatives, in terms of capacity and skillset, in the absence of which these new rights cannot be made effective.”

- **The Bar Council**

Next steps

The consultation process has confirmed that, as highlighted by the Independent Review, judicial review is not an effective route of appeal for patients who are receiving compulsory treatment. We maintain that expansion of the Tribunal's powers would improve the patient's rights in this regard, however, the consultation process has identified concerns, in particular regarding the power sitting with a single judge acting alone and the need for clinical input into the decision-making process, in the interests of patient safety. We will continue to work closely with stakeholders to develop this policy and identify potential means of mitigating the concerns raised by stakeholders.

11. Advance Consent to Admission

Proposals

The Independent Review recommended that we consult on whether the Act should give individuals the right to consent in advance to admission to hospital for treatment for a mental illness. This would mean that, if an individual had given prior consent and they later become unwell and lose the relevant capacity, then they would be admitted as informal or voluntary patients, as opposed to being detained under the Act (or subject to the DoLS/LPS). The White Paper set out our concerns with this proposal around access to safeguards, whether individuals would be fully aware of what they were consenting and whether they would feel they could later object. However, it also set out that the principle that people should be able to make decisions which will endure in the event of future incapacity, including advance consent, is already recognised in law. The White Paper consulted on whether the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act and its Code of Practice to make clear the availability of this right to individuals.

We asked you whether you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA Code of Practice to make clear the availability of this right to individuals, and to provide an explanation for your view.

What you told us in this consultation

There were 1,242 responses to this question. Overall, 64% of responses agreed/strongly agreed with the proposal; while 17% disagreed/strongly disagreed and 19% were not sure.

Although the majority of respondents agreed with the proposal whether responding as an individual or as an organisation, there was a sizeable difference in proportions with 68% of individuals agreeing and just 46% of organisations agreeing.

Whilst overall respondents agreed that the right to give advance consent to informal admission to a mental health hospital should be set out in the Act and its Code of Practice, concerns were raised about the application of this right, and the need to safeguard patients. This was explored further in the next question.

Points raised from those who commented include:

Agree with proposal to clarify advance consent

There was general agreement among respondents that the right to give advance consent to informal admission should be set out in the Act. Those who agreed expressed a general preference for informal admission in hospital and felt this would lead to a quicker access to a bed when needed. Respondents in favour of the proposal also felt that this would give the patient more autonomy and choice over what happens to them when in hospital and what treatment is provided.

Concerns raised about the proposal

In the free text comments, more respondents went on to express their reasons for disagreeing than supporting the proposal. Respondents who did not agree felt that under this proposal, health professionals may not be clear which legal framework they should be using when treating and caring for the person and that this would leave patients without the safeguards of the Act or access to s117 aftercare. Respondents expressed concern about how advance consent would be considered at the point of admission, indicating that decisions should take account of what is happening at the time and not what has been expressed in advance. Respondents also felt that support for this proposal was driven by stigma around detention and preference for informal admission, but this proposal would not guarantee informal admission, because if a patient objected to treatment or tried to leave, they might be detained under the Act.

Implementation

Other respondents were in general supportive of the principle of advance consent but expressed concern about how the proposal would be implemented, flagging the need to increase capacity to provide access to treatment via informal admission. Respondents suggested that patients should specify what they are and aren't consenting to and be admitted informally only when admission aligns with these criteria, and that a proper assessment should be made to confirm understanding of their rights as an informal patient and capacity to give advance consent. Some respondents felt that there was a risk that patients would voluntarily deprive themselves of the rights available under the Act, and that those admitted informally should be granted the same legal safeguards as individuals detained under the Act.

In light of concerns identified by the Independent Review, and set out in the White Paper, we also asked you whether there are any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

The majority of respondents expressed their support for advance consent to admission and had further suggestions of safeguards that could be put in place to support this. These included setting out under what circumstances advance consent is given and putting in place a timeframe for how long the advance consent lasts and frequency of reviews, ensuring patients have the relevant capacity to give advance consent and are aware of their rights under informal admission, and that advance consent is clearly authenticated and documented.

Points raised from those who commented include:

Time frame for advance consent

Some respondents felt that there should be a clear timeframe on how long advance consent lasts to ensure that advance consent was given when the patient had the most recent information available to them, and that after the point of admission, advance consent should be regularly reviewed to ensure that treatment remains in line with the patient's wishes and preferences.

Validity of advance consent

Most respondents suggested safeguards that would ensure that there was a process in place to ensure the advance consent was current or valid. Some respondents felt that there is a role for individuals who support the patient to be part of the process, including nearest relative/ nominated person, family and carers, or that multiple people should be involved in the advance consent decision. Other respondents suggested that advance consent should be clearly documented and accessible and that this could be incorporated into Advance Choice Documents/Advance Directives. Respondents felt that patients should specify what they are and aren't consenting to and be admitted informally only when admission aligns with these criteria. Responders also emphasised the need to ensure patients have capacity and/or competence to give advance consent.

“Once admitted, an informal patient is required to make a series of ongoing decisions including over treatment, discharge and time off the ward during the admission. A current informal patient with capacity makes these decisions, and the hospital team cannot restrict them or enforce treatment upon them. It is unclear how these decisions would be made for an incapacitated individual admitted informally under the advance consent proposals. It would not be realistic for all scenarios to be considered sufficiently in advance of an admission.”

- **Care Quality Commission (CQC)**

Safeguards during process

Another group of respondents expressed concern about the lack of safeguards available to informal patients and recommended that patients should be fully informed of their rights and the implications of informal admission before giving advance consent. Respondents also suggested additional safeguarding measures including the provision of advocacy service to protect against de facto detention, the right to appeal to the Tribunal, and the right to withdraw consent. Some respondents suggested that all informal patients should have access to the same rights and safeguards as under the MHA or under the MCA.

Further engagement with stakeholders highlighted concerns that there might be a general misconception that if service users gave advance consent it would be quicker and easier to access treatment, but that in reality, the use of advance consent may not amount to tangible change, and that the practical outcomes might be very similar without access to the safeguards and protections of the MHA. We have heard that implementing advance consent would require clear guidance setting out the criteria for when an individual can make this decision and what they can consent to.

Organisations on the whole expressed concern or disagreed with advance consent to informal admission, on the basis that it would deny the right to safeguards and complexities around assessing capacity and consent. Some organisations recognised the good intention of recognising patient's prior wishes and decisions made with the relevant capacity when in a state of incapacity but felt that it does not work in practice.

"While we welcome the intention to increase the autonomy provided to individuals in relation to their own treatment and care, we are concerned about this development and the risk of removing vital safeguards from people who are in mental health crisis and may lack capacity to consent to decisions regarding their hospitalisation and care."

- **AHMP Leads Network**

Next steps

Whilst there were many who supported making clearer the right to give advance consent to admission, concerns were raised about how this would work in practice and what safeguards would be put in place to protect patients informally admitted. As the right to give advance consent is already recognised in law, we will continue to explore how advance consent could be implemented within the patient journey, and how this would work in practice, including what safeguards we would need to be put in place to support patients informally admitted on this basis.

12. Nominated Person

Proposals

In the White Paper, we proposed to replace the Nearest Relative (NR) with a new statutory role, known as the Nominated Person (NP), who the patient can personally select to represent them and exercise certain rights on their behalf.

The new Nominated Person will have the same rights and powers to act in the best interests of the patient as Nearest Relatives have now. These include rights to apply for, or object to, the patient being detained under the act, to apply for the person's discharge and to appeal to the Tribunal if this is denied. The NR may also receive information from the hospital about the person's care, detention or CTO, unless the person objects to this.

In addition to these rights and powers, the NP will have the right to be consulted on statutory care and treatment plans, to be consulted, rather than just notified, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO, to be able to appeal clinical treatment decisions at the Tribunal if the patient lacks the relevant capacity, and to object to the use of a CTO if the patient lacks the relevant capacity to do so themselves.

We asked you whether you agree or disagree with the proposed additional powers of the nominated person, and to provide an explanation for your view.

What you told us in this consultation

There were 1,302 responses to this question. Overall, 78% of responses agreed/strongly agreed with the proposal; while 7% disagreed/strongly disagreed and 15% were not sure.

The majority of respondents agreed with the proposed additional rights and powers of the nominated person. Respondents agreed that it was important that the service user could choose someone they trust to represent them so viewed the introduction of the NP role very positively. A small number disagreed with some specific rights and powers being proposed for the NP, specifically the power to object to the use of a CTO and for NPs to be consulted when a service user is transferred between hospitals.

Points raised from those who commented include:

Autonomy and choice

Many respondents believed that the process of being assigned a Nearest Relative was antiquated and didn't allow for flexibility or align with the changing family structures of modern society. The power of the service user to choose an NP was seen to reflect greater autonomy and corrects the perceived imbalance in power between the service user and the authorities making decisions about their care.

Specific powers

Respondents agreed that the NP should be consulted on statutory care and treatment plans, renewals and extensions to detention, as well as appealing to the Tribunal where the person lacks capacity to do this themselves.

During engagement with stakeholders, there was some disagreement around the NP having the power to object to the use of a CTO. There was agreement that the NP should have a specific power to appeal to the Tribunal.

Stakeholders also highlighted that consulting NPs when it comes to transfers between hospitals is not always possible in practice as it may have to be done at speed for the safety of the patient or happen out of hours. Stakeholders suggested that the power to be consulted on transfers could apply in non-urgent cases which can be planned in advance (with the NP still being informed of any transfers). It was felt that guidance which demonstrates how NPs could be consulted as much as possible would be useful.

Quality of relationships

Respondents agreed that the Nominated Person proposal provided a better safeguard in some cases as not everyone has a good relationship with their family, who may not be best placed to represent their needs. For example, people may have minimal contact with the relative representing them or the relative may not be willing to carry out the role. Family members can also represent a safeguarding risk, for example in cases of abuse, where a Nearest Relative may be inappropriate and should not be involved in making decisions about the person's care and treatment.

It was argued that people should be able to choose someone who they trust will make decisions in respect of their care and treatment. Respondents noted that this potentially gave carers better rights as the people who have the best level of knowledge and understanding of the person and their condition, as well as any previously expressed preferences.

Interim nominated person

There was widespread agreement that if a person lacks the relevant capacity and is unable to select an NP, then the AMHP should be able to select an Interim Nominated Person (INP). This was seen to act as a safeguard by ensuring that a person without the relevant capacity is still being represented.

There was also agreement that service users should be able to opt out of having an NP if they decide this at a time when they have relevant capacity, as long as sufficient safeguards are in place, for example access to an Independent Mental Health Advocate.

Respondents also believed that support should be provided to the NP (or INP) to help them understand their role.

“We support the concept of the nominated person (NP) and interim nominated person (INP). The proposals assist in the transfer of greater choice, involvement and control to individuals in the planning and arrangement of their future care and is consistent with the proposed principles. It importantly provides a method to minimise the chances of an ‘inappropriate’ individual having a controlling function in the patient’s care.”

- AMHP Leads Network

Part 3 patients

Patients under Part 3 of the Act are not currently eligible to have a Nearest Relative, but the White Paper proposed changing this and giving them the right to a Nominated Person, with powers limited to care and treatment planning. This question was not asked as part of the consultation. The Department of Health and Social Care will continue to work with the Ministry of Justice, Her Majesty's Prison and Probation Service (HMPPS) and Her Majesty's Courts and Tribunals Service (HMCTS) to explore the rights for Part 3 patients in relation to the Nominated Person, for example support around care planning, and ensure that safeguards are in place where an NP should be overruled or displaced.

Children and young people

For young people aged 16 or 17, the White Paper proposed that they should have the same right to choose a nominated person as an adult, where they have the relevant capacity to make this decision. However, it said the position for children aged under 16 requires additional consideration. The White Paper proposed that if a practitioner establishes that a child is ‘Gillick competent’ (they have sufficient understanding, maturity and intelligence to enable them to fully understand what is proposed), they should be able to choose an NP.

We asked you whether you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as ‘Gillick competence’).

There were 1,282 responses to this question. Overall, 67% of responses agreed/strongly agreed with the proposal; while 15% disagreed/strongly disagreed and 18% were not sure.

The majority of respondents agreed that 16- and 17-year-olds should have the same right to choose an NP as an adult, where they have the relevant capacity to make this decision. In principle, respondents agreed that a child under 16 should be able to appoint a person they trust to be their NP, but there was concern about how this interacts with the roles of others (especially those with parental responsibility or guardians) and any risks which the NP may pose to the child. A small number of respondents felt that children under 16 do not have the maturity to make this decision and that a parent should always be the NP for their child.

Points raised from those who commented include:

Risks to the child

A frequently reported concern was that a child might be coerced into choosing their NP. Concerns were also raised that they might also choose someone who might not act in their best interests or does not know about their clinical history and was therefore not best placed to advocate for them.

Support and safeguarding

In order to protect the child, respondents stated that there needs to be a vetting process to ensure the chosen person does not have an inappropriate relationship with the service user. Respondents suggested that an age limit should be applied so that an NP must be aged over 18. It was recognised that children may need support in helping them decide who to appoint as their NP and would need to be judged to have the maturity to understand the consequences of their decision. Respondents wanted parents and guardians to remain involved in the care of their child even if they were not selected to be the NP.

For a child who is assessed by their practitioner not to have Gillick competence and therefore to lack the understanding, maturity and intelligence to appoint their own NP, respondents were content for an AMHP to appoint an INP as with adults. They were in favour of providing additional guidance to AMHPs regarding selecting an INP for a child and highlighted the importance of working with stakeholders to develop appropriate guidance.

“We welcome the Department’s intention to provide clear, detailed guidance on the powers of the nominated person role [...] to give a clear understanding of how these new powers will work in practice. For example, there might be some challenges determining what weight a doctor should attach to the different views and inputs from a nominated person with specific powers, the views and needs of other individuals close to the patient, and the patient themselves (especially if the patient is under 16yrs and Gillick competent).”

- **The General Medical Council (GMC)**

Next steps

As set out in the White Paper, we will take forward legislative changes to replace the Nearest Relative role with the Nominated Person role so that individuals can choose who represents them. We will provide additional support and guidance for those involved in the person’s care to address stakeholder concerns, introduce safeguards, and clarify how these new powers interact with existing legal rights, including those of parental responsibility.

13. Advocacy

Proposals

Independent Mental Health Advocates (IMHAs) are specialist advocates who are trained specifically to work within the framework of the Act and are independent of mental health services. In the White Paper, we proposed extending the statutory right to an IMHA to all mental health inpatients, including informal patients, patients awaiting transfer from a prison or an immigration detention. This recognises how important it is for all patients to understand and exercise their rights in mental health inpatient settings.

We also proposed to expand the role of IMHAs to support patients to access additional safeguards including helping patients to contribute to their statutory care and treatment plan and prepare their advance choice document, supporting patients to exercise their increased rights to challenge detention, and supporting patients to appeal treatment decisions.

We asked you whether you agree or disagree with the proposed additional powers of independent mental health advocates, and to provide an explanation for your view.

What you told us in this consultation

There were 1,302 responses to this question. Overall, 85% of responses agreed/strongly agreed with the proposal; while 5% disagreed/strongly disagreed and 9% were not sure.

The majority of respondents agreed with the additional powers being proposed and felt that this would further empower service users to have their voices heard and their preferences incorporated into their care. Some respondents had concerns about giving IMHAs the power to challenge a particular treatment where they believe that it is not in the service user's best interests.

Points raised from those who commented include:

Specific powers

Generally, respondents were in favour of the proposed additional powers. The main area of concern raised was that, as IMHAs are not medically trained, they would not be able to weigh up benefits and risks of a treatment. Advocates should be there to help guide and educate the service user only, they should not be a part of clinical decision making. Other respondents highlighted that advocates usually work on the instruction of the service user so they could help the person appeal to the Tribunal but should not be making decisions without being directed by the person. This power to appeal on behalf of the service user aims to ensure that the service user's voice is represented in relation to their treatment preferences.

Accessibility

Access to IMHAs is variable and it was frequently reported that staff on the wards didn't understand the IMHA role so didn't refer service users to them. In order to benefit from the proposals, many respondents noted that more IMHAs are needed as implementation of

these changes will require additional funding and workforce support. Where service users did have access to IMHAs, the quality of services varied.

“We welcome the opportunity for the new Act to support councils to grow the capacity and capability of voluntary sector providers, such as Independent Mental Health Advocacy (IMHA) services.”

- Local Government Association (LGA)

We asked you whether you agree or disagree that advocacy services could be improved by: enhanced standards, regulation, enhanced accreditation, or any other means, and to provide an explanation for your view.

What you told us in this consultation

Enhanced standards - There were 1265 responses to this question. Overall, 85% of responses agreed/strongly agreed with the proposal; while 2% disagreed/strongly disagreed and 12% were not sure.

Regulation - There were 1261 responses to this question. Overall, 78% of responses agreed/strongly agreed with the proposal; while 5% disagreed/strongly disagreed and 17% were not sure.

Enhanced accreditation - There were 1265 responses to this question. Overall, 79% of responses agreed/strongly agreed with the proposal; while 5% disagreed/strongly disagreed and 17% were not sure.

None of the above, but by other means - There were 739 responses to this question. Overall, 21% of responses agreed/strongly agreed with the proposal; while 20% disagreed/strongly disagreed and 59% were not sure.

Respondents agreed that consistent quality and accessibility to IMHAs was important and that accreditation, regulation, and in particular enhanced standards would help improve quality. The majority of respondents were unsure whether 'other' measures were needed to improve advocacy services (individuals 63%; organisations 38%). This could be down to the fact that proposals to improve standards, regulation and accreditation were considered enough, or that the question itself was unclear.

Points raised from those who commented include:

Resources

It was felt that quality would not improve without availability of staff and funding for workforce. An emphasis was placed on the need for some form of scrutiny and holding services to account, as long as this could be done in a way that avoids unnecessary bureaucracy and burden on staff.

Tailoring services to specific groups

Training was frequently brought up as an enabler for improving quality of services as service users will need even greater support to understand their rights and safeguards under the new reforms. In particular, IMHAs should be trained on how to work best with individuals from key groups, including different ethnic minority groups, children and young people, and people with learning disabilities or autistic people. Training would need to be kept updated and IMHAs should undergo a supervision process to ensure continued professional development and consistent quality of services.

Advocacy should be culturally appropriate and a diverse IMHA workforce would help enable this. Increasing the diversity of IMHAs will mean that the needs of all service users are adequately represented. In order to better help patients from all ethnic backgrounds voice their individual needs, we have committed to launch a pilot programme of culturally appropriate advocacy to identify how advocacy can respond appropriately to the particular needs of individuals, especially from black groups where we know there are significant disparities in care and treatment under the Act. We continue to work with specialist stakeholders to ensure that input from under-represented groups is included in every step of the implementation of the White Paper recommendations to address inequalities across the wider mental health reform agenda.

Formalising the profession

Respondents commented that IMHAs are already required to have a qualification and services can be assured through the Advocacy Quality Performance Mark. However, they were concerned that more formal accreditation may deter people with lived experience from becoming advocates. Further formalising the profession may discourage smaller, more bespoke services who could otherwise add to workforce capacity. On the other hand, respondents noted that accreditation may improve the professionalism and reputation of the role which may encourage ward staff to refer service users to the service.

Co-production and working with service users and carers is critical to the quality of advocacy services. Respondents commented that advocates who have lived experience would be able to understand and relate to the service user so would provide a good quality service which is responsive to the needs of service users. The informality and independence of the role can support service users to communicate these needs and respondents noted that this was a key benefit of an IMHA service which encourages inclusion of those with lived experience.

“We agree that an IMHA qualification is important and would want to ensure that all IMHA advocates complete training (and remain competent through re-accreditation) before being allowed to advise patients. However, we would not wish such accreditation structures to discourage smaller bespoke services, or act against user-involvement in IMHA services, leaving only larger providers who are able to ensure enhanced standards to dominate the market.”

- **Care Quality Commission (CQC)**

Next steps

As set out in the White Paper, we will take forward legislative changes to extend eligibility of IMHA services to all mental health inpatients, including informal patients, and to add the proposed additional rights and powers relating to supporting service users with advance choice and care planning, and applying to the Tribunal on behalf of the service user. We will also consider the requirements needed for an opt out service.

As committed to, we will further explore with stakeholders the best way to improve the quality of IMHA services, whether through enhanced standards, accreditation, regulation, or increased training requirements. We will continue to prioritise the development of culturally appropriate advocacy and work with stakeholders to ensure that ethnic minority backgrounds are considered as the reforms are implemented.

14. Mental Health Act (MHA) and Mental Capacity Act (MCA) interface

Proposals

In certain circumstances, where a person has a mental disorder, lacks the relevant capacity and is not objecting to detention or treatment, a practitioner may need to consider whether that person should be detained under the MHA or instead made subject to the Deprivation of Liberty Safeguards, under the MCA (to be replaced by Liberty Protection Safeguards).

We set out our intention in the White Paper to take forward the Independent Review's recommendation that a clearer dividing line be introduced in legislation between the two Acts, based on whether or not a patient is clearly objecting to detention or treatment. The effect would be that all patients without the relevant capacity, who do not object, would be subject to the the DoLS/LPS and not under the MHA.

The Independent Review found that within this interface it is not always clear for practitioners whether the MHA or DoLS should be used if a person lacks the relevant capacity and does not appear to be objecting, and that the MHA is still used in cases where it may be preferable to use DoLS. In parallel to reforms of the MHA, the Government is replacing DoLS with a new LPS framework, which will itself address these issues. The White Paper also agreed with the Independent Review that it is important to assess the impact of implementation of the new LPS, before introducing these reforms to the MCA/MHA interface.

We asked you how should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances.

What you told us in this consultation.

Although there were 1,449 responses, over 1,000 respondents expressed they were unsure, didn't know or felt was difficult to answer. Where detailed responses were provided, respondents recognised the complexity around the current interface and welcomed the intention to provide clarity and support clinicians in their decision making. Responses also identified that the current interface is not always being applied as reflected in case law (and reflected in the MHA Code of Practice). However, there was no significant support for the proposal set out in the White Paper nor overall agreement on what alternative changes to the interface would improve the application. In addition, the proposal to change the interface has been identified as a key concern from a number of stakeholders and organisations in their responses and representations to Government during the consultation period.

Points raised from those who commented include:

Support for the proposal in the White Paper

A small number of respondents supported the proposal set out in the White Paper for objection by the patient to detention or treatment to form the basis of the dividing line between the two Acts.

However, some respondents who supported the White Paper proposal went on to say that patients subject to the MCA (DoLS/LPS) should also be entitled to the same rights available under the MHA.

Some respondents also set out that whilst they support the proposal, they thought it would be sensible to allow time for the new LPS to bed in to see how it interacts in practice with the MHA before implementing any changes to the dividing line.

Do not support the proposal in White Paper

More respondents expressed they did not support the proposal. Although some identified clarity was desirable, respondents did not agree that the division should depend on whether a person is objecting. Respondents felt that objection is not always clear, can fluctuate or can be influenced by other people, and that there was a risk that if objection was not assessed correctly, this could mean that people might be detained under the wrong legislation, therefore would not achieve the desired effect of simplifying decision making or preventing individuals being placed under an act which doesn't best meet their need. These concerns were echoed in engagement with stakeholders.

Respondents also expressed concerns that those deprived of liberty under the MCA would not have access to the same rights and safeguards as are available under the MHA. These concerns were echoed through stakeholder engagement, which raised concerns around the safeguards under the MCA compared to the MHA.

We also heard through consultation and stakeholder engagement concerns that this proposal risked moving away from a patient centred approach, as the current interface allows clinicians to determine which framework is most suitable for the patient, and their particular circumstance.

Some respondents felt that it was not possible to create a clear dividing line between the MCA and the MHA, and/or recommended that we combine the MHA and MCA into a single piece of legislation.

“We do not believe that the LPS provides sufficient safeguards for people with fluctuating capacity or who are likely to respond to medical treatment, including people with mental illnesses. Moreover, we feel that in practice, the concept of objection is extremely difficult to assess and measure. We therefore believe that predicating the Review's proposals on this concept is likely to create more problems than it solves.”

- **Rethink Mental Illness**

Improve the application of the current dividing line

Respondents recognised that decisions around the application of the dividing line are not easy, and shared accounts of how the current interface can be incorrectly applied due to lack of clarity and understanding by decision makers. We also heard insight that decision makers will often opt for the legislative framework that they perceive provides increased protection and access to resources, based on personal opinions of the relative merits of each act. Respondents suggested that more resources should be made available to improve decision makers' capacity and capability before legislative changes are considered, and emphasised that better guidance and training is needed to improve the application of the interface to ensure that individuals are made subject to the most appropriate act. Several alternative suggestions were also proposed to decision making in cases where either act can be used:

- A small number of respondents felt that the decision should always be made on a case-by-case basis and reflect the specific circumstances and preferences of each individual person.
- Some respondents suggested that the decision be based on the risk of harm posed by the individual to themselves and others, and that those felt to be at risk should be detained under the MHA in order to give them the highest level of safeguarding.
- Some respondents felt that there should be a clear distinction between the use of the Mental Health Act for those receiving treatment for mental illness and the use of the Mental Capacity Act for those receiving treatment for physical illnesses. These respondents often felt that the safeguards available under the Mental Capacity Act are not sufficient for those receiving treatment for mental illness.

“We do not agree with using objection as the dividing line. People may be quiet, compliant, resigned, unaware of any options, or lacking the capability to articulate their feelings. People may express their feelings but not have this recognised or acted on as objection. In general, if people are in a mental health hospital for mental health treatment and do not have capacity to agree to their admission, they should be under the MHA which is designed for this purpose.”

- **Mind**

Next steps

In light of the feedback received, we do not intend to take forward reform of the interface, as set out in the White Paper, at this time. We will seek to build the evidence base on this issue through robust data collection, to better understand the application of the interface. In addition, we will continue to engage with stakeholders to understand what support and guidance could help improve application of the current interface.

The Government will shortly publish its consultation on a draft, updated, Code of Practice for the MCA, including the LPS, and the draft LPS regulations. This will set out how we think LPS will operate in detail and invites feedback on that.

The LPS system will be more streamlined and will put the person at the centre of the decision-making process. The LPS will introduce an explicit duty to consult with the person, and those interested in their welfare, to establish the person's wishes and feelings about proposed arrangements. Those who are close to the person will also be able to provide representation and support to them via a new 'Appropriate Person' role. People can also be represented, supported and afforded their rights throughout the process by an Independent Mental Capacity Advocate (IMCA). Furthermore, the rights of people at the heart of the most complex cases will be considered and upheld by new the new 'Approved Mental Capacity Professional' role.

We will review the interface once the new LPS arrangements are embedded, based on a clearer evidence base around application of the interface, and the impact of implementation of the LPS.

15. A&E Holding Powers

Proposals

The White Paper identified that too often police are relied on to hold individuals who are in crisis and are attempting to leave accident and emergency departments (A&E). It therefore set out our intention to improve the powers available to health professionals in A&E so that individuals in need of urgent mental health care stay on site, pending a clinical assessment. The White Paper consulted on which legal framework would be most suitable to provide for this.

We asked you whether you think that the amendments to Section 4B of the Mental Capacity Act achieve this objective, or should we also extend Section 5 of the Mental Health Act (MHA), and to provide an explanation for your view. The choice we gave you was whether to:

- **rely on Section 4B of the Mental Capacity Act only**
- **extend Section 5 of the MHA so that it also applies A&E, accepting that Section 4B is still available and can be used where appropriate**

What you told us in this consultation.

There were 996 responses to this question. Overall, a clear majority of 86% of responses responded in favour of extending Section 5 of the Mental Health Act; while 14% suggested relying on Section 4B of the Mental Capacity Act.

Overall, the majority of respondents were in favour of extending Section 5 of the Mental Health Act rather than rely on Section 4B of the Mental Capacity Act. Where the respondent explained their answer, most expressed support for giving health professionals the power to hold people in A&E under Section 5, as this was preferable to police officers exercising their powers, and they felt this would provide quicker access to assessment and treatment.

A small number of respondents did not express a preference for using Section 5 of the MHA or Section 4B of the MCA. A very small number of respondents objected to the general power to hold individuals who are in crisis and are attempting to leave A&E, on the principle that those who do not wish to be in A&E or to undergo a mental health assessment should be allowed to leave and not held against their wishes.

Points raised from those who commented include:

Support for MHA Section 5

Support for extending Section 5 of the Mental Health Act to provide holding powers to health professionals in A&E were based on the following themes. Respondents felt that the MHA is more familiar to mental health professionals and would provide more appropriate safeguards than the MCA. Other respondents also felt that it would not be appropriate to hold people awaiting a mental health assessment under Section 4B of the MCA as they may still have the relevant capacity, even if they are objecting to treatment/assessment and express a desire to leave.

“We think Section 5 should be extended to A&E. We would be very concerned about patients being held in A&E for 3 days under a doctor's holding power. This is not the same as a patient being held in an appropriate bed on a psychiatric ward. We are also concerned that with time left 'on the clock' that this would impact on the prioritisation of these patients for MHA assessment and, where indicated, admission. We therefore recommend a significant reduction from 72 hours. Patients have told us that they already wait a significant amount of time to be assessed by psychiatric liaison services.”

- **Care Quality Commission (CQC)**

Support for MCA Section 4B

A minority of respondents were supportive of using Section 4B of the Mental Capacity Act only, due to concerns that extending Section 5 could lead to an increase in the number of people later detained under the MHA, and felt that the changes to Section 4B will provide sufficient powers to temporarily hold individuals presenting with mental health crisis in A&E.

Implementation considerations

Some respondents expressed concern about how a new power (irrespective of whether it is an extended Section 5 or new Section 4B) would be implemented and recommended additional staffing, guidance and training on how the power can be applied, to build capability and capacity and avoid causing additional distress. Respondents also felt that A&E is not a suitable location for those undergoing a mental health crisis and can cause further distress, often prompting the person to try to leave. Some respondents suggested that individuals should be held in separate spaces that provide more appropriate safe and secure conditions. Some respondents expressed concern that the 72-hour limit (as provided under Section 5 of the MHA) is too long, and individuals should be assessed and treated sooner.

Further engagement with stakeholders highlighted that organisations thought that Section 5 of the Mental Health Act should not be extended to provide holding powers to health professionals in A&E, due to concerns around timescales.

Organisations were generally supportive of extending the powers available to health professionals in A&E by increasing the scope of Section 5, alongside the use of amended Section 4B when appropriate. However, they also felt that the 72-hour time limit (as provided under Section 5 of the MHA) should be reduced. Feedback also highlighted the need for further clarification on who can exercise these powers and the importance of having safe, suitable, environments to hold people, that minimise further distress. Some organisations were concerned that the focus should be addressing the barriers around access to a timely mental health assessment and felt that extending Section 5 was not necessary.

In parallel to the consultation, we also heard proposals for alternative suggestions, in light of limitations to both Section 5 of the MHA and Section 4B of the MCA. These included: exploring developing a new Section of the MHA, with Section 136 put forward as a potential model to replicate for health professionals; putting in place a provision to transfer the patient from one hospital to another; and allowing for assessment by one doctor and an AMHP.

Next steps

We will seek to give powers in legislation to health professionals in accident and emergency departments so that individuals in need of urgent mental health care stay on site, pending a clinical assessment. We will carefully consider the points raised by those who responded to the public consultation about how this should be implemented, including how best to address the limitations of Section 5 of the MHA and Section 4B of the MCA, as highlighted through consultation.

16. Caring for patients in the Criminal Justice System - Independent role to oversee secure transfers from prison and immigration removal centres (IRCs)

Proposals

We proposed to establish a new designated role for a person independent of the health or criminal justice systems to manage the process of transferring people from prison or immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health.

We asked you which of the following options you thought is the most effective approach to achieving this, and to provide an explanation for your view. The options were:

- **expanding the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison or IRC transfers**
- **creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service (HMPPS) to manage the prison or IRC transfer process**
- **an alternative approach (please specify)**

What you told us in this consultation

There were 979 responses to this question. Overall, 63% of responses were in favour of creating a new role with NHSEI or across NHSEI and HMPPS; 30% of responses were in favour of expanding the AMHP role; 4% of responses were in favour of an alternative approach.

In general, respondents were supportive of the proposal and felt that this could improve the process of transfers from prison or IRC, with a preference for introducing a new role within NHSEI or across NHSEI and HMPPS.

Points raised from those who commented include:

A new role within NHSEI or across NHSEI and HMPPS

The majority of respondents felt that the most effective approach would be to create a new role within NHSEI or across NHSEI and HMPPS. A high number of respondents stressed that this role would require specialist skills and training, and while some argued that this role should be entirely independent of the system, and a larger number noted that close links to NHSEI and HMPPS would be important in order to navigate existing systems effectively.

Expanding the existing Approved Mental Health Professional role

Around one third of respondents felt that expanding the existing Approved Mental Health Professional role would be the most effective approach. Overall, respondents frequently highlighted that AMHPs have the correct skills and knowledge – which could be further improved through additional support and training. However, a common theme was that the AMHP workload is already too high to take on this responsibility.

An alternative approach

A small number of respondents suggested alternative approaches. Suggestions included increasing the role played by charities and non-profit organisations, and increasing the expertise and training of existing staff in the criminal justice system.

“It will be vital that this new role also supports people returning from hospital, including to ensure people get their entitlement to Section 117 Aftercare if they return to prison.”

- **The Centre for Mental Health**

Further engagement with stakeholders echoed the views received through the consultation. Stakeholders also highlighted key differences between IRCs and the criminal justice system, including that there are several routes in and out of IRCs that are not available in prisons. As such, more specialism may be required for IRCs. Stakeholders also stressed that the role could not cover the improvements needed on other issues such as funding, or the process of referrals to assessment within prison.

Next steps:

We will continue work to introduce the independent role, utilising feedback received through the consultation when deciding where the role should sit. We will use this feedback to create draft job descriptions, which will then enable us to test out the duties, scope and placement of the role from an operational perspective and with key stakeholders. We also recognise the key differences between prisons and IRCs, which we will take into account as part of this work.

17. Caring for patients in the Criminal Justice System - Introducing a 28-day limit from immigration removal centres and prisons to a secure hospital

Proposals

As set out in the White Paper, we propose introducing a 28-day time limit to speed up the process of transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings. This time limit will be split into two sequential, statutory time limits of 14 days each: first from the point of initial referral to the first psychiatric assessment, and then from the first psychiatric assessment until the transfer takes place. We will commence this provision once the recently published NHSEI guidance on transfers and remissions is properly embedded.

We asked you whether any further safeguards need to be in place before we can implement a statutory time limit for secure transfers, and to provide an explanation for your view.

What you told us in this consultation

There were 1141 responses to this question. Overall, 28% of responses indicated yes to the proposal; while 11% indicated no and 61% were not sure.

Overall, respondents were mainly in favour of introducing a time limit, although there was a number of specific issues raised in regarding resourcing, safeguards, and the practicalities of the time limit.

Points raised from those who commented include:

Additional safeguards and considerations

Many respondents agreed that further safeguards need to be in place before the statutory time limit is implemented. Of these respondents, the most common theme was the need to ensure the availability of beds in secure hospitals, which can at times be a barrier to timely transfers. Respondents also noted that this should be complemented by sufficient levels of appropriately trained healthcare staff.

Some respondents argued that clearer responsibility for the transfer process and strong reporting mechanisms are required, in order to ensure the appropriate person is managing the transfer process, and that there is a clear process for handover with the reporting of relevant information.

Other respondents stressed the need for access to advocacy and representation for patients awaiting transfer. Meanwhile, some noted the importance of practical considerations – such as the means of transport and the location of the secure hospital.

Time limit

A number of respondents commented on the time limit itself, with a diverse range of views. For example, some expressed concern that 'rushing' the process to meet the time limit could be harmful, or that parties involved in transfers would delay 'starting the clock' for fear of missing the deadline, while others argued that the time limit should be shorter – noting that time spent in custody can exacerbate existing conditions and cause more harm.

Appropriate care and services

Another common theme in responses was ensuring appropriate care in prison before transfers take place to avoid the worsening of mental health, alongside wider calls for improved mental health identification and support across the secure estate.

“Transfer from prison under the Mental Health Act remains problematic. Despite best efforts, reviews continue to report lengthy delays for people who are acutely ill. For this reason, we propose that a timeframe should be included in the Act within which the statutory time limit for secure transfers is implemented.”

- **Prison Reform Trust**

“The MHLA is of the view that 28 days is a long time to get someone assessed (cf assessments for admission under Part II: two doctors and an AMHP within 7 days of the second medical recommendation). Greater emphasis should be placed on the fact that the individual concerned should be regarded as a patient not simply a prisoner. If it is possible for a patient held at a police station to be assessed within 24 hours, it ought to be possible for someone held in custody elsewhere to be assessed in a similar period. This might require more and specialised resources.”

- **Mental Health Lawyers Association (MHLA)**

During further engagement, stakeholders reiterated the fear of unintended consequences, such as risk of being sanctioned stopping practitioners 'starting the clock' on a transfer, and good practice not being followed in order to meet the timeline.

There was a range of views on the length of the proposed time limit, with some stating it was still too long, and concern that practitioners would work to that time frame when in fact transfer may be able to be completed quicker, while others argued that the length was unrealistically short in the current context and would add to the above unintended consequences.

The nature of a sanction for failing to meet a potential limit was discussed, with mixed views on implementation and severity.

Next steps

We recognise that the average wait is above 28 days at present, and that this is a longstanding problem, but note that introducing a limit with no additional resourcing, or addressing the reasons for current delays, may result in further issues.

We will take forward legislative change to introduce the 28-day time limit. However, this will only be commenced once the NHSEI guidance on transfer and remissions has been fully embedded, and we will take into account other reforms such as the introduction of the independent role to help in meeting the new time limit.

18. Caring for patients in the Criminal Justice System - supervised discharge

Proposals

We consulted on the introduction of a new power of “supervised discharge” which would enable a small group of restricted patients who are no longer therapeutically benefitting from treatment in hospital, but continue to pose a risk that could not be safely managed in the community without constant supervision, to be discharged from hospital with conditions amounting to a deprivation of liberty.

We proposed that individuals would only be eligible to be discharged in this way if it posed the least restrictive option for them.

We asked whether you agree or disagree that this is the best way of enabling these patients to move from hospital into the community. And to provide an explanation for your view.

What you told us in this consultation

There were 1,200 responses to this question. Overall, 56% of responses agreed/strongly agreed with the proposal; while 19% disagreed/strongly disagreed and 25% were not sure.

We also proposed that a supervised discharge order for this group of patients would be subject to annual Tribunal review. Do you agree or disagree with the proposed safeguard? Beyond this, what further safeguards do you think are required?

There were 1162 responses to this question. Overall, 65% of responses agreed/strongly agreed with the proposal; while 17% disagreed/strongly disagreed and 18% were not sure.

Overall, the majority of respondents agreed with introducing the new power of supervised discharge, and that this is required to address the current gap in legislation. Some respondents also raised queries on the practicalities and details of the proposed new power.

Points raised from those who commented include:

In the main, respondents recognised the need for a new power which would provide a legislative route to fix the current gap. Whilst there is general support for this approach some respondents raised queries on the practicalities and details of the proposed new power.

Further practical detail on supervised discharge is required

Some respondents requested further detail on how the new power of supervised discharge would work in practice, such as where the patient would be discharged, how therapeutic benefit would be defined, and who would be responsible for the enforcement of restrictions.

Respondents also highlighted the financial implications of the current operational policy – to be addressed by supervised discharge - which means this group of patients may be in the community on long-term section 17 leave. This interim policy requires hospitals to keep open a bed – although there were diverse views on whether potential cost savings from no longer having to do so would be a positive consequence, or if this could act as a perverse incentive to use the new power, leading to overuse.

Additional provision and regulation required

A number of respondents stressed that adequate community provision and support for patients will be key to meeting the aims of supervised discharge – including appropriate residences and specialist forensic services. There were also some suggestions for how this could be achieved, such as the use of electronic equipment for monitoring purposes.

Some respondents also suggested that there should be regular review and monitoring of how frequently supervised discharge is used, with independent oversight and scrutiny to guard against rising use.

Public protection concerns

Public protection was a key theme across the responses, and a small number argued that if a patient continues to pose a risk, hospital remains the most appropriate setting. Respondents stressed that risk should be carefully managed and defined.

Patient rights and experience

There was a range of views regarding the rights and experiences of patients under supervised discharge. Some respondents argued that supervised discharge would be open to abuse and infringe on the human rights of patients – in particular regarding overuse of the power – although others highlighted where this would be beneficial and necessary for the small group of patients in question, providing a route for progression into the community.

Key points were also raised on the involvement of patients and their families and carers when developing arrangements and updating on progress, in addition to taking into the individual needs of those with learning disabilities or autistic people. Some respondents argued that individuals under supervised discharge should have the same access to advocacy services, such as an IMHA.

Timing of the Tribunal review, and monitoring in the community

There was a range of views on the timing of the Tribunal review for patients under supervised discharge. A number of respondents argued that cases need to be reviewed by the Tribunal more frequently than the proposed annual review, for example every 6 months or quarterly, to provide additional oversight. Others, however, agreed with the proposed annual review, which is in line with the Court of Protection decisions on similar cases, or alternatively stressed the need for regular oversight and monitoring in the community which could be provided separately to the Tribunal oversight. Suggestions here included multidisciplinary plans featuring regular reviews and clear risk formulation, and the involvement of victim liaison officers and MAPPA.

Meanwhile, a small number argued that the Tribunal review should be less frequent as one year may not allow for meaningful change in terms of the patient's condition or level of risk, while others suggested that the timelines should be flexible in order to respond to changes in circumstances.

“Following the Supreme Court judgement in *Secretary of State for Justice v MM* [2018] UKSC 60, and mindful of the judgement in *Secretary of State for Justice v KC* [2015] UKUT 376 (AAC), it is clear that there is presently no lawful way in which patients with capacity to do so can agree to their supervision in the community, where that supervision essentially amounts to continuous control and supervision. Statutory provision to address this is most welcomed [...] However, the Mental Health Lawyers Association is of the view that there should be a review process to ensure any conditions are no more onerous and no more of a deprivation of liberty than is necessary to achieve a stated aim.”

- **Mental Health Lawyers Association (MHLA)**

“We are concerned about unintended consequences because of a pressure to discharge people from inpatient services before treatment programmes are completed and could lead to a much larger group being deprived of their liberty in the community for prolonged periods of time.”

- **Royal College of Psychiatrists**

There was a general consensus that supervised discharge would require appropriate independent oversight and scrutiny, and the majority agreed with an annual review by the Tribunal. Participants also felt there could be an option for patients to elect for a hearing without oral evidence in cases where neither the patient nor clinician were asking for any change, such as a change in conditions or a conditional discharge. The Tribunal panel would always maintain the option to adjourn in order to hear oral evidence. Other proposed safeguards included the right to an IMHA for patients under supervised discharge, restricting discharge addresses to settings regulated by the CQC, and the use of a rigorous test when deciding whether to use this power – based on evidencing why a conditional discharge could not be used. Attendees also felt that the ability to ‘step down’ conditions outside of the Tribunal process could be built into supervised discharge.

Further comments included the need to consider interaction with the DoLS/LPS framework where a patient may also be subject to supervised discharge, and the need for clear guidance and training for care providers and those supervising in the community.

Next steps

We will move forward with our plans to provide the Tribunal and the Justice Secretary with the power to grant a supervised discharge to restricted patients where they are satisfied that this is the least restrictive option when:

- The patient is no longer therapeutically benefitting from treatment in hospital; but
- Continues to pose a level of risk which would require a degree of supervision and control amounting to a deprivation of their liberty; and so, could not be managed via a conditional discharge.

As noted in the White Paper, we propose that patients on a supervised discharge would be subject to annual review by the Tribunal. We will continue to engage with experts to consider further the role for the Tribunal and other appropriate safeguards which should accompany this new power to ensure that its use is limited and proportionate, for the small number of cases for which it is intended.

In order for the proposed measures to work well, appropriate and well-resourced community provision must be available.

19. Caring for patients in the Criminal Justice System - The role of social supervisor

Proposals

Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. Social supervision is an important role, balancing public protection with the care and support of conditionally discharged patients. Social supervisors work closely with the Ministry of Justice Mental Health Casework Section and can request recall of patients to hospital. Despite this important function, there is some confusion about where this role should sit and a lack of national guidance about how it should operate, leading to local divergence in practice and standards.

The Government wishes to strengthen and further develop the role of social supervisor and has consulted with stakeholders on how best to achieve this.

We asked you how do you think the role of social supervisor could be strengthened.

What you told us in this consultation.

Respondents provided suggestions on how to strengthen the role of social supervisor which ranged from changes to the training necessary to take on the role, and who should be responsible for it, to improving practice and the support social supervisors have whilst discharging their duties.

Points raised from those who commented include:

Changing the role

The greatest proportion of respondents suggested that the best way to strengthen the role of social supervisor, and to reduce the local disparities in the service, was through the redefinition of the role at a national level. Respondents believed that to better discharge their functions, clearer national guidance on the role should be in place. In the opinion of the respondents, redefinition should achieve three main goals: (1) ensure that anyone taking up the role must complete mandatory standardised training that includes topics such as cultural awareness, mental health, and learning disabilities and autism, (2) better define responsibilities and who should be accountable for the role implementation and oversight, and (3) clarify the professionals that can take up the role.

Changing practice

Some respondents believed that to strengthen the role of social supervisor there should be improvements to practice. They felt social supervisors should meet patients more often or for longer to develop a relationship with them to promote the best possible outcome. Linked to this, some respondents believed patients should be kept better informed and have their wishes taken into consideration whilst under supervision. They believed that this would make patients more likely to comply with conditions and avoid recalls. Respondents also supported the idea that improved communication between social supervisors, the institutions involved in care, and the families of the patients would strengthen the role. By

achieving this, respondents believed that all professionals involved in care would be better informed, allowing them to discharge their functions more expertly.

Providing greater support to social supervisors

Where increased resources were suggested as a way to strengthen the service, the majority suggested the workforce should be increased to reduce caseloads to improve service quality. Some respondents suggested that local authorities should offer further support to social supervisors wherever possible, including making available community support services to patients in an effort to relieve pressure on the social supervisor. Linking to this, respondents believed that if robust care and treatment planning were in place, this would increase the support available to patients and prevent their relapse and consequent potential risky behaviour, which would make patient supervision easier. Finally, suggestions were made to implement a peer support network for social supervisors to increase support and improve practice through sharing of information and expertise.

“Registration and regulation of the role, with an annual/bi-annual training requirement similar to the AMHPs 18-hour annual training requirement may help ensure the maintenance of the skills and knowledge required in the social supervisor role. It may help to define the particular group of professionals able to undertake the role to ensure standardisation of practice. [...] Clear guidance on who the responsible body is to provide and carrying out the role of social supervisor would be welcomed; [...]”

- **Association of Directors of Adult Social Services (ADASS)**

White Paper proposal not supported

A minority of respondents believe the role of social supervisor should not be strengthened. This was either because they felt the social supervisor service works well as it stands, or because they believed it should be abolished altogether. Respondents that suggested the latter believed that patients should not be subjected to further restrictions when in the community, or that these patients should not be released into the community at all, and therefore the role of social supervisor would not be necessary.

Next Steps

The Government will continue to work with stakeholders to understand how to best redefine the role of social supervisor in order to drive improvement of the service at a national level, and to reduce the regional disparities currently observed. The Government will explore updating the guidance with the aim of clarifying the institutions responsible for the role's delivery, the professionals eligible to discharge it, and the training required of professionals, including training required to supervise patients with a restriction order. The Government will also survey the increased support and resources that may be necessary as a result of a redefinition of the role of social supervisor.

20. People with a learning disability and autistic people - Limiting the scope to detain people with a learning disability and autistic people under the Act

Proposals

The White Paper recognises the considerable concern about inappropriate admission and long lengths of stay for some people with a learning disability and autistic people to mental health hospitals under the Mental Health Act. Therefore, the White Paper proposes to reform the Act to be clearer that for the purposes of the Act, neither a learning disability or autism can be considered to be mental disorders warranting compulsory treatment under Section 3 of the Act. This is because learning disabilities and autism are conditions which cannot be removed through treatment, although some autistic people and people with learning disabilities may require treatment for mental illness.

Under the proposals, people with a learning disability and autistic people could be detained under Section 2 of the Act when their behaviour is so distressed that there is considered to be a substantial risk of significant harm to self or others and there is a probable mental health cause to that behaviour that warrants investigation. If detained, the assessment process under Section 2 should seek to find the driver of this distressed behaviour and if a mental health condition is identified as the driver then the patient may follow a treatment pathway for the mental health condition under Section 3 of the Act. They should only be detained after all alternatives have been considered. A Care (Education) and Treatment Review (CETR) is also expected to be conducted before a detention to provide evidence as part of any decision made. If, however, if no mental health condition is identified then the individual could no longer be detained under the Act and detention should cease.

We asked you whether you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people, and to provide an explanation for your view.

What you told us in this consultation

There were 1,236 responses to this question. Overall, 62% of responses agreed/strongly agreed with the proposal; while 16% disagreed/strongly disagreed and 22% were not sure.

The majority of respondents were supportive of the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people. The main reason cited for this was the view that detention under the Mental Health Act was not appropriate for this group of people in the absence of a co-occurring mental health condition.

We also asked you whether you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition? And to provide an explanation for your view.

What you told us in this consultation

There were 1,190 responses to this question. Overall, 42% of responses agreed/strongly agreed with the proposal; while 22% disagreed/strongly disagreed and 35% were not sure.

More respondents agreed than disagreed that the proposed reforms would provide adequate safeguards, although this was not a majority view. Concerns were raised that following the reforms more people with a learning disability and autistic people could be detained under the Mental Capacity Act, with less safeguards and concerns about the distinction between civil and criminal patients seemed to drive this reduced level of support.

Points raised by those who commented on these two questions include

Detention

Many respondents supported the view that people with a learning disability and autistic people should not be detained under the Mental Health Act unless they had a co-occurring mental health condition and were a serious risk to themselves and/or others. A smaller number of people felt that detention under the Mental Health Act was never appropriate for people with a learning disability and autistic people (irrespective of whether they have a co-existing mental health condition), noting the negative impact detention in a mental health unit can have on individuals. A proportion of respondents felt that the same approach should also be applied to people with other conditions, such as dementia or a traumatic brain injury.

“VODG also welcomes the White Paper’s proposals to limit the scope, and make it harder, to detain people with a learning disability and/or autism under the Act, including supporting the proposal that learning disability and autism are not considered mental ‘disorders’ warranting detention under Section 3.”

- **Voluntary Organisations Disability Group (VODG)**

Alternative support approaches

One theme that emerged is that for reforms to provide adequate safeguards to people with a learning disability and autistic people it was critical that community services are provided with suitable financial support and resources.

Respondents also had concerns that current community services could not provide a) appropriate care to people with learning disabilities or autistic people in crisis, b) timely and agile care or c) appropriate aftercare. Some felt this could lead to the positive elements of the reform proposal being undermined.

Often it was indicated that the proposed reforms offered an inappropriate approach to solving wider problems in the mental health system for people with learning disabilities or autistic people (such as inadequate alternatives to inpatient care) and that this would lead to further exclusion from appropriate hospital care and recommended aftercare.

Others were concerned about the 28-day period for assessment under Section 2, citing that this may not be long enough to undertake assessments and questioning how individuals would be supported after this time has elapsed.

A number of respondents explicitly stated that they did not feel the proposals set out any future alternative approaches to support people with a learning disability or autistic people who would no longer be eligible for inpatient treatment following the proposed reforms.

Assessment process and diagnosis

Some respondents were concerned that a lack of professional expertise could lead to a misdiagnosis or lack of diagnosis, meaning individuals do not get the right support under the proposed reforms. Others were concerned health professionals could deliberately diagnose a mental health condition in order to detain individuals with a learning disability or autistic people. Respondents were concerned that these would mean the reforms may not actually lead to a reduction of people with a learning disability and autistic people being detained. Others picked up on the incidence of mental health conditions for people with learning disabilities and autistic people and discussed the complexities this can introduce, for example, where there is an overlap between autistic and other mental health condition patterns of behaviour.

Mental Capacity Act and the Criminal Justice System

Weakened safeguards arising from the proposed reforms was cited explicitly by some respondents as concerns. There were various reasons behind the perceived weakening of safeguards, however two main concerns described by respondents were that it would lead to more people with learning disabilities or autistic people a) being at risk of imprisonment or b) for those who were deemed to lack capacity to be detained under the Mental Capacity Act and to be placed on Liberty Protection Safeguards (LPS)/Deprivation of Liberty Safeguards (DoLS). Some felt that this would lead to a reduction in safeguards for individuals, with the Mental Capacity Act felt to offer fewer safeguards through DoLS/LPS than the current Mental Health Act offers.

A significant number of people were concerned that civil and criminal patients would be treated differently under the proposed reforms, creating a 'two-tier' system. Many felt that the reforms should apply in both civil and criminal circumstances.

Possible risks

Respondents raised concerns over the implications of no longer considering a learning disability or autism to be mental disorders warranting compulsory treatment under Section 3. The most common of these concerns was that the Mental Health Act can be a useful avenue for people with a learning disability and autistic people to access appropriate assessment and treatment. Others felt that detention could help manage risks to the individual subject to the Act and/or to others. Some respondents questioned what the proposed reforms would mean for the Section 117 aftercare status for those people with

learning disabilities or autistic people assessed under Section 2 who are not assessed to have a diagnosable mental health condition.

Many of the respondents stressed that for the reforms to be effective there is a) a need for health professionals with expertise in learning disabilities or autism to be part of the assessment team, b) for suitable training and education provided to all health professionals involved in this process and c) adequate timescales for assessment.

Definitions and criteria

Some respondents had concerns over how the proposed reform will be interpreted or is currently defined, with some of these people pointing out the need for criteria and responsibilities to be clearly defined. Some were concerned that there is currently no clear way to determine whether an individual's distressed behaviour arises from a mental health condition or an unmet physical, social or emotional need.

“Reform is needed so any reform is welcomed, especially if there is investment in specialist community provision to include intensive, crisis and forensic community support and seven day a week specialist multi-disciplinary services and crisis care in every area.”

- **South West Advocacy Network (SWAN)**

Further engagement with stakeholders raised concerns that revising the wording of the Mental Health Act so that a learning disability or autism are not sufficient grounds for detention under Section 3 may not reduce the number of inpatients. Possible issues included:

- Local providers using alternative routes to admit individuals, specifically the Mental Capacity Act or criminal justice routes.
- That local areas would change the justification for admission, for example using alternative diagnoses such as personality disorders or redefining what is considered treatment.
- That there would still be limited financial incentives for private providers to discharge individuals already in inpatient settings.

Further concerns were raised about the possible detrimental impacts on the quality of care for people with a learning disability and autistic people, including:

- That a learning disability and/or autism may become an 'exclusion' criterion for inpatient services even when it is clinically appropriate for some individuals to be admitted.
- That lack of appropriate community services may lead to substandard care and therefore poorer outcomes.

- That there is limited time to appropriately assess and diagnose complex cases and agree a treatment plan on the proposed timelines.

Suggested options for managing these risks included:

- Ensuring provision of appropriate community services.
- Clear drafting in the Act and associated guidance.
- Strengthening the protections in place for individuals at risk of being subject to detention by means other than the Mental Health Act.
- Aligning Mental Capacity Act definitions and protections to reduce the risk of increased admissions through that route.

Next Steps

We will continue to consider the best way to take forward these reforms, taking into account the potential risks and practical implications respondents raised and identifying how to ensure appropriate safeguards are in place for individuals. We recognise the link between some of the responses to this question and part 7 of the White Paper on the interface between the Mental Health Act and the Mental Capacity Act.

We have noted the link between the responses to this question referencing community support provisions and the White Paper proposal to create a new duty on local commissioners to ensure adequacy of supply of community services. We also recognise the need for clear guidance and training to ensure the reforms and safeguards work as intended.

21. People with a learning disability and autistic people - Unintended consequences of reforms

Proposals

The White Paper recognises the considerable concern about inappropriate admission and long lengths of stay for some people with a learning disability and autistic people to mental health hospitals under the Mental Health Act. Therefore, in order to reduce admissions of people with a learning disability and autistic people, the White Paper proposes to reform the Act to be clearer that for the purposes of the Act, neither a learning disability or autism can be considered to be mental disorders warranting compulsory treatment under Section 3 of the Act. This is because learning disabilities and autism are conditions which cannot be removed through treatment, while some people with autism and learning disabilities may require treatment for mental illness.

Under the proposals, people with a learning disability and autistic people can be detained under Section 2 of the Act when their behaviour is so distressed that there is considered to be a significant risk of harm to self or others. The assessment process under section 2 should seek to find the driver of this distressed behaviour and if a mental health condition is identified as the driver then the patient may follow a treatment pathway for the mental health condition under Section 3 of the Act. They should only be detained after all alternatives have been considered. A Care (Education) and Treatment Review (CETR) is also expected to be conducted before a detention to provide evidence as part of any decision made. If, however, if a mental health condition is not identified as the driver then the individual could no longer be detained under the Act and detention should cease.

The White Paper proposes that these changes will only be made for civil patients to ensure that accused people and offenders who may currently be diverted to an inpatient setting are not forced into the criminal justice system which cannot cater for their needs.

We asked you whether you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people, and to provide an explanation for your view.

What you told us in this consultation

There were 1,171 responses to this question. Overall, 48% of responses indicated yes to the proposal; while 9% indicated no and 43% were not sure.

Almost half of respondents felt that there would be unintended consequences of these proposals, with a slightly smaller number being unsure. Respondents indicated a range of concerns, the most common of these focusing on alternative care options.

Points raised from those who commented include:

Treatment/support for people with a learning disability and autistic people

Respondents on the whole were supportive of a move towards better community support and treatment for people with a learning disability and autistic people. They felt that

community support and exploring new methods of support other than detention could greatly benefit people with a learning disability and autistic people.

However, a large proportion of respondents had concerns about the types of alternative care that would be available. There were worries that there may not be the necessary provisions in place within the community, largely due to the lack of funding, leading to individuals falling through the net, their condition potentially deteriorating, and potentially resulting in detention or entering the criminal justice system (CJS).

Some respondents were worried that limiting the scope to detain autistic people and learning disabilities under the Act will lead to individuals not receiving the appropriate mental health diagnosis and care, as professionals will want to avoid detention and may wrongfully attribute their behaviour to their neurodivergence. Others were concerned that professionals may force a diagnosis on individuals to justify detention.

There were concerns that removing the provisions of detention might lead to an increase in the use of ineffective medication and inappropriate diagnoses, whilst other respondents were concerned that the reforms to the Act may actually lead to an increase in hospital admissions if individuals' needs are not fully identified and met early enough.

Impact on detention

Some respondents were hopeful the reforms would reduce detention rates and the amount of time individuals will be detained for. Respondents were worried that the reform may lead to the overuse of Part 3 powers (MHA) or, for people deemed to lack capacity, greater use of MCA/DoLS/LPS to detain people with a learning disability or autistic people because these alternative pieces of legislation do not necessarily have fixed detention times. There were also worries that the reforms may lead to the criminalisation of learning disability or autistic behaviours to facilitate hospital detention and more individuals may end up in the CJS as a result of their behaviour being misinterpreted as presenting a risk. Linked to this, there were concerns that these reforms do not ensure that there are the necessary safeguards in place to protect those who are given support in the community, as well as the reduced safeguards the MCA/DoLS/LPS are perceived to provide when detaining an individual.

A small number of respondents indicated that there will be people with a learning disability or autistic people who are not diagnosed with a mental health condition, but still need to be detained to access the necessary support, as their behaviour may be a risk to themselves or others. They were concerned that the reforms of the Act may prevent this from happening. Linked to this, some respondents felt that to ensure all individuals are being provided with the appropriate care, the application of the new Act should be applied on a case-by-case basis, especially in terms of the length of detention, as the 28-day limit for assessment may not be sufficient to provide the necessary support. There were worries there may be a reduction in appropriate detentions, as a result of reductions in funding for hospital care. Others were concerned about public protection from people with a learning disability or autistic people who are a risk to themselves and others but may be refused detention due to not having a mental health diagnosis.

Professional and public understanding

Respondents felt the reform could help to promote more awareness of learning disabilities and autism, create a more inclusive society and reduce inequalities. However, for this reform to be successful, there needs to be more training offered to professionals to ensure the appropriate application of the reformed Act and to guarantee individuals do not fall through the net. Furthermore, the public need to develop a greater understanding of learning disabilities and autism to allow the successful integration of these individuals into their communities.

Legislation

Respondents felt that the White Paper proposals lacked concrete detail on how this reform will be practically implemented, including the available workforce and the framework for treatment. Furthermore, a number of respondents felt it was difficult to predict the unintended consequences, but there needed to be periodic reviews of the reform to ensure that any unforeseen consequences are appropriately dealt with.

“The ambition to decrease the number of people with a learning disability and/or autistic people being detained inappropriately and ‘getting stuck in the system’, may have unintended consequences. There is a risk that ‘diagnostic overshadowing’ (of the learning disability or autism) will occur. Some who require support, may be less likely to access the right mental health care, due to not being detained.”

- **Royal College of Nursing (RCN)**

“There is a risk that the removal of learning disability and autism from the longer-term use of the Mental Health Act could result in a transfer of those people out of MHA care and into LPS care.”

- **Association of Directors of Adult Social Services (ADASS)**

Next steps

We have noted the concerns raised in relation to the proposed reforms, as well as the link between these responses and other consultation responses. We will take these into account when further developing our proposals. We will also consider implications for the LPS in any reform and the design of which will be consulted on.

22. People with a learning disability and autistic people – the criminal justice system

Proposals

In the White Paper, we proposed that changes to limit the scope to detain people with a learning disability or autistic people under the Act would only apply to civil patients. Our rationale for this position was to ensure that accused people and offenders whom the courts, or the Secretary of State for Justice, might currently divert to an inpatient setting are not forced into the criminal justice system, which is not able, or indeed intended, to cater for their needs.

We asked you whether you agree or disagree that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system, and to provide an explanation for your view.

What you told us in this consultation

There were 1,171 responses to this question. Overall, 29% of responses agreed/strongly agreed with the proposal; while 34% disagreed/strongly disagreed and 37% were not sure.

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

What you told us in this consultation.

Overall, there was a diverse range of views on this issue. The biggest proportion of respondents were 'not sure', and while some agreed and argued that use of the Act is an important safeguard for this cohort of people, a large number of respondents disagreed with proposal to not apply the changes to patients in the criminal justice system. A number of stakeholders also argued that the wider proposals for people with learning disabilities and autistic people could have negative unintended consequences, including that more people come into contact with the criminal justice system.

Points raised from those who commented include:

Agreement with the proposals not applying to the criminal justice system

A distinct group of respondents agreed with this proposal and argued that use of the Act is important to ensure that people with a learning disability or autistic people can be diverted from custody to an inpatient setting. Respondents stressed that custody can be an inappropriate setting for people with a learning disability and/or autistic people

Applying the proposals equally

A significant number of respondents felt that the proposed changes should apply equally to civil and forensic patients. This group of respondents argued that to not apply the proposals to patients in the criminal justice system would be discriminatory and contradict

the wider direction of travel set out for civil patients. Respondents also felt that this could 'criminalise' learning disabilities and/or autism, if long-term hospital care could only be accessed via criminal justice route and stressed the need to avoid the development of a 'two-tier' system.

Some respondents felt that the proposals should apply equally, but only where there is an appropriate level of specialist provision across the community and in prison.

Neurodiversity and the criminal justice system

Across both questions, a large number of respondents commented on the need to improve support for people with 'neurodivergent' conditions across the criminal justice system, which includes people with learning disabilities and autistic people. Respondents reflected that the criminal justice system may not be an appropriate setting for people with learning disabilities and autistic people, but argued that wider reform should also take place to improve understanding, identification and support for people with neurodivergent conditions across the police, courts, prisons, and probation.

Community provision and unintended consequences

The most common 'unintended consequence' highlighted by respondents was that more people with learning disabilities and autistic people could be 'pushed towards' the criminal justice system if they could no longer be detained under section 3 of the Act as civil patients, and suggested that this could lead to increased pressure on prisons. A number of respondents highlighted that current civil patients can present 'risk' and may fall within this category.

To avoid this, respondents stressed that improvements need to be made to community provision – both in terms of early intervention, and tailored support for those identified as at risk of contact with the criminal justice system.

“This approach will create a confusing and unhelpful distinction between civil patients and people caught up in the criminal justice system. [...]

Creating an anomaly, whereby the same person may be exempted from long term detention in civil proceedings yet may be subject to long term detention in hospital through the criminal justice system is an unjust solution. Hospitals should not be used for detention without therapeutic benefit.

One alternative is to undertake reform of the criminal justice system alongside that of the Mental Health Act [...] It would surely make sense to ‘join the dots’, and endeavour to create a system that is integrated, flexible and coordinated – able to respond to the particular needs of the individual rather than ‘shoe-horning’ them into a service simply because it is there/already exists.”

- **Prison Reform Trust**

“Diverting autistic people away from the criminal justice system is incredibly important in situations where they actually need more support. Without a mechanism for doing this, we are concerned that more autistic people would end up in prison, which can also be incredibly difficult environments, without appropriate support or understanding. We also believe that support in prisons for autistic inmates needs to be improved. [...] However, the duty to have sufficient community-based services in both mental health and social care will again be crucial here. Without this support, autistic people risk hitting crisis in a way that may involve the criminal justice system and Part III of the Act. Investment in these community services is therefore a necessity.”

- **National Autistic Society (NAS)**

Further engagement with stakeholders indicated a general consensus that whilst criminal justice settings are not an appropriate environment for many people with learning disabilities and autistic people, the Mental Health Act is not the vehicle to address this. Some solutions suggested were:

- Making the Mental Health Act consistent for civil and Part 3 patients, meaning that if inpatient stays are only appropriate when there is a co-occurring mental health conditions then this must be true for all parts of the Act.
- Strengthening community services for individuals at risk of contact with the criminal justice system.
- Using the legislative framework to strengthen the role of expertise and advocacy throughout user pathways, including the use of CTRs and Tribunal panels.

Stakeholders also raised concerns that the proposal may lead to local systems changing their behaviour and increasing the number of admissions under Part 3 instead of reducing overall inpatient numbers. Potential risks associated with this include:

- That individuals being admitted will no longer have access to the same safeguards that were available when admitted under Part II such as Tribunals' abilities to direct services.
- That there may be differential thresholds for discharge, leaving open a risk of detentions of indeterminate length, particularly if they become a 'restricted' patient. This could lead to stays being longer than would be expected in a criminal justice setting and individuals getting 'stuck' in the Act.

Next steps

We recognise the importance of ensuring that reforms to the Act for people with learning disabilities and autistic people strike an appropriate balance in terms of application to the criminal justice system. We will therefore commit to exploring this issue further, including through an expert group.

More widely, the MoJ is committed to improving support and outcomes for neurodivergent offenders. This includes our independent Call for Evidence on neurodiversity in the criminal justice system, which has been led by HM Inspectorate of Prisons and Probation, and will help us to bring forward key improvements in how we recognise, understand and support this cohort.

23. People with a learning disability and autistic people - care (education) and treatment reviews

Proposal

The White Paper recognises that if a person with a learning disability or an autistic person is detained under Section 3 of the Act due to a co-occurring mental health condition, then this could lead to a lengthy detention. The White Paper sets out that it wants to ensure that discharge is a priority from day 1 of detention under Section 3 of the Act. To ensure this happens, the White Paper proposes putting recommendations from Care, Education, and Treatment Reviews (C(E)TRs) for children and Care Treatment Reviews (CTRs) for adults on a statutory footing because C(E)TRs have been proven to reduce hospital admission when they are undertaken correctly and acted upon. It also proposes the introduction of a statutory requirement for the Responsible Clinical (RC) to consider the findings and recommendations made as part of the C(E)TRs and CTRs in the patients care and Treatment Plan and that any deviation from the recommendations made in the C(E)TRs should be justified by the RC.

We asked you whether you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians (RCs) required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR, and to provide an explanation for your view.

What you told us in this consultation.

There were 1,125 responses to this question. Overall, 62% of responses agreed/strongly agreed with the proposal; while 6% disagreed/strongly disagreed and 32% were not sure.

Overall, the majority of respondents agreed or strongly agreed with this proposal. Where they did not, this often related to the role of the Responsible Clinician, highlighting that other parties play an important role in the care of people with a learning disability and autistic people.

Points raised from those who commented include:

Improving care and accountability

Many respondents felt this proposal would lead to improved care and would strengthen the C(E)TR process. A strong theme that emerged from the consultation responses was the importance of accountability in making sure that recommendations are acted upon, however some respondents questioned what the consequences would be if actions were not taken. Some responses noted the importance of monitoring whether this proposal had its intended effect if implemented.

Involvement of the right individuals and organisations

Many respondents highlighted the need for the C(E)TR process to involve the right people, with the right skills. Some respondents felt that it was not appropriate for Responsible Clinicians (RC) to explain why recommendations had not been acted upon, when they may not hold all the levers to make them happen. A whole system approach is important to generating the best outcomes and ensuring delivery. Some respondents commented on the central role of the RC – with some responses suggesting this could be unhelpful, for example where more than one RC is involved during a period of detention. Others noted the value the RC could bring. Linked to this, respondents highlighted the importance of considering how this approach would fit with existing processes such as Tribunals.

“[...] we consider that it essential that the requirements placed on the RC to explain why recommendations are not taken forward are also extended to all other relevant agencies, together with a duty on the RC and relevant agencies to collaborate and co-operate in implementing recommendations, enabling effective accountability, oversight and enforcement.”

- **The Law Society**

Person-centred approach and involvement of families

Respondents highlighted the importance of involving individuals and their families in planning care and treatment and felt that this approach could be useful in encouraging more of an emphasis on this, ensuring the right support is in place and ability to challenge when it is not. Many felt that the proposed approach would improve transparency about steps being taken to act on the recommendations, which would benefit the individual and families.

Taking forward recommendations

Beyond the immediate proposal, many respondents highlighted that the necessary resources would need to be in place to take forward the recommendations made. Some respondents also noted that recommendations need to be appropriate. Examples were given as to recommendations that had previously been made in CITRs, that respondents felt were unrealistic and led to raised expectations and then disappointment when they were not implemented. Equally, other responses noted that recommendations were not always as creative or ambitious as needed to improve the individual's circumstances.

Administration

Some responses noted that there may be a resource implication to this proposal and that it could be seen as more paperwork or form filling, leading to concerns it could become a box-ticking exercise. In some cases, respondents felt that this should already be happening.

Timing/circumstances

A number of respondents highlighted the importance of CITRs in avoiding admission. Some expressed the need for more clarity over timings of the CITER including whether the CITER would take place in advance of admission under Section 2 or between that and any subsequent detention under Section 3. Others also raised the distinction between patients detained under Section 2 and those detained under Section 3 and questioned whether the same requirements around CITRs would apply to both groups, with some feeling they should.

“We agree that the incorporation of the CTR and CITER processes into a statutory care and treatment plan can only be a good thing. However, we believe that these processes need strengthening to ensure that their recommendations are acted upon.”

- **Halton Borough Council**

Next Steps

While most respondents agreed with this proposal we have noted their thoughts and concerns around the practicalities of the proposal. We will continue to explore how this duty can be put into practice accounting for the feedback given.

24. People with a learning disability and autistic people – Duties on local commissioners

Proposals

In order to ensure the right services are available in the community, for people with a learning disability and autistic people to prevent unnecessary admission into hospitals and to speed up discharges, the White Paper proposes to create a new duty on local commissioners to ensure adequacy of supply of community services for people with a learning disability and autistic people.

It recognises that this could create new funding requirements on local authorities and so also proposes to undertake a formal new burdens assessment to establish implications for local government, informed by the consultation responses.

To support this duty, we committed to creating a related duty on commissioners that would ensure every local area understands and monitors the risk of crisis at an individual level for people with a learning disability and autistic people in the local population.

The White Paper sets out that commissioners will do this through the creation of a local “at risk” or “support register”, where they will have to work with local authorities to identify and monitor the support needs of individuals.

We asked you whether you agree or disagree with the proposal to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people, and to provide an explanation for your view.

What you told us in this consultation.

There were 1,227 responses to this question. Overall, 87% of responses agreed/strongly agreed with the proposal; while 2% disagreed/strongly disagreed and 10% were not sure.

An overwhelming majority of respondents agreed with this proposal, with only a very small number disagreeing. This is consistent with the fact that the need for appropriate community services was a common theme across responses to all of the learning disability and autism proposals.

We asked you whether you agree or disagree with the proposal to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local at risk or support register. And to provide an explanation for your view.

What you told us in this consultation

There were 1,133 responses to this question. Overall, 69% of responses agreed/strongly agreed with the proposal; while 9% disagreed/strongly disagreed and 22% were not sure.

This proposal was supported by a majority of respondents, although to a lesser degree than the duty to ensure adequacy of supply of community services. Written responses tended to focus on how such a register might work in practice.

Points raised from those who commented include:

Resources

A recurrent theme in answers to the question on community services related to the resourcing to support the proposed duty. A high proportion of respondents providing text answers indicated that there needed to be adequate resourcing for the proposed reform to achieve the intended effect. They felt that additional funding would be required for commissioners to be able to commission the necessary services, with costs needing to be fully understood. A small number of respondents felt that the funding for community-based services for people with a learning disability should be ring-fenced i.e. protected and dedicated for the purpose of providing community services.

Another aspect raised by respondents was the need to invest in and develop the workforce to support an adequate provision of community-based support which was raised by some respondents. It was felt that the workforce needs to have the right skills to be able to support people with a learning disability and autistic people and that this wasn't necessarily the case now.

Some responses said there was a need for funding to ensure the success of "support registers." For some respondents, it was felt that having a risk register would allow for commissioners to understand the needs of the population and, consequently, provide resources to the services/areas that are most in demand. Concerns were raised over data protection and sharing, while others raised potential staffing and resourcing complications as a concern.

Some respondents felt that if there were suitable provisions in place to support people with learning disabilities and autistic people in the community, there would not be a need for a risk register. Other responses set out that this was not the most effective solution to the issue being raised or they felt that the register would not be enough to address the needs of this cohort of people.

"It is not enough to impose duties on local commissioners without considering the funding issues: local commissioners have a range of duties, in the case of local authorities very broad duties, and decisions on funding community services for people with learning disabilities have to be made in the context of demands for other services."

- Isle of Wight NHS Trust

Providing the right community services

Ensuring that the duty leads to the intended impact for individuals is essential.

Many respondents highlighted the need to provide the “right” services in the community and that this could be underpinned by clear direction and guidance as to what services should be available for people with a learning disability and autistic people informed by evidence. A high proportion of respondents providing written text answers cited there being an inadequate supply of the right services and support for people with a learning disability and autistic people in the community at present. Many respondents thought that the provision of appropriate community services removed the need for the Act to be used at all and that the introduction of the proposed duty on commissioners was considered essential for the wider changes to the Act to work as intended.

Services should be provided with the right approach and culture. Many respondents provided examples of how they thought the duty should work in practice with answers which included examples of best practice community support that respondents felt should be commissioned in response to this duty. On a similar note, respondents commented that “support registers”, similar to the proposed approach, are already in place within some local areas, with positive responses to this being expanded nationally. Some respondents felt that having “support registers” would provide protection to those who are most vulnerable and help to provide them with the support they need.

A small number of respondents highlighted the importance of co-production of (the design of) the services provided as a result of this duty and that people with a learning disability and autistic people should be involved in this process.

On a related point, in terms of the proposal on the “support registers”, respondents felt that, in order for the register to be successful, integrated care and the availability of the right support for individuals in crisis or at risk were essential. It was also felt that having a register would be a positive enabler to joint care planning for individuals.

More generally, there was a view that the adoption of the duty and resultant provision of services would reduce the occurrence of mental health problems.

The scope of the proposed duty

Some respondents considered that the scope of the duty, to ensure adequacy of supply of services, should be broader than learning disability and autism alone as other people with mental health conditions and/or neurodevelopmental conditions would benefit from better community-based services. By limiting the scope to learning disability and autism there are potential impacts on other groups of people if it leads to shifting resources around. Some respondents were concerned about the exclusion of some people where diagnoses weren't made, specifically for autistic people.

A small number of respondents felt the scope of the duty should be broader than commissioners only and could extend to other organisations such as Government and the police. Some respondents suggested that the scope could cover specific aspects of provision such as quality.

A small number of respondents indicated that a review of commissioning arrangements more generally was needed or would be prompted by the introduction of this duty. The approach taken to commissioning services was felt to be important. Some comments indicated a need for oversight of commissioning at a regional or national level.

Similarly, for “support registers” some respondents felt that this register needed to be wider than for just those with a learning disability or autistic people, for example it should be extended to those with a brain injury. Respondents also felt that the responsibility should not just be on commissioners but should encompass the wider sector for example the local authority and service providers.

Practical implications and making the legislation work

Some respondents felt that the duty to ensure adequacy of supply of services must have “teeth” – it must be enforceable so that it leads to real change. The implementation (or performance) of the duty should be monitored to ensure that it is working as intended. There will be practical issues associated with defining what “adequacy” means in practice which is why attention is needed.

Some respondents queried if the proposed duty would replicate existing provisions and requirements. There were questions about how this duty is different to what is already in the Care Act 2014 or other requirements on commissioners. There was also concern about whether it was appropriate for the proposed duty to be located in the Mental Health Act.

On the register question, many respondents raised concerns about how the register would work in practice, for example who would hold the register, how would it be updated and what support would be available for people who are on the register. There were also concerns that the register may not capture how quickly someone can fall into crisis. Some were concerned about the clarity of the eligibility criteria for the register, specifically around the need for diagnosis and ensuring that the criteria for inclusion on the register prevent people who need support being missed.

A number of consultation respondents raised potential negative impacts of the register, including that a register may be too intrusive into people's lives, being on a ‘risk register’ could be stigmatising, and that the register may be used inappropriately if safeguards are not in place. Another theme to emerge was the need for funding to ensure the success of the register.

“Practical implications and enablers of successful implementation. However, it is important there is consistency over criteria used, and for it to be clear what action they should prompt –in terms of commissioning the right services in the community (and how it links to duties around commissioning adequate support for people with a learning disability and autistic people), and at the individual level that people can actually get the support they need when they need it. (See NAO 2017 report on local support for people with LD which highlights issues that need to be addressed to ensure effective risk registers).”

- **Challenging Behaviour Foundation (CBF) and Mencap**

We undertook some additional engagement with stakeholders.

The discussions raised the point that commissioners are already expected to shape local services but that this hasn't led to the changes needed in all cases. This makes the creation of a duty very important, however the introduction of a duty should build on evaluations of the impact of previous interventions.

A number of challenges were raised that might limit the likelihood that this proposal will lead to improved local services, these included:

- A lack of clarity about 'what good looks like' for commissioning local services, leading to systems commissioning the 'same old services' with limited innovation. A lack of training for commissioners also makes it difficult to implement improvements even when best practice is known.
- A lack of clear accountability between NHS and local authority commissioners for the development of services, including debate over funding flows. This includes confusion in some areas over responsibility for funding the autism element of care.
- Insufficient choice of providers in local areas, especially in the short term, leading to commissioners having to use sub-standard providers to ensure that their duties are fulfilled.

Participants discussed a number of options to mitigate these risks, such as:

- Including clear obligations in the duty to ensure co-ownership of service development between NHS and local authorities. Ideally this would incorporate the role of wider services (such as housing or provider collaboratives) to reflect the holistic approach to service design without compromising accountability. These directions should reflect the findings of the work being done by the Ministerial delivery board on best practice for community services.
- Linking the use of pooled budgets to meeting this duty, to ensure services are designed in a way that meets the needs of the individual. This funding should follow the individual and be flexible enough to quickly respond to changing need. It was suggested that EHCP (Education, Health and Care Plan) may be a good

example on which to base such a budget. If implemented, this would work best if applicable to all individuals under the Act.

- Encouraging system level thinking by using learning disability and autism services as a test case for the new CQC approach to system level regulation.
- Offering further training to commissioners on how to incentivise behaviour change in the providers in their area.

Discussions also raised the point that there is already a push to use dynamic risk registers to understand local need but that this hasn't achieved its objectives in all areas. Therefore, some challenges associated with introducing the proposed duty included:

- A lack of clarity on how best to interpret and manage risk, including systems possibly interpreting risk as 'risk to others' rather than 'risk to the individual'.
- This may create a focus on immediate crisis management rather than longer term preventative services.
- A lack of join up between carrying out risk monitoring and using this information to shape local services, meaning the duty has limited impact. This may be due to lack of knowledge in local systems on how to understand and act on risk information.
- Variation in local diagnosis rates and criteria for inclusion on the register, an area with less strict criteria will have greater ability to intervene early but will also have a greater burden. There may also be issues if some individuals do not want to consent to being on the register due to associated labelling or perceived stigma.

A number of options to help mitigate these risks were discussed, including:

- Providing clear directions on risk management best practice alongside the Act, setting expectations on inclusion criteria and use of risk information.
- Ensuring the drafting of the Act and associated guidance clearly sets out local accountabilities, including linking the responsibility to monitor risks to the duty to design local services. These accountability structures should reward focus on preventative services.
- Making use of frontline and lived experience expertise in the decision-making process.
- Increasing local transparency on the design and use of dynamic support registers, including clarity over individual responsibilities.

Next steps

Based on strong support we intend to proceed with the proposal on adequacy of supply. Work will consider what guidance might need to sit alongside the duty and there will need to be more detailed work on the impact assessment to consider resource implications for local government and the NHS.

With regards to “support registers”, we have noted the concerns and suggestions raised by respondents and will continue to explore how this proposal could work in practice to ensure the best outcomes for people with a learning disability and autistic people.

25. People with a learning disability and autistic people – pooled budgets

Proposal

Section 75 of the NHS Act 2006 is the existing mechanism for pooling budgets between an NHS body and local authority. The White Paper does not have a specific proposal to improve pooling budgets for services for people with a learning disability and autistic people and asks for views on this.

We asked you what can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people.

What you told us in this consultation.

Points raised from those who commented include:

To overcome challenges to using pooled budgets, the key things respondents suggested were:

Integrate health and social care

Respondents felt truly integrated health and social care services, including greater inter-agency collaboration, were needed to overcome the challenges regarding pooled budgets. The forthcoming Health and Social Care Bill (as set out in the health and social care White Paper) and establishment of Integrated Care Systems are seen as a good opportunity to enhance partnership working between health and social care. Combined budgets for health and social care were also seen as a way of overcoming the challenges of pooled budgets.

A consistent national approach

Some respondents thought there should be an enforceable duty to collaborate across all local services. Others expressed that there is often a need for greater clarity about joint funding tools and what constitutes a health or social care need, and felt there is less scope for disputes if roles are clearly clarified. Others pointed to the existing guidelines on pooled budgets, such as those by NICE and Social Care Institute for Excellence (SCIE), and felt these should be implemented. Another theme which arose was the need to provide training on pooled budgets and share learning between regions to ensure national consistency.

Effective joint commissioning

Some respondents felt the focus should be on the individual - not who should pay for services - as disputes can lead to delays in commissioning services for people. Such challenges could be overcome by any system whereby funding followed the patient through whichever pathway taken. Some also expressed the view that service users

should have their views taken into account during the decision-making process. There were suggestions that a designated single lead commissioner who has expertise in relation to people with learning disabilities and autistic people should be appointed. The need for effective governance systems was also highlighted. Some respondents also made suggestions in relation to the s.117 provision for free aftercare, including: develop s117 rules to ensure that anyone who leaves hospital can receive free after care and support for a time limited period, and; update Continuing Health Care rules and integrate to s.117 to ensure that people are effectively cared for if they have complex health and care needs.

Funding and Budget Arrangements

Many respondents feel there needs to be more Government funding for these services and for social care in particular – setting out that until there is sufficient funding, there will be challenges using pooled budgets. Other suggestions that came up multiple times included that budgets should be ringfenced to ensure that they are spent on learning disability/autism services and that one organisation should hold the budget. Other respondents were against pooled budgets, feeling that learning disability, autism and mental health services should be funded separately. Some felt that pooled budgets were not useful for children.

To improve reporting on spend

The need to improve reporting on spend was also a theme that emerged, including transparent spending reporting from all local areas. Some felt that agreed targets and outcome measurement tools would offer an improvement, while others suggested agencies and commissioners should be required to publish and report on the spend on services for people with a learning disability and autistic people.

Some respondents suggesting introducing mandatory spend reporting, applying the same rules as the Mental Health Investment Standards. Other suggestions included integrated data systems to enable national data comparisons and the independent review of budgets and spending.

“Funding mechanisms also need to be improved and made more transparent. This would help to guarantee that funding for the sector reaches the frontline services that people with a learning disability and autistic people rely on and need most, and is invested in establishing the full range of high-quality services these groups of individuals need to live as independently as possible”

– NHS Providers

“We strongly believe that pooled budgets are a prerequisite for success in supporting autistic people better in the community, in their homes and near their families. There have been many attempts to encourage their use, and while some areas have taken the initiative, too many haven't. With the proposals in the Department of Health and Social Care on the future of the NHS in England, there is an opportunity to finally make this happen. If it is not, the disincentives in the system will persist.”

- **National Autistic Society (NAS)**

“Such challenges could be overcome by any system whereby funding followed the patient through whichever pathway taken. We encourage further promotion of NHS-Led Provider Collaboratives to deliver whole pathways of care. Consideration could be given to the creation of a case-working role similar to that proposed in the White Paper for prison transfers, especially to oversee pathways of patients who have hospital admissions and to ensure opportunities for discharge are not lost. Patient care can be seriously disadvantaged, and progress reversed, as a result of delays caused by funding battles between commissioning agencies. It should be possible for the law to provide that care should be moved forward when needed, and funding issues dealt with afterwards.”

- **The Care Quality Commission (CQC)**

Next steps

We will continue to consider the options for pooled budgets, taking into consideration the challenges and solutions proposed by respondents. We will also look at how best to report spend on these services and for spend to be made transparent.

Respondents were broadly receptive to the increased use of pooled budgets, although some pointed to these not being useful for children or felt that learning disability, autism and mental health services should be funded separately. Respondents were realistic about the challenges associated with pooled budgets and many felt they needed more information to properly respond.

26. The role of the Care Quality Commission

Proposals

The Government wishes to strengthen the role of the Care Quality Commission (CQC) in monitoring the use of the Act, and has consulted with stakeholders to consider extending monitoring powers to cover all those who commission and provide services under the Act.

We asked you how could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers.

What you told us in this consultation.

Responses to this question ranged from suggested improvements to CQC's current approach to monitoring and intelligence gathering, through to proposed changes to ensure the body has the power to drive improvements.

Points raised from those who commented include:

Developing systems-wide solutions

A substantial proportion of respondents suggested that with extended monitoring powers, the CQC may be empowered to recommend system-wide solutions to inadequate care. Several respondents noted that resourcing constraints ought to form part of these recommendations, where appropriate.

A number of respondents suggested improvements to care could be achieved by monitoring how effectively local systems identify and address local concerns, including how well partner agencies such as the police are able to provide support to individuals in a timely and appropriate manner.

"CQC, as a national regulator has an important role to play in drawing attention to systemic barriers and would be able to do this more effectively if its monitoring powers were extended to consider the effectiveness of local joint working. We therefore support this proposal in principle."

- NHS Providers

Expanding the scope of monitoring powers

Several respondents, including key stakeholders, recognised the potential for the CQC to ensure successful implementation of the reforms as a whole. In this context, respondents suggested the CQC's role could extend to include holding services to account for the quality of statutory Care and Treatment Plans, and Advance Choice Documents.

In addition, respondents noted that the Government should consider expanding the scope of providers monitored beyond those registered with the CQC, in order to drive

improvements in a wider picture of the provision of care. This included care provided by supported living schemes, and private providers.

Emphasise improvement, not inspection

A sizeable proportion of respondents emphasised that the way CQC engages with different bodies was equally as important as their monitoring role. Specifically, many respondents commented that the relationship between the CQC and providers was not always most conducive to driving improvements. In this context, some suggested we should be working to change this relationship and move toward a culture where providers feel comfortable raising and working through concerns with the CQC.

Other means of strengthening the CQC's role in monitoring the Act

Several respondents raised concerns with *current* monitoring arrangements and suggested targeted action to improve this would drive improvements to care quality and safety.

Specifically, some respondents noted that current approaches to inspections mean that significant issues can sometimes be missed. Some respondents thought that planned inspections incentivise providers to present an unrepresentative picture of care provided, meaning issues could not be picked up and addressed. Possible solutions suggested included requisite impromptu visits, improvements to data quality to improve monitoring, as well as inspectorates broadening the types of engagement and intelligence gathered (beyond easily quantifiable metrics) to inform performance ratings.

The importance of patient engagement was raised by many in this context. Many respondents noted that better quality and frequency of patient engagement would enable the CQC to build a more complete picture of patient's needs, to make meaningful recommendations regarding gaps in provision. The CQC's engagement with advocacy providers was also highlighted as a positive shift to better understanding patient's perspectives.

“Some of the changes to the CQC's ways of working, prompted by the coronavirus pandemic, have undoubtedly had positive consequences for people detained under the Mental Health Act. The fact that the CQC are now routinely engaging with advocacy providers for inpatient mental health services has given advocates more of a national voice, and allowed them to raise issues with the regulator. We think that this should continue, and be formally included in the CQC's monitoring.”

- **Rethink Mental Illness**

Those who did not agree

Of those respondents who did not agree, several raised that increased monitoring may translate to increased bureaucracy which takes professionals away from clinical work.

Next steps

We will continue to consider this proposal as the reforms are implemented, and within the context of broader changes to the CQC's role being considered as part of the NHS Bill, including their role in overseeing the new Integrated Care Systems and Local Authority assurance.

27. Community Treatment Orders (CTOs)

Proposals

The White Paper set out a series of proposals to reform Community Treatment Orders (CTOs). This included: strengthening the requirement for evidence and justification for use; increasing the number of decision makers before someone is put on a CTO; introducing a time limit and increasing the frequency of review; and requiring that they provide a genuine therapeutic benefit to those who are subject to them.

CTOs were introduced in 2007. Around 5,000 new CTOs are made annually, far higher numbers than were originally anticipated. Additionally, CTOs are disproportionately used for people from black backgrounds. NHS Digital's annual report on the use of the Act reported that in 2019/20 people included within the data category of black or black British people were now over ten times more likely to be given a CTO than white people. We committed in the White Paper, therefore, to further review and update Government policy on the use of CTOs in line with the emerging evidence on their use.

What you told us in this consultation

Although we did not ask any consultation questions on CTOs, we have heard from stakeholders during this period, via written submissions and during policy development workshops held in parallel to the consultation. Stakeholders we have heard from are broadly supportive of our proposals and were pleased to see that the White Paper took forward a number of recommendations from the Independent Review. Many stakeholders thought our proposals represented a step in the right direction but raised concerns and practical considerations in implementing proposals.

Strengthening the requirement for evidence and justification for use

Stakeholders raised concerns that strengthening the requirement for evidence and justification for the use of a CTO, could lead to patients who are ineligible for a CTO deteriorating in the community and then being made subject to detention under the Act. Additionally, stakeholders stated that by focusing on a patient's history may mean that it is difficult to put a person on a CTO if they are not known to mental health services for a long time.

Though other stakeholders were supportive of the aim to increase the threshold for CTOs and would even support us going further.

“We propose that the legislation is strengthened to ensure that the RC and AMHP consider the patient’s history *and* are satisfied that there is within that history, evidence to show a significant risk of the patient disengaging with services and requiring readmission for their mental disorder.”

- AMHP Leads Network

Increasing the number of decision makers before someone is put on a CTO

Stakeholders generally welcomed the Governments’ proposals to introduce the requirement for the community responsible clinician (RC) to be involvement in the creation, renewal and extension of a CTO. However, stakeholders raised many practical considerations around the policy’s implementation. For example, whether the community RC has to undertake a face to face assessment. Further engagement with stakeholders revealed a consensus that communication between inpatient services and the community is often poor. We heard how information about conditions around CTOs are sometimes not communicated to patients and the community RC is often unaware of the transfer of responsibility for a patient placed on a CTO. Some stakeholders proposed the need for a joined-up safety mechanism to ensure communication between the inpatient RC and the community RC.

“We are pleased to note however the proposals as to the involvement of the community RC in the creation of CTOs, as to the ability of the nominated person to object to the CTO. We are also heartened by the Government’s stated commitment to reducing their use and to reducing the glaring disparity of their use in respect of members of the black community.”

- The Bar Council

“This requirement for agreement is welcomed but the supervising community clinician should not be expected to undertake a face to face assessment. This would be an unnecessary clinical burden and this was acknowledged in the Wessely Review to be the basis for this legislation. Best practice indicates that the community RC is consulted but they must not be required to see the patient in person at the start of the order.

Thought should also be given to a simple process which requires evidence of agreement from the three parties but no unnecessary three-step “countersigning.” It is hard to see what value such an approach has and so the need to countersign should be removed from commencement, renewals and revocations of CTOs.”

- Royal College of Psychiatrists (RCPsych)

Introducing a time limit

Engagement with stakeholders revealed a variety of opinions on our proposals to introduce a time limit for CTOs. Many stakeholders stated that the two year expectation could have significant unintended consequences and goes against the principle of therapeutic benefit. Stakeholders acknowledged the Act should only be used where clinically appropriate and that a subset of patients may benefit from the structure a CTO provides. If a CTO is removed without clear evidence and due to a statutory time limit, this could lead to a patient relapsing and being re-admitted. There were comments that guidance could be included in the Code of Practice similar to the guidance around considering a CTO after a patient has first satisfactorily undertaken 7 days leave under Section 17. However, there was criticism that an arbitrary timeframe would be ethically questionable and potentially damaging to patient care.

Stakeholders welcomed our proposals to limit the use of CTOs and recognised the balance that needed to be struck between CTOs providing therapeutic benefit and proving to be the least restrictive option.

During our engagement, many stakeholders raised comments on abolishing CTOs, though we also heard from some stakeholders that they would be alarmed at the prospect of abolishing CTOs. As set out in the White Paper, we have committed to keep CTOs under review.

“CTOs can often be a valuable tool in supporting patients with eating disorders, by enabling them to avoid the far more restrictive intervention of inpatient admission. We are concerned that the proposed “expectation” of a two year maximum, could in practice become a blanket rule. An arbitrary limit of two years for CTOs could contradict the principle of person-centred care in cases where the patient requests and would benefit from their continuation.

The abolition of CTOs – discussed in the Independent review, although not proposed in the White Paper - would be an alarming prospect for some patients with eating disorders, their carers and clinicians. Therefore, it is crucial that the five year period of monitoring proposed in the White Paper fully accounts for the utility of CTOs in the treatment of people with severe eating disorders.”

- **Beat Eating Disorders UK**

Recalling patients on CTOs to hospital

During our consultation, stakeholders had differing views on our CTO recall proposals. Some stakeholders highlighted that recalling patients to alternative places may be problematic if the alternative location cannot compel treatment, and had concerns around safety and risk management if patients are recalled to alternative locations. Some respondents thought that a Community Mental Health Team (CMHT) would be the only alternative place for recall. For example, a depot clinic at a CMHT location rather than a hospital may be a good alternative place for recall. Stakeholders thought it would provide

therapeutic benefit and reduce anxiety as service users perceive recall to hospital as a threat and fear being admitted. Some stakeholders who raised the idea of a CMHT location as an alternative place for recall thought that such locations could increase patient autonomy, choice and control as a service user could choose to go to the clinic or hospital for the purpose of recall.

Stakeholders cautiously welcomed the introduction of a recall criteria of substantial risk of significant harm, but thought it raised many practical considerations. Stakeholders wanted to know how this would be defined in legislation. For example, if a person becomes unwell because they have not received their medication, and have not yet deteriorated but inevitably will, how can the risk of likelihood be assessed?

“It is proposed that when a patient does not require hospital treatment, the appropriate location to which a patient may be recalled should not be limited to a hospital and should be at the discretion of the RC. The MHLA considers clear and detailed guidance will need to be available to clarify which locations are justified as an appropriate place for recall. If this does not happen, the MHLA is concerned that it has the unintended consequence of opening the floodgates to an unnecessarily broad interpretation. For instance, an individual could be recalled to his home address, Community Mental Health Team or custody.“

- **Mental Health Lawyers Association (MHLA)**

Next steps

The consultation process has confirmed that, as highlighted by the Independent Review, stakeholders remain divided on the use of CTOs but agree on the need for change. The Government is committed to reforming CTOs and we believe our proposals will limit the number of CTOs and ensure they are only used where there is strong justification and where they provide therapeutic benefit to the individual.

While there was broad support for this proposal to reform CTOs, many respondents raised potentially negative, unintended consequences, as well as practical considerations associated with implementing our proposals. Some of these concerns may be resolved through clearer guidance in the Code of Practice and strengthening governance structures around the use of CTOs, so they are only used when absolutely necessary and when communicated to all parties involved. We will continue to work closely with stakeholders to develop this policy and identify potential means of mitigating the concerns raised by stakeholders.

28. Use of remote technology

What you told us and next steps

The White Paper discussed the use of video technology and whether digital and online methods can suffice to make medical assessments for the purposes of the Act.

At the time of the White Paper's publication, the position of the Government and NHSEI was that the Act may be interpreted to allow for this. However, the High Court found otherwise in the case *Devon Partnership NHS Trust v Secretary of State for Health and Social Care* in January 2021. The Court found that the terms "personally seen", as required of an AMHP under Section 11, and "personally examined", as required of a medical practitioner under Section 12, cannot be satisfied by the use of remote technology.

In parallel to the consultation process, the Government held discussions with stakeholders to consider whether the Act should be amended to allow an interpretation of these terms which allow for the use of remote assessments. We have decided not to do so. The broad consensus was that the presence of professionals in the room with people is required. It is in the interest of patients, and preserves established good practice.

29. Section 117

What you told us and next steps

In parallel to the consultation process, the Government held discussion workshops with stakeholders about the future of Section 117 aftercare. There are two particular areas that are being considered.

Firstly, as the Independent Review and the White Paper both set out, work is needed to ascertain how responsibilities under Section 117, which are an obligation for both health and social services, should be split between those systems. Stakeholders were clear that there is a need for the Government to work with the Local Government Association (LGA), ADASS and with NHSEI to produce national guidance.

Secondly, this year's High Court judgment in the case of *R (Worcestershire County Council) v Secretary of State for Health and Social Care and Swindon Borough Council* ('the Worcestershire case'), has in the Government's view, highlighted the need for greater clarity within the Act about how the concept of Ordinary Residence should be interpreted in practice. We have explored initial proposals to make it more straightforward in some cases to establish which local area is responsible for the aftercare of a person, particularly in more complicated personal histories which have included placements out of area. Initial feedback from stakeholders we have engaged with has been positive. We will continue to develop proposals in close liaison with stakeholders in local Government and NHSEI.

30. Impact Assessment

We published a consultation impact assessment alongside the White Paper. This document sets out our analysis of the impact the White Paper proposals might have, if taken forward, in terms of economic, social and health impacts. As part of this consultation, we sought views on the impact assessment and asked people to submit any further evidence which could help us accurately assess the impact of the proposals. The evidence received was considered when updating the impact assessment, which has been published alongside this document. A further iteration will be published alongside the draft Bill.

Rethink Mental Illness summary of findings

Rethink Mental Illness (RMI) is a charity which improves the lives of those severely affected by mental illness through local groups and services, expert information and training and successful campaigning.

Alongside the public consultation, RMI held a number of focus groups with the purpose of ensuring individuals with lived experience of the MHA were supported to have their voices heard. RMI established panels of Lived Experience Advisors who grouped key questions from the White Paper into themes to explore in the focus groups.

The focus groups were held with 105 people across 23 sessions, including 59 individuals currently detained under the Act, and 46 individuals who had been previously detained, as well as family and carers. The age range of participants was between 16 years to 70 years of age. 71% of participants identified as female and 29% as male. 13% of participants were from black, Asian and minority ethnic groups. 23% of participants identified as LGBT.

In order to ensure that the engagement events were able to reach a broad range of participants, RMI also worked with other organisations: Hafal in Wales and YoungMinds who interviewed 19 children and young people aged between 16-25 years. Five sessions were also held in low and medium secure facilities with a good geographical spread across England and Wales and two sessions were held in high secure facilities.

Findings:

All cohorts expressed very strong support for embedding the proposed principles across the Mental Health Act but noted that service users would need help in understanding their rights, and how to make use of them. The currently detained cohort were particularly supportive of the principle of least restriction.

“Principles need to be used to create collaborative discussions so there’s fairness and people are treated as individuals.”

- Participant quote

Participants agreed that the addition of therapeutic benefit has the potential to make a significant difference to care and treatment. This involves more than just medical intervention, but may also include individual or group talking therapies, education and employment training, or peer support. Participants expected staff to provide clear and easy to understand information regarding their rights, the reason for their detention, the available support services, and a clear purpose to their hospitalisation.

Participants also wanted the therapeutic benefit proposals to be extended to the Act and felt that to do otherwise would be unjust and discriminatory.

There was some concern that raising the detention threshold would mean some people may be unable to access help, but equally that some people could be discharged too early. Participants saw their detention experience as a part of their wider mental health

journey and felt that not being treated with respect when admitted could have an impact on their recovery journey. It was also suggested that more attention be paid to an individual's situation outside of being detained and other problems they are facing such as physical illness or housing.

ACD and CTPs were considered to be the main mechanisms for enhancing choice and involvement in care (and 'humanising' patients) so should be hard to override. Participants also wanted to be able to state preferences for locations to receive treatment (to reflect positive or negative experiences they'd had in particular hospitals or wards, and have their previous experiences taken into account in their ACDs). Participants wanted their CTPs to include information about them even if it wasn't clinically relevant, including their aspirations and long-term goals. Currently detained young people stressed that this is especially important when they come to the end of their time in CAMHS and transition into adult services.

"I think the advance choice document is a good development and well needed. It's almost like a birth plan, where you put down your wishes and wants, but sometimes it doesn't always go to plan, but adaptations and preferences are there to be enacted upon and considered."

- Participant quote

Participants viewed the proposed Nominated Person powers very positively and highlighted the need for support for the Nominated Person to exercise this role. However, there was some concern that service users could choose inappropriate people to represent them so guidance would be welcome.

Access to IMHAs was variable (better for service users of high secure and CAMHS services). Participants hoped that the proposed changes to the role would improve accessibility to advocates. Other factors cited as improving service users' experience of using advocates included provision of the same advocate on a consistent basis (and robust handover processes when that advocate moves on) and following best practice around recruitment (e.g., service users on interview panels).

Young people:

YoungMinds reported that the young people they interviewed felt that their rights are not clearly communicated, and they do not feel listened to or able to engage meaningfully in care. They frequently reported feeling like a burden and found it difficult to access advocates. Some young people reported experiences of racism, homophobia and transphobia. They felt that advocacy should be available for all, including voluntary patients and that staff must be aware of and promote advocacy services. There was also frequent reporting of informal patients being threatened with section if they are seen to be 'challenging' their treatment and care.

“When I was in hospital, I was informal so didn't have access to an advocate which was really scary. Even when you're informal, it doesn't mean you're free.”

- **Participant quote**

Despite these negative experiences, young people were encouraged by the proposed reforms. They were supportive of being able to choose a Nominated Person and felt that this better accommodates for different and changing family relationships. They wanted flexibility around who is involved in their care, and for their care and treatment to be individualised and holistic. They were keen to access advocates and especially to be supported through the Tribunal process which they found distressing and difficult to navigate. They wanted better communication of their rights, wanted to be respected, and felt that positive relationships with staff was key.

“A lot of people are given their rights but nothing is really properly explained to young people [...]. If you're in hospital and really poorly, you're not going to have the brain power to properly understand this information. Therefore, people end up being really compliant when they don't really know what's going on.”

- **Participant quote**

YoungMinds recommended as a result of their findings that when a young person is detained, staff should always take the time to have a supportive conversation with the young person to discuss their rights and recognise that each young person may need their rights explained to them in different ways and at different times, depending on how unwell they are.

Conclusion:

Across all cohorts, there were high levels of support for the White Paper proposals balanced with high levels of scepticism that the ambition will be realised, particularly for those who have been detained in services for a longer period of time.

Implementation of these proposals is at least as important as the proposals themselves – funding, workforce capacity and training are key enablers. Participants reflected on the vital importance of the Long Term Plan, including rollout of the Community Mental Health Framework, in preventing detention in the first place, and community services supporting people's health and recovery after discharge.

“Regardless of legislation, so much relies on the extent to which it is put into practice and the competence and resource of services to be able to implement it properly. The Mental Health Act is only one part of the equation.”

- **Participant quote**

BILD summary of findings

Alongside the public consultation, the British Institute of Learning Disabilities (BILD) in collaboration with the Restraint Reduction Network (RRN) held a number of focus groups with autistic people and people who have learning disabilities (LD) and lived experience of the MHA.

BILD supports people and organisations who provide support to autistic individuals and those with learning disabilities and helps to champion human rights. They help to champion human rights, develop the organisations to provide better services and support member organisations including universities, Government departments, local authorities, NHS trusts, and service providers. The RRN is an independent network which brings together committed organisations providing education, health and social care services, with the goal of reducing reliance on restrictive practices.

The RRN established a steering group comprising two psychiatrists, a speech and language therapist, autistic people, people with learning disabilities, and parent-carers. The steering group advised on the format of the focus groups to ensure that accessibility and communication preferences were accommodated.

140 individuals were interviewed (all of these had lived experience of autism or learning disabilities and 61% had lived experience of being detained under the MHA). The age range of participants was between 9 years to 70 years of age. 60% of participants were female and 40% were male. 18% of participants were from black, Asian and minority ethnic groups. 23% of participants were Welsh and the remainder were English.

In summary, people agreed with the changes to the Act pertaining to autism and learning disabilities. However, they do so reservedly.

Only 4 of the 140 participants felt that autism and learning disability should continue to qualify as mental disorders under Section 3. The majority of participants agreed that these shouldn't be considered mental disorders in themselves and that the removal of these from the category of qualifying mental disorder would redress issues of legislative discrimination surrounding the detention and treatment of autistic people and people with learning disabilities.

“The problem is that we get detained. The unit isn't the right place for us. We react to the stressors in the unit. The sensory triggers. And then we end up anxious, depressed and looking mentally ill.”

- Participant quote

People felt that until appropriate community provision is in place changes to the criteria and threshold for detention should not be enacted. People spoke of worse outcomes for autistic people and people with learning disabilities. They worried that autism and learning disabilities would become criteria for exclusion from services, preventing them from being admitted when they needed help.

Participants were concerned about unintended consequences. These included fears of inappropriate use of the Mental Capacity Act (MCA) for these individuals and the resulting difference in safeguards. Many people were also concerned that there would be an increase in people entering the criminal justice system.

Specific communication issues were raised, and people felt excluded from having their voices heard. Assessment for autistic people and people with learning disabilities must be of a high enough quality where reasonable adjustments are embedded into the process.

Tribunals are not an effective means to challenge detention for these individuals due to poor accommodation of communication needs. People explained that they are often misunderstood and misrepresented in Tribunals, and that they have a reduced ability to self-advocate when in stressful settings. Speech and language adjustments must be made to enable fair and equitable participation. Participants highlighted the importance of cocreation of support tools and suggested using experts by experience and advocates to achieve this.

“I wasn't ill, I just couldn't communicate in the way neurotypicals do. Nobody tried to understand that and communicate with me in another way and so I stayed detained.”

- **Participant quote**

People had previously experienced failings in the Care, Education and Treatment Review C(E)TR process so were pleased with the suggested changes to put these on a statutory footing. Participants were pleased that accountability for recommendations and progress towards discharge is included but thought more strength is needed. People also suggested that C(E)TR recommendations should be included as part of the Tribunal process.

People welcomed Advanced Choice documents however felt that they are a 'sticky plaster' for poor care and treatment and could create a two-tiered rights system for those with capacity and those without.

Overall, people responded positively to all of the changes discussed in principle., However, there was overwhelming belief that some changes, whilst right and important, should not be enacted until improvements are made in community and crisis care otherwise it was strongly felt that people would suffer worse outcomes.

Engagement with black and minority ethnic groups

Whilst experiences vary across different ethnic minority groups, the Independent Review highlighted poor experiences and outcomes of individuals from black African and Caribbean groups. People from this group are over four times more likely to be detained under the Mental Health Act and over ten times more likely to be subject to a Community Treatment Order.

The White Paper set out proposals to rebalance the Act by helping address the inequalities that black, Asian and minority ethnic service users experience. The Government accepted recommendations to pilot culturally appropriate advocacy to understand how advocates can better work with and support people from these backgrounds to voice their individual needs.

This is an important step towards delivering an advocacy service that can effectively meet the diverse needs of all service users. Work to scope the requirements for these services and inform the commissioning of pilots is now underway.

Given the scale of disparity that exists, and the further inequalities the impact of Covid has highlighted, we must ensure the proposed changes from the White Paper will have a positive impact on people from black groups. It is vital to enable discussion, reflection, and debate among the people most affected by the changes, beyond the online consultation. We will continue to consider how best to engage with experts by experience to shape policy and implementation of the MHA reforms in a way that stays true to the spirit of the original intention of the review.

Legislation is only part of the picture. Effective implementation will determine whether the aims of the review are met, especially relating to discrepancies in the detention criteria through detentions happening only when absolutely necessary, increased opportunities to challenge detention sooner, giving people choice and empowerment to take decisions about their care, and increased access to advocacy services.

Annex A: Consultation demographics

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1. Overview

Responding to the public consultation on the MHA reforms could have been done using a number of routes such as main online consultation, an easy read version of the consultation, and via email. The quantitative analysis draws on responses to the main online consultation and emails covering the same format. The qualitative analysis draws on the main online consultation and responses from other routes. In total, we received 1,710 responses across all routes.

We received 1,378 responses to the main online MHA consultation document. We also received 201 responses by email of which 71 were in a similar format to the main online consultation so those have combined with the 1,378 online responses. This gives a total of 1,449 responses used in the quantitative analysis. Of these, 35 were received from people living in Wales, 17 in Scotland/Northern Ireland, and 6 individuals indicated living outside the UK, these all have been retained in the analyses.

To minimise risk of disclosure, numbers 5 or less have either been suppressed or grouped with another category if appropriate. Percentages may not sum to 100% due to rounding.

Each response is taken on face value. We have not assigned a weighting where a response might reflect multiple individuals or organisations.

Overall Responses Received

Responses	Number	Percentage (%)
Overall Responses Received	1,710	100%
Quantitative analysis: Received to main online questionnaire	1,378	95%
Received by email and similar structure to main online questionnaire	71	5%
Total	1,449	100%

Responses used in the Quantitative analysis by Individual/Organisation

Individual or Organisation	Number	Percentage (%)
Individuals	1,119	77%
Organisations	330	23%
Total used in analysis	1,449	100%

Of the 1,449 responses used in the qualitative analysis, 1,119 responses (77%) were received from individuals, 330 responses (23%) were received on behalf of organisations.

The other 130 responses received by email have been used to support the qualitative analysis, along with 131 responses to the easy read version and contextual responses to the main online questionnaire.

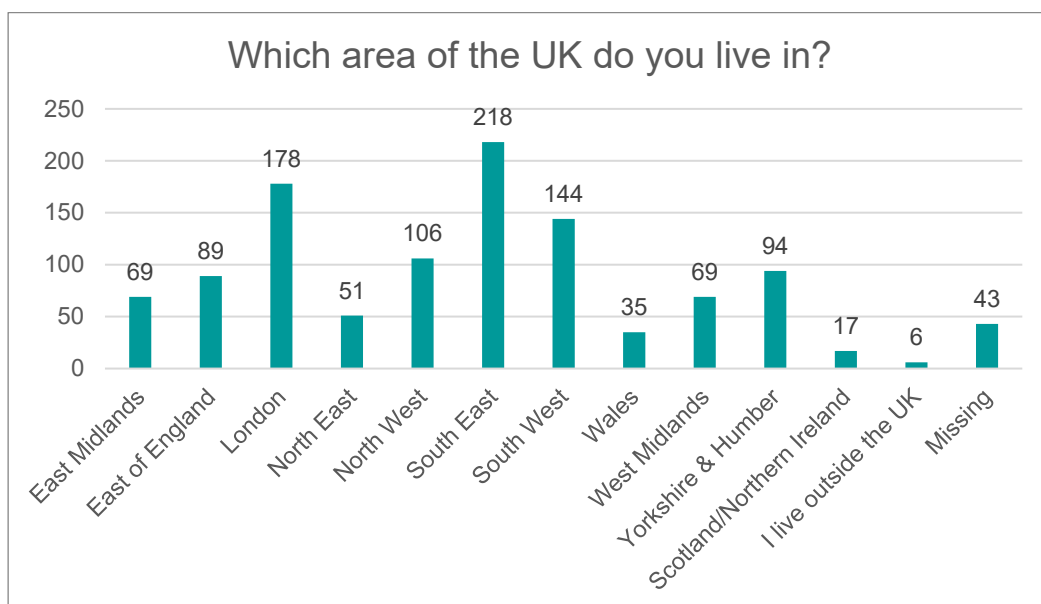
2. Individual Demographics

2.1. Which area of the UK do you live in?

Of the 1,119 individual responses, these were distributed around the UK as illustrated below.

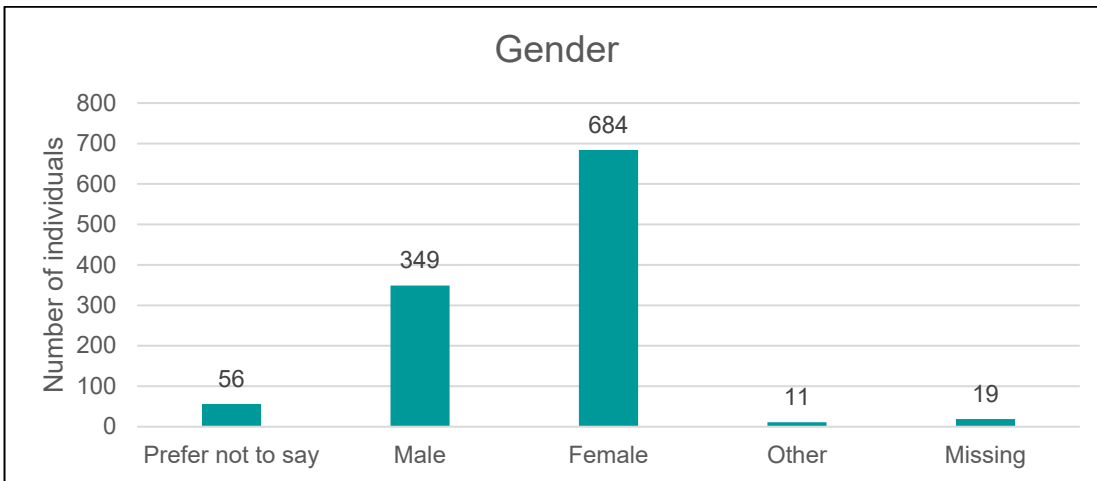
Which area of the UK do you live in?

Where Respondent lives	Number	Percentage (%)
East Midlands	69	6%
East of England	89	8%
London	178	16%
North East	51	5%
North West	106	9%
South East	218	19%
South West	144	13%
West Midlands	69	6%
Yorkshire & Humber	94	8%
Scotland/Northern Ireland	17	2%
Wales	35	3%
I live outside the UK	6	1%
Missing	43	4%
Total	1,084	100%



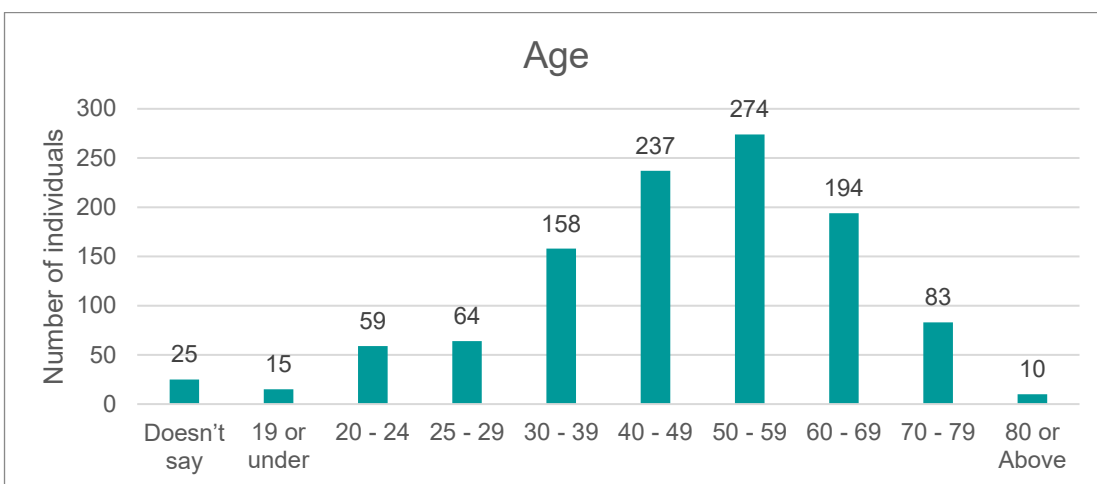
2.2. Gender

Of the 1,119 individual responses, 684 responses were received from females (61%), 349 responses were received from males (31%), 56 responses (5%) preferred not to say, 11 responses specified other (1%) and a further 19 did not specify gender.



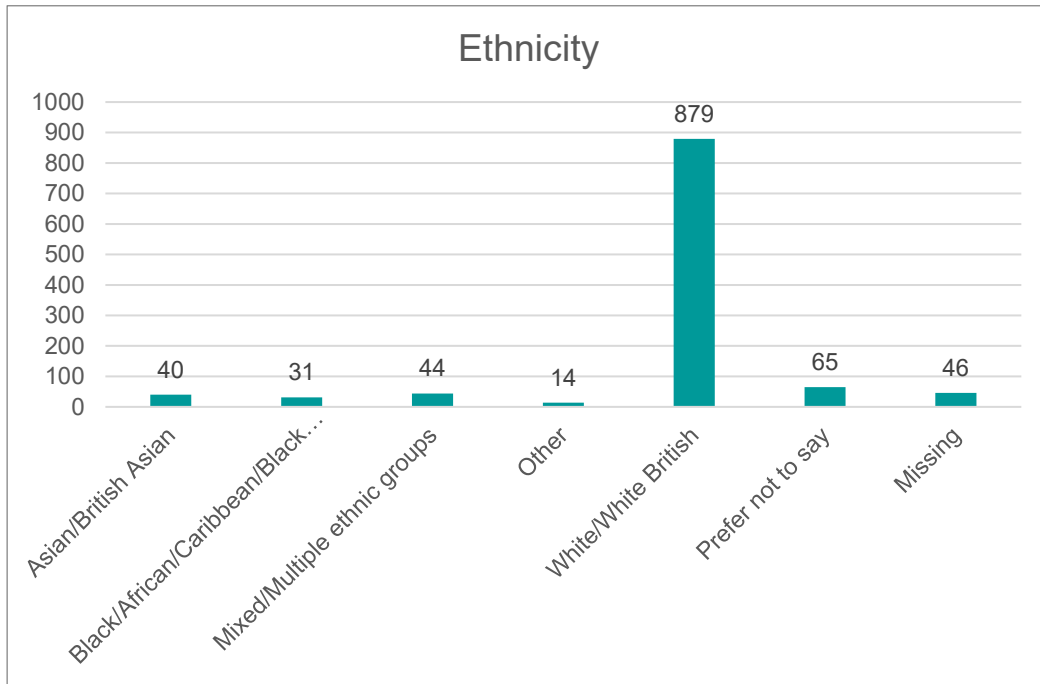
2.3. Age

Of the 1,119 individual responses, 74 of responses (7%) were received by people aged under 25, 222 from people aged 25-39 (20%), 237 from people aged between 40-49 (21%), 274 aged between 50-59 (24%), and 287 from people aged 60 or over (26%). 25 respondents did not specify age.



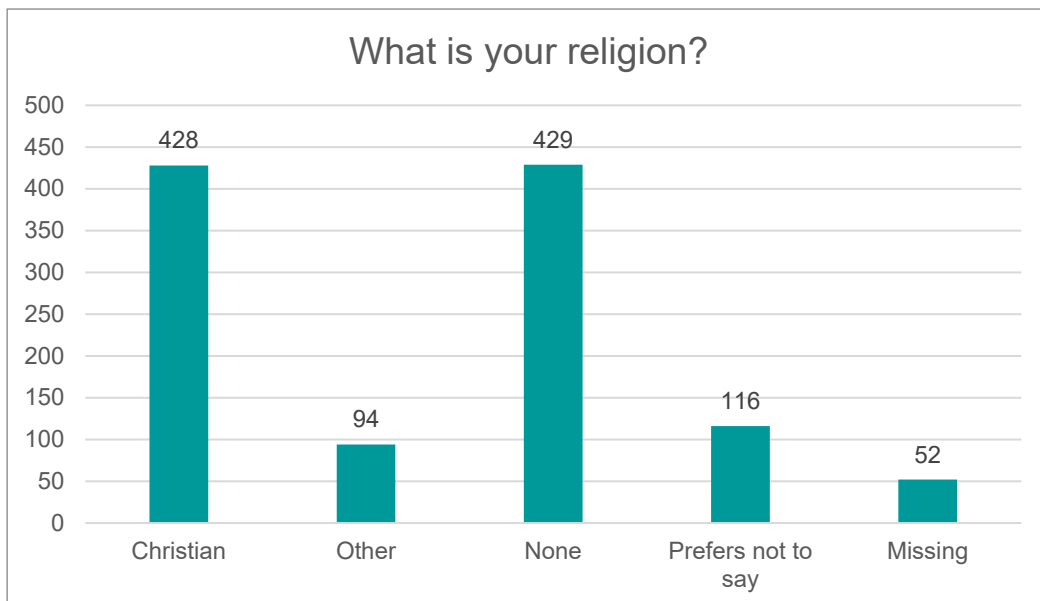
2.4. Ethnicity

Of the 1,119 individual responses, 879 were white/white British (79%), 44 were from a mixed background (4%), 40 were Asian/British Asian (4%), 31 were black/black British (3%), 14 were categorised as other (1%), 65 preferred not to say (6%) and a further 46 did not specify.



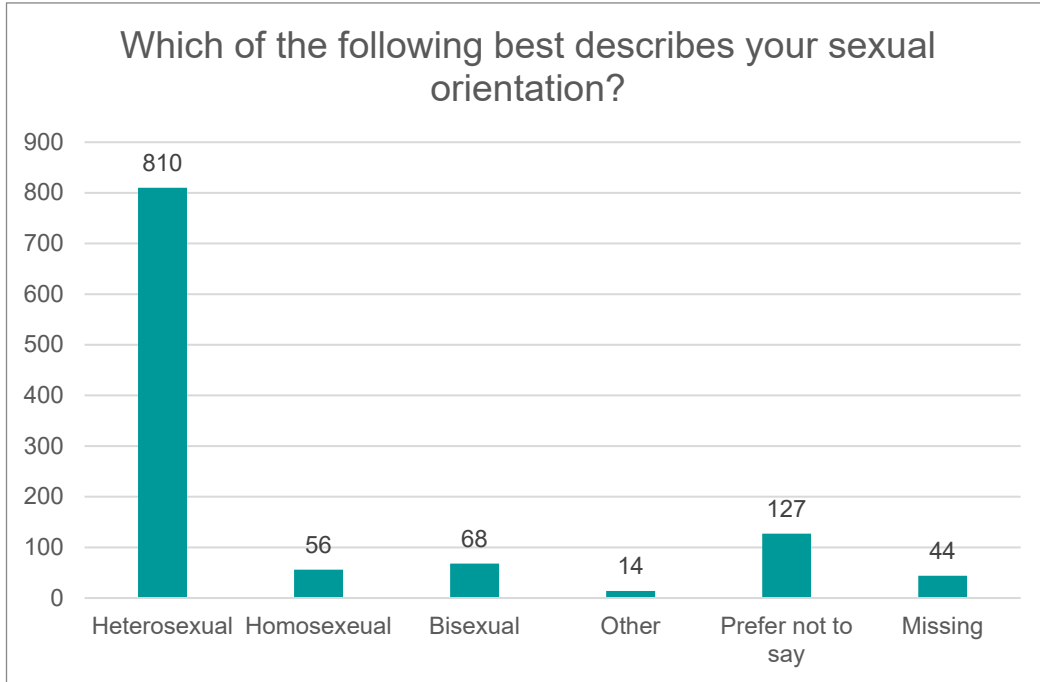
2.5. Religion

Of the 1,119 individual responses, 428 indicated they were Christian (38%); 94 indicated another religion (8%), 429 indicated none (38%), 116 preferred not to say and 52 were missing.



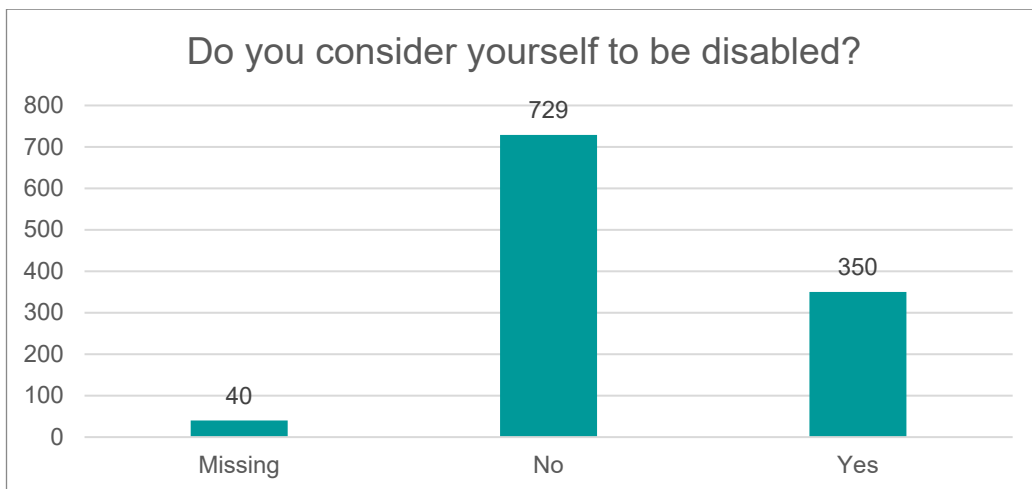
2.6. Sexual Orientation

Of the 1,119 individual responses, 810 identified as heterosexual (72%), 68 as bisexual (6%), 56 as homosexual (5%), 14 stated something 'Other' (1%); 127 preferred not to say (11%), and a further 44 did not specify.



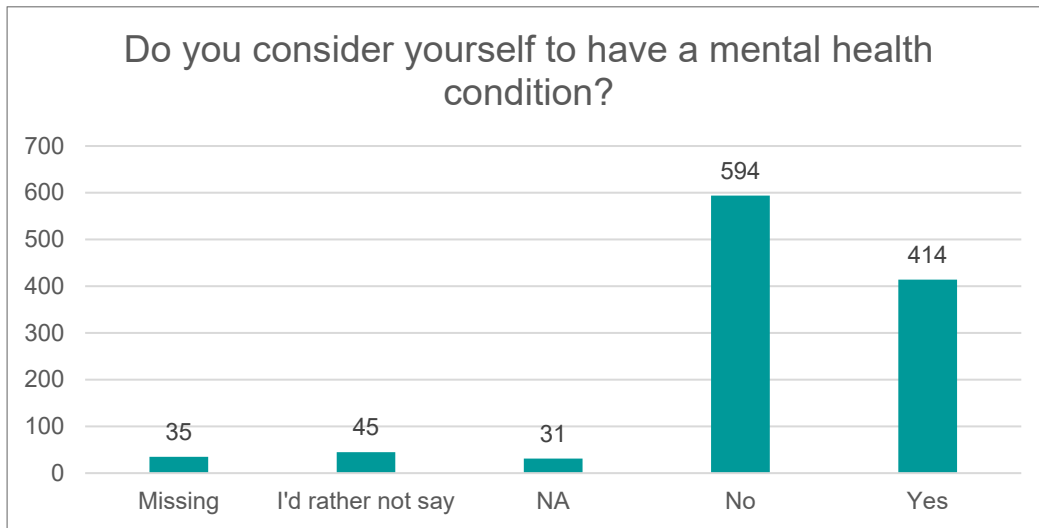
2.7. Whether considered self to be disabled

Of the 1,119 individual responses, 729 respondents indicated they did not have a disability (65%), 350 respondents indicated they did (31%) and 40 respondents did not specify.



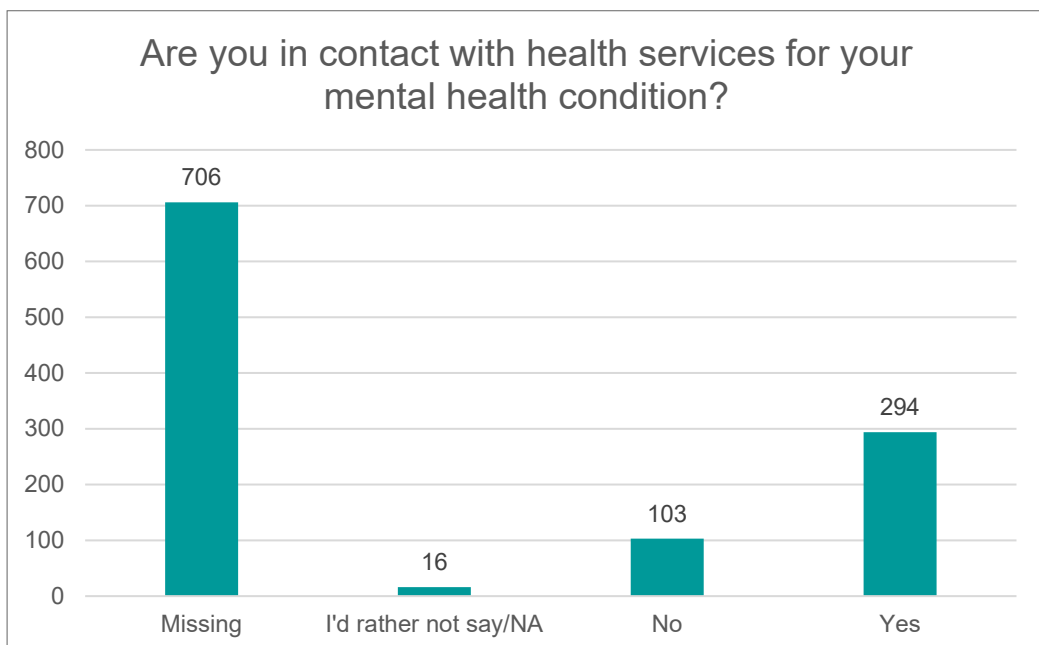
2.8. Whether considered self to have a mental health condition

Of the 1,119 individual responses, 594 respondents (53%) indicated they did not have a mental health condition, 414 respondents indicated they did (37%). 45 respondents preferred not to say, 31 listed as N/A and a further 35 did not specify.



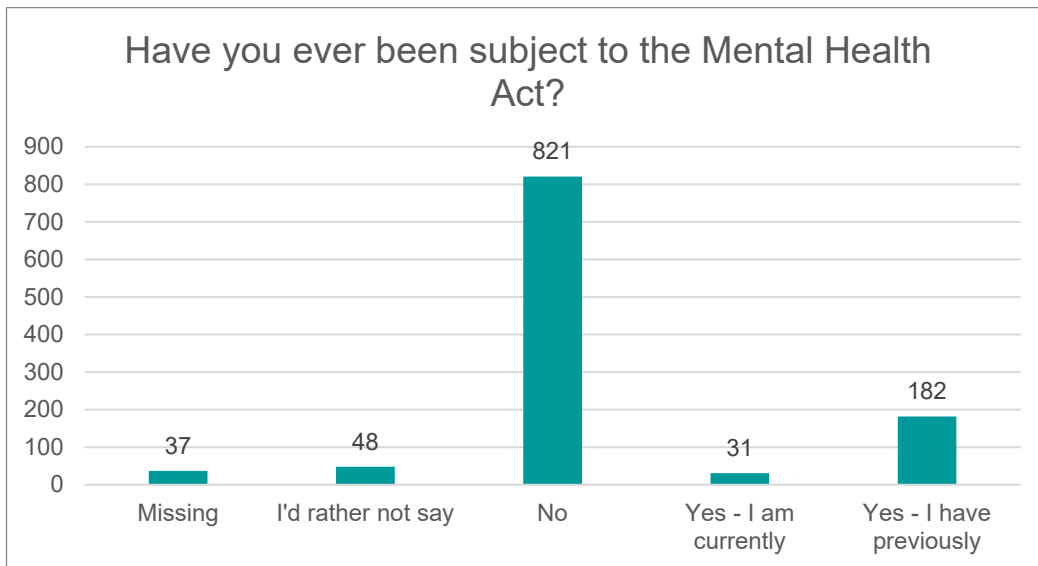
2.9. Whether have been in contact with health services for a mental health condition

Of the 1,119 individual responses, 294 respondents (26%) indicated they had been in contact with health services for a mental health condition. 103 had not been (9%).



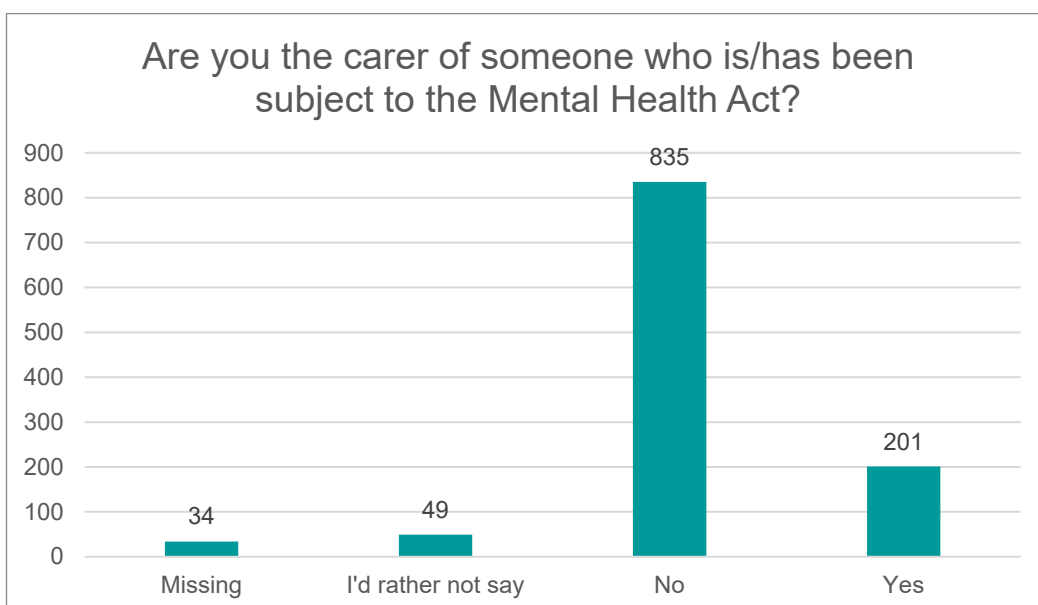
2.10. Ever been subject to the Mental Health Act?

Of the 1,119 individual responses, 821 respondents (73%) indicated they had not ever been subject to the Mental Health Act. 31 (3%) said they currently were and 182 (16%) said they had been previously. 48 respondents preferred not to say, and 37 respondents did not specify.



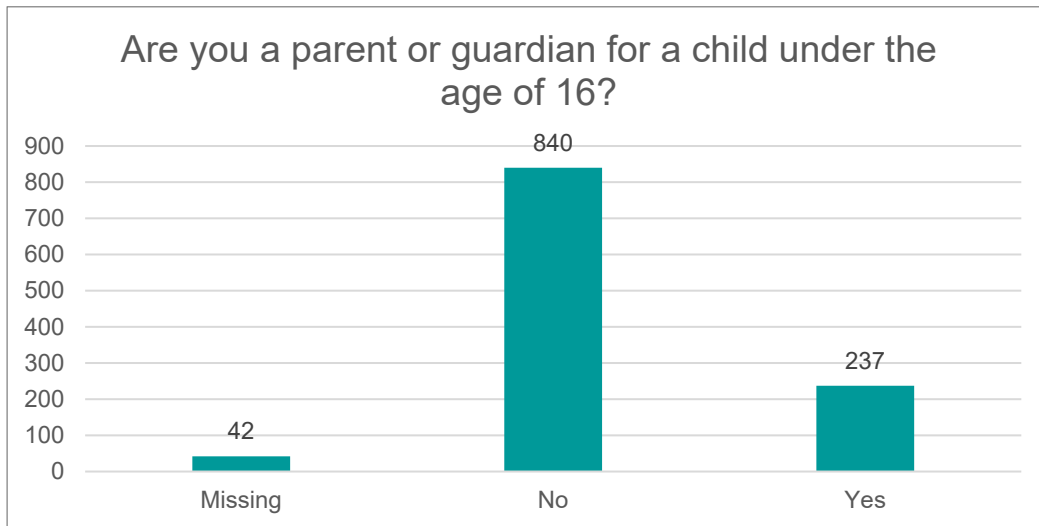
2.11. Carer of someone that is /has been subject to the Mental Health Act?

Of the 1,119 individual responses, 835 respondents (75%) indicated they are/were not a carer of someone subject to the MHA. 201 respondents (18%) indicated they were. 49 respondents preferred not to say, and 34 respondents did not specify.



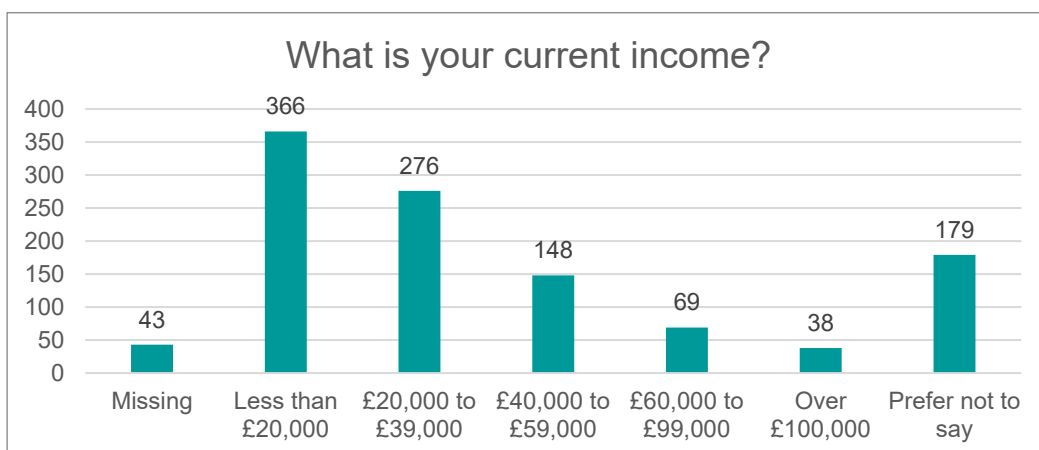
2.12. Parent or Guardian

Of the 1,119 individual responses, 840 respondents (75%) indicated they were not a parent or guardian for a child under the age of 16, and 237 indicated they were (21%) and 42 respondents did not specify.



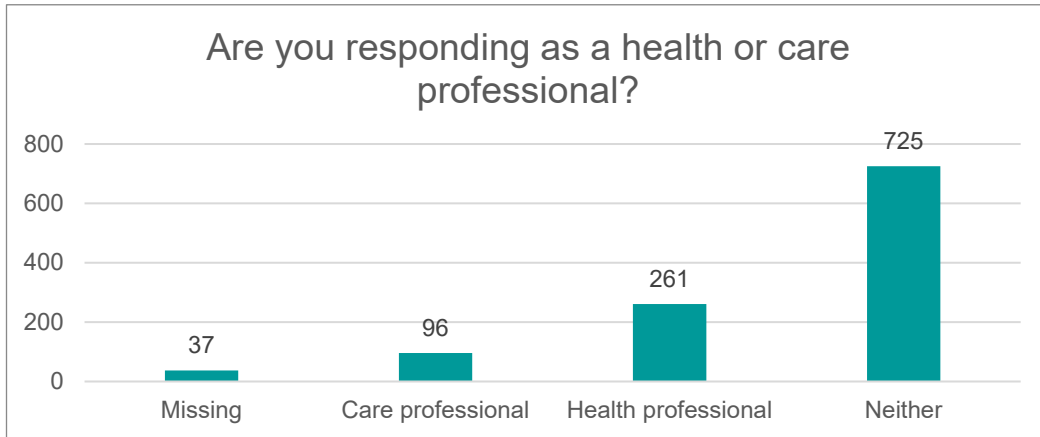
2.13. Income

Of the 1,119 individual responses, 366 respondents (33%) indicated an income less than £20,000, 424 (38%) indicated an income £20,000--£59,999; 107 (10%) indicated an income £60,000 or more. 179 preferred not to say and 43 respondents did not specify.



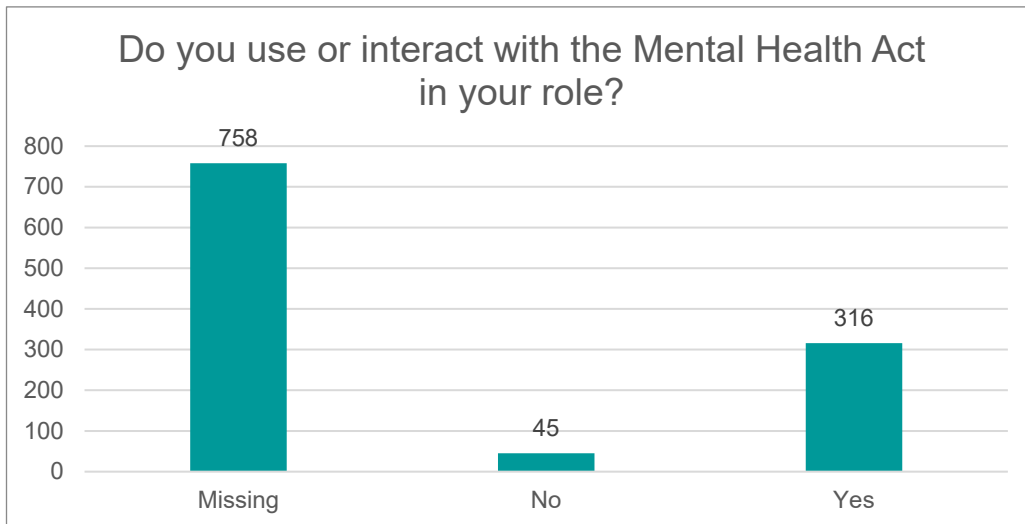
2.14. If health/ care professional

Of the 1,119 individual responses, 725 respondents (65%) were responding as neither a health or care professional; 261 (23%) were responding as a health professional and 96 (9%) as a care professional. 37 respondents did not specify.



2.15. Whether use/interact with the Mental Health Act?

Of the 1,119 individual responses, 316 respondents (28%) indicated that their role uses or interacts with the Mental Health Act. 45 (4%) responded it didn't and 758 did not specify.



3. Responses from Organisations

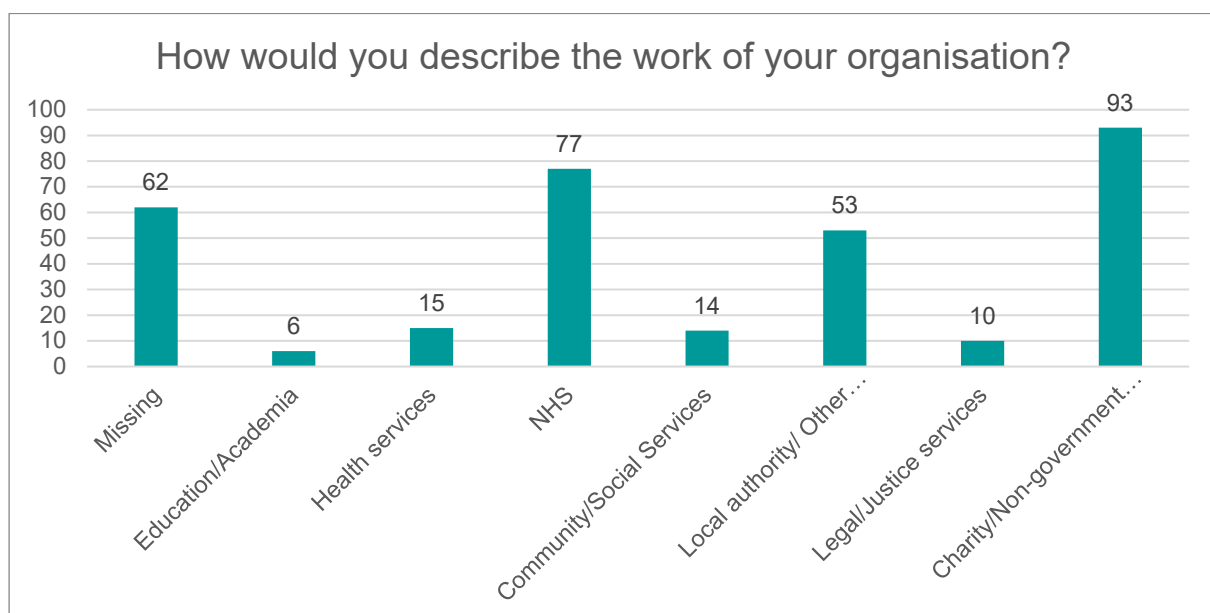
3.1. Which Sector does your Organisation work in?

Of the 330 responses received from organisations, 111, (34%) were from Health/Social care sector; 123 (37%) from the public sector; 11 from the private sector (3%); 3 from Education/Academic Sector (1%); 15 listed as Other sectors (5%). 67 organisations didn't say.



3.2. How would you describe the work of your Organisation?

Of the 330 responses received from organisations describing the work they do, these were categorised as below with 92 (28%) were from NHS or Health services; 53 (16%) from local authorities and other Government organisations; 14 (4%) from community or social services; 10 (3%) from legal or justice services; 6 (2%) from education or academia; 93 (28%) from charity or nongovernmental organisations. 62 organisations didn't say.



4. Other responses to the consultation

In total, we received 1,710 responses. In addition to the main online responses, we received 114 responses to the easy read online questionnaire and a further set of 17 easy read responses via email. We also received 130 responses by email in a more general format. These have been brought into the qualitative analyses.

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