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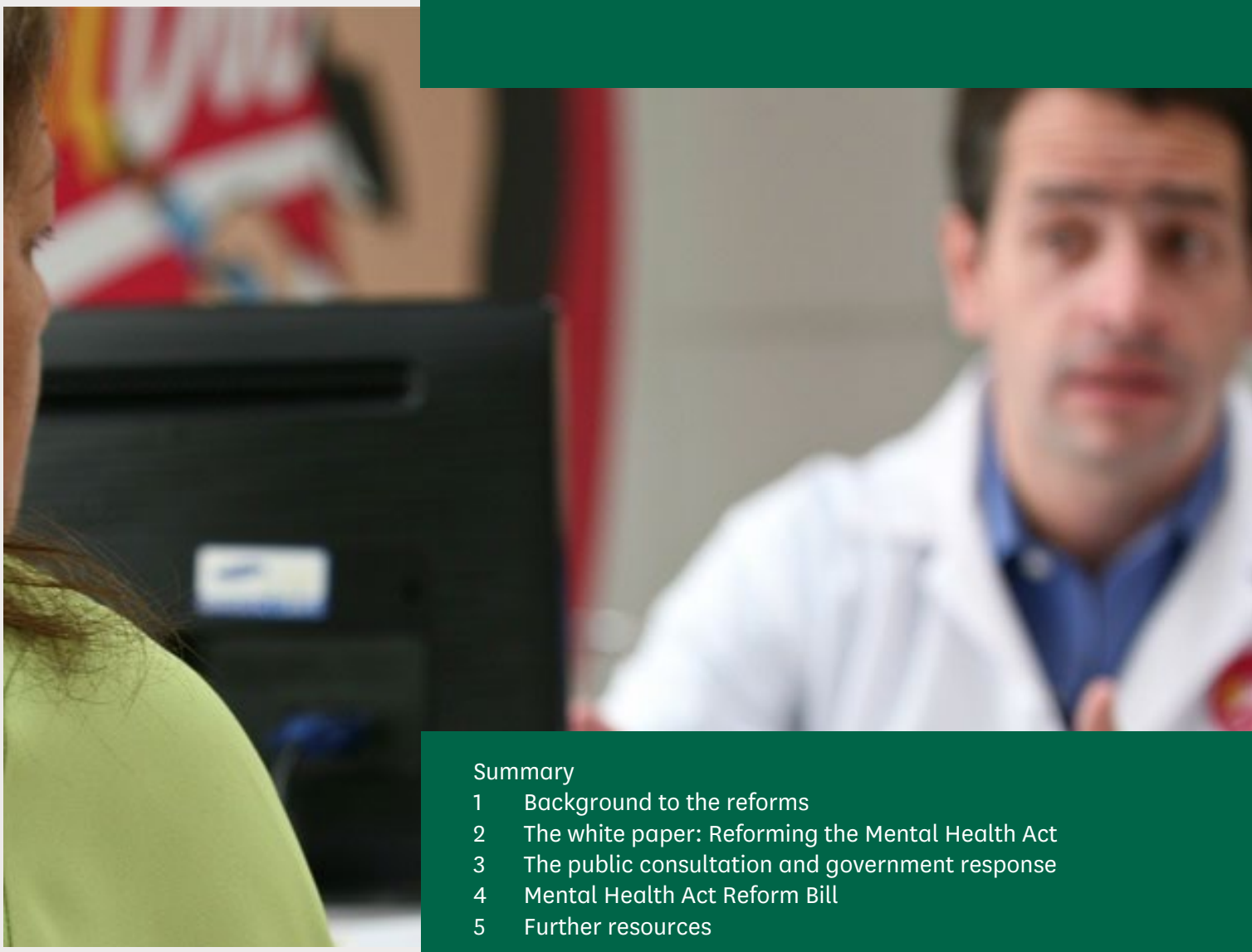
Reforming the Mental Health Act



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Summary

The Government's white paper on Reforming the Mental Health Act, published on 13 January 2021, contains wide-ranging proposals to reform the Mental Health Act 1983 (as amended in 2007) in England and Wales.

This briefing outlines the background to the reforms, some of the main proposals in the white paper and initial reactions. It also outlines the Government's response to a consultation on the white paper proposals. Further information on wider mental health policy in England can be found in the Library Briefing Mental Health Policy in England.

The white paper was preceded by an Independent Review which published its final report, Modernising the Mental Health Act, in December 2018. The purpose of the Independent Review was to understand:

- the rising rates of detention under the Mental Health Act;
- the disproportionate numbers of people from black, Asian and minority ethnic groups (BAME) in the detained population; and
- investigate concerns that some processes in the Act are out of step with a modern mental health system.

The Independent Review recommended changes to the law to make it easier for patients and service users to participate in decisions about their care, to restore their dignity and recognize the importance of human rights in mental health care. The Independent Review made over 150 recommendations and the Government accepted most and incorporated them in the white paper.

The white paper is divided into three sections – the first focuses on the legislative changes; the second outlines what policy and practice changes are required to support the new law and improve patient experiences; and the final section considers the Government's response to the earlier Independent Review.

The white paper includes a range of proposals to reform the Act as well as to bring about improvements in policy, practice, and service delivery. The overall aim is to bring the law in line with modern mental health care and ensure that patients are involved more closely in decisions about their care and treatment.

Included in the proposals for legal change are plans to tighten the admission criteria and raise the threshold for compulsory detention; reduce the use of community treatment orders; strengthen some of the statutory safeguards by giving more frequent access to the tribunal to review detention; bolster support from family members and independent advocates; and enable patients to make advance choices about their future mental health care and treatment. There are also proposals designed to reduce the use of the Act for

persons with a learning disability and/or on the autism spectrum, and a range of measures targeted at improving the experiences of persons from BAME groups.

The Government consulted on the white paper proposals from January to April 2021 and published its response to the consultation in August 2021. Respondents were broadly supportive of the proposals. The Government said it would continue to work with stakeholders to refine the proposals, to make final policy decisions and develop a draft Bill.

The Queen's Speech in May 2022 included an announcement on draft legislation to reform the Mental Health Act. The draft Bill will be subject to pre-legislative scrutiny before it is introduced in Parliament.

1 Background to the reforms

1.1 The Mental Health Act 1983

The Mental Health Act 1983 is the law that regulates compulsory detention and treatment of persons with a mental disorder in England and Wales.[1] Mental disorder is broadly defined in the Act as any disorder or disability of the mind.

Currently, patients can be admitted without their consent for a short-term assessment under section 2 (up to 28 days), for assessment in an emergency under section 4, or for longer-term treatment under section 3 (initially for up to 6 months, but renewable thereafter). There are separate statutory provisions covering Scotland[2] and Northern Ireland.[3]

The 1983 Act was amended in 2007 after a lengthy reform process.[4] Several changes were made which included widening the admission criteria by broadening the definition of mental disorder; introducing independent mental health advocacy to support some detained patients; expanding the range of professional roles involved in the process, as well as bringing in new provisions for supervised treatment in the community on discharge from hospital (so called Community Treatment Orders).

The Commons Health Select Committee scrutinised the 2007 changes in 2013 and noted with concern:

- the rising rates of detention under the Act;[5]
- variations in the use of Community Treatment Orders;[6]
- problems with the operation of independent advocacy to support patients;[7]
- the over-representation of persons from black, Asian and minority ethnic (BAME) groups in the detained population.[8]

1 Mental Health Act 1983, legislation.gov.uk
2 Mental Health (Care and Treatment) (Scotland) Act 2003, legislation.gov.uk
3 The Mental Health (Northern Ireland) Order 1986, legislation.gov.uk
4 Mental Health Act 2007, legislation.gov.uk
5 Health Committee, Post-legislative scrutiny of the Mental Health Act 2007, 10 July 2013, para 24
6 As above, Chapter 5
7 As above, Chapter 3
8 As above, Chapter 7

Since the Health Committee report was published, detention rates under the Act have continued to rise. NHS Digital reported a year on year rise in new detentions, from 45,864 in 2016/17[9] to just over 50,893 in 2019/20,[10] and 53,239 in 2020/21.[11]

The rise in use of the Act to detain people in England was examined by the Care Quality Commission (CQC) in January 2018. The report concluded that the causes are multi-factorial, though changes to law and policy over the past decade may have contributed to the rising rates.[12] Other possible drivers identified by the CQC are demographic changes and social factors that influence the use of the Act, such as rising inequality and increased drug use.[13]

Continuing concern about the operation of the legislation led the Government to appoint an independent body in October 2017, chaired by a consultant psychiatrist, Professor Sir Simon Wessely, to review how the Act is used and consider how practice can improve.

1.2 The Independent Review: Modernising the Mental Health Act

The purpose of the Independent Review was to understand: the rising rates of detention; the disproportionate numbers of BAME groups in the detained population; and investigate concerns that some processes in the Act are out of step with a modern mental health system.

The review produced an interim report in May 2018,[14] followed by a final report on Modernising the Mental Health Act in December 2018. [15] The review team emphasised the need to reform the Act to make it easier for patients and service users to participate in decisions about their care, to restore their dignity and recognise the importance of human rights in mental health care.

The review team made over 150 recommendations to reform the law and practice, including:

9 NHS Digital, Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics, 10 October 2017
10 NHS Digital, Mental Health Act Statistics, Annual Figures 2019-20, 27 October 2020
11 NHS Digital, Mental Health Act Statistics, Annual Figures - 2020-21, 26 October 2021
12 CQC, Mental Health Act – The rise in the use of the MHA to detain people in England, 23 January 2018, p19
13 As above, p23
14 Department of Health and Social Care, Independent review of the Mental Health Act: interim report, 1 May 2018
15 Department of Health and Social Care, Modernising the Mental Health Act – final report from the independent review, 6 December 2018

- strengthening the focus on human rights and including principles on the face of the Act which focus on patient choice and autonomy;
- introducing advance choice documents to enable people to set out their wishes about care and treatment;
- providing skilled advocates for all mental health in-patients;
- enabling patients to choose a family member or friend as a nominated person with a role in decisions about the use of compulsory powers;
- increasing the scope for tribunals to review detention and people's concerns about their care; and
- including a statutory right to a care and treatment plan.

1.3 The Government response

The Government responded to the Independent Review in December 2018 by initially accepting two of the Independent Review's recommendations on advance choice documents and proposals for a new nominated person.[16] At that time, then-Health and Social Care Secretary Matt Hancock said he was "determined to do everything I can to protect people's mental health and get them the help they need" and he also wanted to "make sure that our mental health laws are fit for the modern age."[17]

A general debate on reform of the Mental Health Act took place in Westminster Hall in July 2019 led by Neil Coyle MP, who pressed the Government on reform and said:

> The White Paper that has been promised must be delivered and must reflect the spirit and ambition of the independent review....
>
> New legislation must also be passed to update the Act. It is not just about getting a better piece of legislation; more importantly, it is about better treatment for the thousands of people with mental health conditions and their families up and down the country.[18]

It was announced in the Queen's Speech in October 2019 that the Government planned to reform the Act when parliamentary time allowed, although detailed proposals in a white paper were delayed by the impact of the Covid-19 pandemic in 2020. [19]

16 Department of Health and Social Care, Government commits to reform the Mental Health Act, 6 December 2018
17 As above
18 HC Deb 25 July 2019 c671WH
19 Prime Minister's Office, Queen's Speech 2019, 14 October 2019

2 The white paper: Reforming the Mental Health Act

The White Paper was introduced on 13th January 2021 to "rebalance the Mental Health Act, to put patients at the centre of their own care and ensure everyone is treated equally."[20] It was accompanied by a statement to MPs in Parliament by the then-Health and Social Care Secretary, Matt Hancock, saying the White Paper aims to bring the Act into the 21st century.[21]

As set out in Part 3 of the white paper, the Government has accepted most of the Independent Review's recommendations to change the law and practice.[22]

The planned reforms to the Mental Health Act are cited in the Government's National Disability Strategy, which states "We want to give people more control over their treatment and make sure they are treated with the dignity and respect they deserve."[23]

2.1 Legal changes

Guiding principles

The proposals in the white paper are based on four new statutory principles that will, for the first time, be embedded in the legislation to guide all decision-making under the Act. These guiding principles were proposed by the Independent Review as integral to inform patient-centred practice and have been developed in collaboration with people with lived experience of the Act.

The new principles are:

- **choice and autonomy**, which means ensuring that service users' views and choices are respected;
- **least restriction,** which means ensuring that the Act's powers are used in the least restrictive way;
- **therapeutic benefit,** which means ensuring that patients are supported to get better, so they can be discharged from the Act;

20 Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, p10

21 Department of Health and Social Care Oral statement to parliament, We must bring the Mental Health Act into the 21st century, 13 January 2021

22 Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, part 3

23 Disability Unit, Equality Hub and Department for Work and Pensions, National Disability Strategy, 28 July 2021, p87

- **the person as an individual**, which means ensuring that patients are viewed and treated as individuals.

Detention criteria

In response to the rising rates of detention, the white paper proposes to clarify and strengthen the criteria for in-patient detention to limit the use of the Act for certain groups.

It proposes introducing a higher risk threshold for the use of compulsory powers in sections 2 and 3, by replacing the current criteria that detention should be "necessary for the health or safety of the patient or for the protection of others" with the requirement for "a substantial likelihood of significant harm to the health, safety or welfare of the person or the safety of another person".[24]

This would be coupled with a requirement that for longer term admission under Section 3, the purpose of the care and treatment is to bring about a "therapeutic benefit",[25] which cannot be delivered to the individual without their detention. As under the current law, there is also a need for appropriate treatment to be available in detention to the patient.

Advance choice documents

Advance choice documents (ACDs) are proposed in the white paper to promote and facilitate patient autonomy and choice. The Independent Review viewed ACDs as an important mechanism to secure the right to respect for the will and preferences of patients in line with the first principle proposed in the white paper.

The white paper envisages that an ACD would be made when a person has the relevant capacity to "record a range of choices and statements about their care and treatment in preparation for a future situation in which they are too unwell to express these decisions themselves".[26] The document would follow a standard format and approach, and should include the following information:

- any treatments the person does not wish to consent to as well as their preferred clinically appropriate treatments;
- the name of their chosen nominated person;
- preferences and refusals on how treatments are administered;
- communication preferences;
- religious or cultural requirements;
- crisis planning arrangements; and
- other health needs and/or reasonable adjustments.

24 Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, p25
25 As above, p24
26 As above, p36

ACDs would be offered to everyone who has previously been detained and the Government consulted on whether they should also be offered to those who are perceived to be at heightened risk of detention.

ACDs would work in a similar way to advance refusals of treatment under the Mental Capacity Act 2005 (MCA), which are currently used in the context of physical and community mental health care. However, in contrast to advance refusals in the MCA which are legally binding, the white paper says there will be a legal requirement to "consider" ACDs if the person subsequently loses capacity.

Further information on advance decision making under the MCA is available on the NHS website.[27]

Independent mental health advocacy

Independent Mental Health Advocacy (IMHA) was introduced into the Act in 2007 and is described in the white paper as playing a "critical role… in ensuring patients are supported and helped to exercise their rights".[28] The Independent Review received strong evidence from service users and clinicians that advocacy "enables patients to understand and exercise their rights and gives them support to make shared decisions".[29]

The white paper proposes expanding the role of the Independent Mental Health Advocate to offer greater support and representation for every detained patient, and especially to ensure culturally sensitive support. A pilot project of culturally sensitive advocates would be trialled to identify how to respond to the diverse needs of BAME patients.

IMHAs will have a new role in supporting patients in care planning; preparing advance choice documents; challenging a particular treatment and appealing to the tribunal on the patient's behalf, in addition to supporting patients to understand their legal rights as they do currently.

Whilst the nature of the IMHA role would be expanded in this way, the proposals in the white paper differ slightly from the Independent Review proposal for independent advocacy which would have applied to all mental health in-patients, regardless of whether they are formally detained under the Act.

The Government is supportive in principle of the Independent Review's recommendation and believes that advocates are "well placed to support informal patients to understand their rights".[30] Nevertheless, it argues that expanding advocacy in this way will create an additional burden for local authorities, therefore any further expansion "will be subject to future funding

27 NHS, Advance decision (living will), (Accessed 19 March 2021)

28 Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, p53

29 Department of Health and Social Care, Modernising the Mental Health Act – final report from the independent review, 6 December 2018, p90

30 Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, p54

decisions".[31] There have been long-standing concerns about access to, and commissioning of, advocacy services by local authorities which the white paper is also seeking to address.

Nominated person

The white paper proposes to introduce a new nominated person to support the patient in the compulsory detention process. This will replace the current Nearest Relative role.

The Nearest Relative is currently selected from a fixed and outdated hierarchical list in section 26 of the Act. At present, the Nearest Relative has certain powers and responsibilities to protect the rights of the patient, including making an application for formal admission; being consulted and or/given information about an application for formal admission; and objecting to an application for formal admission.

Unlike the Nearest Relative, the nominated person will be chosen by the patient and will have expanded rights and powers, including the right to be consulted on transfers between hospitals and the power to apply for discharge on the patient's behalf. The nominated person will be provided with additional support which is important given the expansion in powers and nature of the role.

The Independent Review had recommended replacing the Nearest Relative with a new nominated person in this way, as the current model "reflects neither the makeup of modern families and their diverse cultures, nor the wishes of the patient themselves."[32] The proposed changes should mean that the right person is appointed to support the patient, rather than potentially unsuitable people being selected automatically from the hierarchical list.

Other changes proposed will make it easier for professionals to appoint a nominated person for patients who are not able to express a preference, and to apply to the tribunal to displace an unsuitable nominated person, rather than having to go to the county court as under the current system.

Statutory care and treatment plans

There will be a duty on the doctor in charge of the patient's care (the Responsible Clinician) to formulate a detailed care and treatment plan (CTP) for each person within seven days of being detained, which is subject to approval by a Medical/Clinical Director within 14 days of detention.

The plan will be subject to regular review and should include details of:

- The full range of treatment and support available to the patient;

[31] Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, p54

[32] Department of Health and Social Care, Modernising the Mental Health Act – final report from the independent review, 6 December 2018, p85

- Why the compulsory elements of treatment are needed;
- Details of the least restrictive way in which the care could be delivered;
- Any areas of unmet (social and medical) need;
- Planning for discharge and estimated discharge dates;
- For people with learning disability or autism, how Care (Education) and Treatment Reviews have informed the plan;
- Acknowledgment of any protected characteristics; and
- The wishes and preferences of the patient, so that decisions made when the patient has capacity are followed and for those who lack capacity, through an ACD.

Significantly, where the person's wishes are not followed, the Responsible Clinician must state the rationale and the CTP must carefully document when treatment refusals are overruled.

Care and treatment plans are, under the current Act, advised as best practice, but the white paper would go a step further by imposing a statutory duty to provide a CTP for all detained patients.

Consent to medical treatment and invasive procedures

There is a new framework proposed for patient consent and refusal of medical treatment during detention in Part IV of the Act, with additional safeguards and processes proposed for invasive procedures such as electro-convulsive therapy (ECT).

Notably, the approval of a High Court judge would be required for ECT to override a refusal (at the time or in advance) for patients with capacity, if it is necessary to save life or prevent a serious deterioration of their condition.

In cases where the patient lacks capacity to consent, the Second Opinion Approved Doctor (SOAD) system would be strengthened, such that it must be documented in the records and the Care Quality Commission (CQC) must be informed if ECT is approved. There would also be requirements for the SOAD to consult with the Nominated Person and family members in such cases.

For all other general treatments for a mental disorder, including medication, there are significant changes proposed in the White Paper to tighten the procedures. Significantly, patients with capacity who refuse medication (either at the time or in advance through an ACD) are entitled to a SOAD review 14 days after detention (as opposed to within 3 months at present). For patients who lack capacity, a SOAD review will be required within 2 months (rather than 3 months currently).

Emergency treatment can still be provided under the Act where it is immediately necessary to alleviate serious suffering by the patient.

Tribunal review

The Mental Health Tribunal provides an important safeguard to review the grounds for continued detention of mental health patients. The Independent

Review received a lot of evidence from a range of stakeholders, including service users and members of the tribunal judiciary, for stronger tribunal powers.[33] Accordingly, the Independent Review recommended a number of changes to the powers of the tribunal which have been accepted in the white paper.

The Government proposes giving patients increased access to the tribunal to review their detention with more frequent review opportunities. There would also be expanded powers for the tribunal to scrutinise treatment decisions, as patients would be able to challenge a specific treatment through the tribunal. This would mean giving patients stronger rights to challenge detention. They wouldbe supported in this process by the IMHA and with the additional powers given to the Nominated Person.

Community treatment

Community Treatment Orders (CTOs) were introduced in 2007 as a form of supervised community treatment on discharge from hospital for patients who have been detained in hospital under section 3, partly to reduce the risk of readmission and also to improve care for patients who are deemed to be high risk.

The Independent Review considered the evidence on the use of CTOs, in particular it mentioned three randomised control trial studies that have been carried out, one of which is from England.[34] There is no conclusive evidence from these studies that CTOs reduce the risk of hospital readmission. Nevertheless, the Independent Review received evidence from service users, carers and professionals that in some cases, CTOs represented the least restrictive option, such that removing CTOs from the Act could have a detrimental impact on some services users. Consequently, the Independent Review recommended retaining CTOs but limiting their use and increasing the safeguards at every stage.[35] The Government has accepted these recommendations.

The white paper proposals are designed to limit the use of CTOs. The criteria would be tightened so they can only be used where there is a strong justification, with a substantial likelihood of significant harm and therapeutic benefit. There would be shorter time limits for a CTO (up to a maximum of two years) and opportunities for more frequent tribunal review. Currently, a CTO lasts initially for six months, but can be renewed by the Responsible Clinician for a further six months, and thereafter renewed annually for 12-month periods (section 17C, section 20A (3) of the Act). There are also changes proposed to involve more personnel in the process by way of checks and balances, and a new right for the Nominated Person to object to the CTO.

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33 Department of Health and Social Care, Modernising the Mental Health Act – final report from the independent review, 6 December 2018, p122.

34 As above, p132

35 As above, p134

Race and culture

One of the major drivers for reform has been the experiences of BAME patients and disproportionately higher rates of detention under the Act.

NHS Digital Data indicates that in 2018/19, known rates of detention for Black or Black British people were over four times higher than for White people (321.7 detentions per 100,000 population, compared to 73.4 per 100,000 population).[36]

Much of the available evidence points to profound inequalities in access to mental health services, mental health outcomes and experiences of care and detention under the Act. For example, in 2018/19, known rates of Community Treatment Order use for Black or Black British people was over ten times higher than for White people.[37]

The Independent Review recommended a range of measures to tackle racial inequalities and acknowledged the wider structure of existing systems needs to change to bring about improvements in the overall quality of services and patient experiences.[38]

Enhancing the patient voice and strengthening rights to challenge detention in the white paper are regarded as two mechanisms to address such disparities and will be accompanied by a range of other proposed initiatives. These include:

- provision of culturally appropriate advocacy to promote engagement with people from minority ethnic groups;
- establishment of the Patient and Care Race Equality network to support NHS mental healthcare providers and local authorities to improve access and engagement with local communities;
- promoting a more diverse and representative workforce and increasing cultural competence throughout the workforce;
- reducing the use of community treatment orders for Black people;
- up to £4 million investment in research focusing on interventions for Black African and Caribbean people, and other minority ethnicities.

A POST note on Mental Health Act Reform - Race and Ethnic Inequalities (May 2022) outlines research on race and ethnic inequalities in relation to the Act, summarises proposals for reform and stakeholder views.[39]

Autism and learning disability

The white paper affirms the Government's commitment to reducing the reliance on specialist inpatient services for autistic people and people with a

36 NHS Digital, Mental Health Statistics, Annual Figures, October 2019

37 As above

38 Department of Health and Social Care, Modernising the Mental Health Act – final report from the independent review, 6 December 2018, pp163-164

39 POST, Mental Health Act Reform - Race and Ethnic Inequalities, POSTnote 671

learning disability, and to developing community alternatives. Evidence of abuse uncovered at Whorlton Hall in 2019,[40] and Cygnet Yew Trees in 2020,[41] demonstrated that detained patients do not always receive therapeutic care in inpatient environments. Further information is available in the Commons Library briefing on Support for people with a Learning Disability.[42]

The Independent Review identified numerous concerns about the way the Act works for people with learning disabilities and/or autism. The recommendations were designed to limit the use of the Act for autistic and/or people with a learning disability. The Independent Review recognised however that legal reform alone is not sufficient to bring about the required changes as:

> There is an overwhelming need for a sustained programme of investment to ensure, that as far as possible, people are cared for in the community; admission to hospital is only used as a last resort at a point of crisis; and that services can facilitate a timely discharge.[43]

The white paper proposals would limit the detention of persons with a learning disability and/or autism under the Act to short-term admission for assessment under section 2 only when there is evidence of a co-occurring mental disorder and when the behaviour is so distressed there is a substantial risk of significant harm to self or others. The admission threshold would therefore be raised with the new criteria.

The white paper advises that detention for assessment under section 2 should only be considered after alternatives to respond to the distressing behaviour have been tried. The assessment would enable practitioners to identify the primary driver of the behaviour, and only if it is driven by a mental health condition could longer term detention and treatment under section 3 be sought.

Finally, in response to the Independent Review's comments about community provision, the white paper proposes a new statutory duty to collaborate for health and social care providers to ensure a sufficient supply of community based support and treatment for people with learning disability or autism, to avoid admission into hospital and facilitate discharge into the community.

Children and young people

The Act does not have age limits and the proposals in the white paper would apply to children and young people who may be subject to the Act. This includes the range of strengthened supports and safeguards, such as the

40 CQC, CQC inspections and regulation of Whorlton Hall 2015-2019: an independent review, 18 March 2020.

41 The Guardian, "Essex hospital where staff abused patients was warned by CQC", 24 September 2020

42 Commons Library briefing CBP-07058, Support for people with a learning disability

43 Department of Health and Social Care, Modernising the Mental Health Act – final report from the independent review, 6 December 2018, p183

provisions for advance choice documents, the nominated person, and statutory care and treatment plans.

The Independent Review highlighted the need to reform the current legislative arrangements for children and young people due to its complexity and overlapping legal frameworks (including the Children Act 1989 and the Mental Capacity Act 2005, which applies to those over the age of 16).

The white paper recognises that the law in this area is complex but is not proposing any major legal changes targeted specifically at this group. Instead it recommends making improvements to guidance to assist professionals, young patients and their parents/carers.

Further information on children and young people is available in the Library briefing on Children and young people's mental health – policy, CAMHS services, funding and education.[44]

Interface with the Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a legal framework to make decisions, including treatment decisions, for or on behalf of someone else who lacks the relevant capacity to make that decision.[45]

Where an adult (over 18 years) is deprived of their liberty, the Mental Capacity Act's Deprivation of Liberty Safeguards (DoLS) can be used to protect the rights of that person in a hospital or care home. In some cases, where a person has a mental disorder and lacks the relevant capacity, professionals may need to consider whether the person should be detained under the Mental Health Act or made subject to a DoLS.

The DoLS are due to be replaced in 2022 with a new system of Liberty Protection Safeguards (LPS) that will apply to people over the age of 16. Further information on the DoLS and new LPS is available in the Library briefings, Deprivation of Liberty Safeguards[46] and Implementing the Mental Capacity (Amendment) Act 2019.[47]

The King's Fund research with health and social care practitioners (commissioned by the Department of Health and Social Care) suggests there is a lack of clarity and consistency in how they determine which Act to use.[48] The white paper considers the interface between the different statutory regimes and accepts there are challenges for professionals to navigate

44 Commons Library briefing CBP-7196, Children and young people's mental health – policy, CAMHS services, funding and education

45 Mental Capacity Act 2005, legislation.gov.uk

46 Commons Library briefing CBP-8095, Deprivation of Liberty Safeguards

47 Commons Library briefing CBP-9341, Implementing the Mental Capacity (Amendment) Act 2019

48 The King's Fund, Understanding clinical decision-making at the interface of the Mental Health Act (1983) and the Mental Capacity Act (2005), February 2021.

between the legal frameworks. Accordingly, the Government sought views in the consultation as to where the dividing line between the two Acts should be.

Interface with the criminal justice system

Part III of the Act relates to people who are in contact with the criminal justice system who may need to be admitted to hospital for treatment for a mental disorder. The White Paper includes this group of patients and says the proposals for them will differ in several respects, due to the need to protect the public from those who have been convicted of serious offences. The differences will include:

- The revised criteria for detention will not apply to ensure that those subject to the criminal justice system are still able to access the care and treatment they need;
- Other limits placed on the use of civil powers for individuals with a learning disability and autism will not apply either;
- There will be limits to the powers of the new nominated person for patients detained under Part III;
- There will be limits to tribunal powers and automatic referrals for patients detained under Part III.

Further changes proposed include speeding up the process of transfers from prison or immigration removal centres to hospital under the Act (by introducing a 28-day time limit) and extending the statutory right to independent advocacy to patients awaiting transfer. These changes are designed to facilitate access to treatment and support for this group.

There are also reforms proposed to the provisions for restricted patients detained under Part III. Restricted patients are offenders with a mental disorder who are detained in hospital for treatment and subject to special conditions. The clinician in charge of the patient's care must seek the consent of the Secretary of State for Justice to allow the patient to leave, be discharged or transferred to another hospital.

There will be a new supervised discharge power to authorise a deprivation of liberty for restricted patients that will be reviewed annually by the tribunal. This is designed to "adequately and appropriately manage the risk they pose" in the community. [49] It will only be available to restricted patients and will apply irrespective of their mental capacity. The conditions for the order will be that the patient:

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

[49] Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, p76

2.2 Changes to policy and practice

The Government acknowledges legal reforms must be accompanied by policy and practice changes. Accordingly, the white paper includes a range of initiatives setting out how the Government intends to work in partnership with other bodies and organisations to bring about wider service delivery and cultural change within the mental health system. These changes will support implementation of the new Act and include:

- A quality improvement plan developed in partnership with NHS England and NHS Improvement (NHSE/I) and Health Education England (HEE) to improve ward cultures;
- Working with relevant stakeholders and arm's length bodies to implement new patient safety interventions and programmes, with a focus on improving sexual safety on wards;
- Continuing to work with Mental Health Safety Improvement Plan to reduce the use of restrictive practices in mental health settings and suicide prevention;
- Working with relevant stakeholders to review the guidance and data collection on mixed sex accommodation.
- Consulting on possible expansion and changes to the Care Quality Commission's monitoring role;
- Updating national guidance on the provision of Section 117 after care under the Mental Health Act and exploring what guidance is needed to support care planning and implementing statutory care plans;
- Working with stakeholders on the workforce implications and any national support and training requirements;
- Exploring further modernisation of the Act through digital delivery of processes and procedures;
- Establishing a new national agreement to reduce the use of police custody for persons with mental disorder who may be detained after being removed from a public place to a place of safety under Section 136 of the Act.

2.3 Resource implications: workforce and service delivery

The white paper and accompanying Impact Assessment recognise that there are significant resource implications to the proposals.[50] There are workforce shortages to address, as well as significant gaps in current service provision.

Consequently, the white paper says the law reform proposals will be complemented by a "significant expansion in community provision"[51] and

[50] Department of Health and Social Care, Reforming the Mental Health Act, 24 August 2021, p17

[51] As above, p23

strategies to "transform mental health crisis care",[52] as set out in the NHS Long Term Plan (January 2019). The Long Term Plan includes ambitions for transforming mental health services, with a commitment of an additional £2.3bn of new investment a year by 2023/24.

The white paper acknowledges the reforms will require additional workforce over and above what is to be delivered in the NHS Long Term Plan, which will be challenging for the system to deliver. There are also important commitments to improve staff morale and workforce diversity.

As noted above, an important strand to support legal reform is working with all the organisations involved in the operation of the Act to bring about improvements to the supporting infrastructure and processes, including developing new data collection and digital approaches to streamline service delivery.

The Government intends to work closely with the Welsh Government to consider how the Act currently operates alongside other legislation, mental health services and policy in Wales. Health policy is devolved to Wales and the UK Government will engage with the Welsh Government and other stakeholders to ensure consultation responses are shared to inform policy decisions in Wales.

[52] As above, p105

3 The public consultation and government response

A public consultation on the white paper ran for 14 weeks and closed on 21 April 2021. The Government published the consultation outcome and its response to it on 24 August 2021.[53] It also published the outcome of policy development workshops with service users (led by Rethink Mental Illness and the British Institute of Learning Disabilities) which took place alongside the public consultation. There were over 1,700 responses to the consultation. The Government noted the high level of interest and "overwhelmingly positive response to the proposals."[54] Respondents were broadly supportive of the aims of the reform agenda, the introduction of new guiding principles and proposed changes to the detention criteria, as well as a new Nominated Person role. However, respondents raised concerns about how the reforms will apply to children and young people and the interface between the Mental Health and Mental Capacity Acts. Respondents also noted that some of the proposals are complex and will require further consideration and a stronger evidence base.

Given the high level of support for the reform agenda, the Government has committed to continue to work closely with stakeholders to test and develop policy proposals and work on a Bill to reform the Act.

A revised impact assessment was published alongside the Government's response, and a further iteration is planned alongside the draft Bill.[55]

General Principles

The Government proposed introducing 4 new guiding principles "to drive a more patient-centred system".[56] There was wide support for the principles and embedding them in the Act and Code of Practice. Many respondents suggested the principles should be applied more broadly beyond the Act throughout the mental health (and/or wider health and care) system, to

53 Department of Health and Social Care, Reforming the Mental Health Act: government response, updated 24 August 2021

54 As above, p6

55 Department of Health and Social Care, Reforming the Mental Health Act: government response: Impact Assessment, 15 July 2021

56 Department of Health and Social Care, Reforming the Mental Health Act: government response, updated 24 August 2021, p13

ensure they are more prominent and embedded in practice.[57] Challenging Behaviour Foundation (CBF) and Mencap said:

> 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.[58]

Changes to the detention criteria

Respondents overwhelmingly supported changing the detention criteria to require "therapeutic benefit" but urged caution in defining the concept to guard against potential unintended consequences resulting from the change. On the one hand, some respondents favoured a holistic approach and broad definition, to ensure people receive the help they need with access to a range of therapies. Others supported a narrower definition to guard against unnecessary detentions. Overall, there was wide support for the proposal to amend the definition and respondents commented that the conditions for detention should be set at a high bar.[59]

Care and Treatment Plans

The proposal to introduce statutory Care and Treatment Plans received significant support. Some respondents were keen to see integration of the Care and Treatment Plan with other care planning requirements and felt its scope should be extended to encompass housing and finance arrangements. The Government has committed to work on this aspect of the Bill to ensure the plan considers existing statutory planning requirements, encourages joint working and that there is flexibility regarding the contents. It will also work with stakeholders to ensure there is a realistic governance and implementation structure in place.[60]

Nominated Person

The proposal to replace the Nearest Relative with a new statutory role, known as the Nominated Person, was supported and many respondents also agreed with the proposed additional rights and powers for the Nominated Person. Respondents said this role would provide a better a safeguard, as not all family relationships are good and there may be safeguarding risks from family members. It would also give carers strengthened rights as they have

57 Department of Health and Social Care, Reforming the Mental Health Act: government response, updated 24 August 2021, pp13-15

58 As above, p14

59 As above, pp16-19

60 As above, pp39-42

better knowledge and understanding of the person, their condition, and preferences.[61]

Advocacy

Most respondents agreed/strongly agreed with the proposal to expand the powers of Independent Mental Health Advocates, as it would further empower service users to have their voices heard and preferences respected. Respondents commented that consistent quality and accessibility to advocates is important. Many respondents also agreed that advocacy services could be improved by enhanced accreditation, standards, and regulation.[62]

Advance Choice Documents

Respondents were generally supportive of the scope of Advance Choice Documents (ACD) as set out in the white paper. Respondents suggested including preferences about who should be included and excluded from their care and treatment and to include wider information about the person as an individual. Overall, respondents cautioned against placing too many limits on the content of the ACD and ensuring effective implementation. The Law Society said:

> 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.[63]

The Government recognised these concerns and said it would continue to work with stakeholders to establish what contents are critical, how to overcome practical challenges and align ACDs in the Mental Health Act with advance choice decision making under the Mental Capacity Act 2005.[64]

Tribunal review

Respondents were broadly supportive of the proposals to give patients more rights to challenge detention and ensure that detentions are more frequently scrutinised.[65] However, concerns were expressed about the proposed timelines for different groups of patients, and the impact of the process on patients and the tribunal system. The Government intends to work closely with Her Majesty's Courts and Tribunal Service to carefully plan these changes and "ensure that access to justice is maintained effectively".[66]

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61 Department of Health and Social Care, Reforming the Mental Health Act: government response, updated 24 August 2021, pp53-56

62 As above, pp57-60

63 As above, p38

64 As above, pp33-38

65 As above, pp20-48

66 As above, p23

Refusal of treatment

Just over half of respondents agreed that patients with capacity should have the right to refuse urgent compulsory treatment if it is against their wishes. They commented that it would promote parity of esteem with treatment for physical health, in line with the new guiding principles of choice, autonomy and respect for the individual. However, concerns were expressed by some that it could potentially undermine the principle of therapeutic benefit, as the refusal could impinge on recovery. It could also create ethical challenges by failing to provide the patient with urgent treatment when they are undergoing serious suffering.[67]

Community Treatment Orders

Numerous proposals were set out in the white paper to amend Community Treatment Orders (CTO), although the consultation did not ask specific questions about them. Nevertheless, the Government received written submissions and feedback during the policy workshops about these proposals. Many submissions supported the proposals but expressed concerns about the unintended consequences of plans to reduce time limits and strengthen the evidence for justification for use. Stakeholders agreed on the need for change but remain divided about the use of CTOs. The Government confirmed it was committed to reforming CTOs and believes the proposals will limit their use.[68]

Caring for patients in the Criminal Justice System

The consultation responses largely favoured the proposed changes to mental health care for patients in contact with the Criminal Justice System (CJS). However, an overarching theme was the need to improve mental health detection and support within the prison setting, alongside the proposed reforms to transfers and supported discharges.

There were also calls for more detailed guidance on the proposals, such as redefining the role of the social supervisor. The Government plans to take forward its proposed reforms and consider updating relevant guidance.[69]

People with a learning disability and autistic people

Respondents agreed that the Mental Health Act is not a suitable framework for people with a learning disability and people on the autistic spectrum who do not have a mental health condition. There was support for the proposals to change the detention criteria under Section 2 and 3 of the Act. However, respondents also said this group should be treated in the community where

67 Department of Health and Social Care, Reforming the Mental Health Act: government response, updated 24 August 2021, pp43-45

68 As above, pp107-110

69 As above, pp68-78

possible and strongly agreed with a new statutory duty on local commissioners (local authority and NHS).

There was less support for limiting the scope of the changes to detention criteria to civil patients only. There was widespread agreement among respondents that the CJS is not equipped to support neurodivergent people and some respondents said the Mental Health Act should be used to divert them into health services. However, others felt that the proposed changes should be applied equally across society. Prison Reform Trust said:

> 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.[70]

In response to these concerns, the Government said it will establish an expert group to explore the matter further. [71] HM Inspectorate of Prisons and Probation have recently concluded a call for evidence and published a report on neurodiversity in the CJS.[72]

The role of the Care Quality Commission

Respondents, including NHS Providers,[73] felt that extending the Care Quality Commission's (CQC) monitoring powers would enable it to investigate system-wide barriers to quality care, such as how well services work with each other. There were also suggestions that the CQC could hold services accountable for the quality of proposed reforms, such as statutory Care and Treatment Plans.

Some respondents said that before extending its powers, improvements first need to be made to current CQC practices, including improving the CQC's relationship with providers and its monitoring procedures.

The Government said it will continue to explore changes to the CQC in line with the broader changes being considered under the Health and Care Bill 2021-22.[74]

Mental Health Act and Mental Capacity Act interface

The Government's proposal to create a clearer legislative divide between when to use the Mental Health Act or Mental Capacity Act 2005 was not met with widespread support. Some respondents and key stakeholders did not agree that a patient's objection to detention or treatment should be the basis

70 Department of Health and Social Care, Reforming the Mental Health Act: government response, updated 24 August 2021, p89

71 As above, pp83-104

72 HM Inspectorate of Prisons, Neurodiversity in the criminal justice system, 15 July 2021

73 Department of Health and Social Care, Reforming the Mental Health Act: government response, 24 August 2021, p89

74 As above, pp104-16

for the decision on which Act to use. There were also concerns that the Mental Capacity Act 2005 does not offer the same safeguards and rights as the Mental Health Act.

Respondents said the current interface allows decision makers to choose the most suitable route for the patient's circumstances. However, respondents felt this could be improved with more training and guidance for practitioners.

Mind said:

> 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.[75]

The Government said it had decided not to take forward this proposal at present and plans to review the interface after the implementation of the new Liberty Protection Safeguards, which will replace the Deprivation of Liberty Safeguards, by virtue of the Mental Capacity (Amendment) Act 2019.[76]

[75] Department of Health and Social Care, Reforming the Mental Health Act: government response, 24 August 2021, p64

[76] As above, pp61-64. See Commons Library briefing CBP-9341, Implementing the Mental Capacity (Amendment) Act 2019

4 Mental Health Act Reform Bill

The Secretary of State for Health and Social Care, Sajid Javid, wrote to Jeremy Hunt, Chair of the Health and Social Care Committee in February 2022 to confirm the Government's intention to legislate to reform the Mental Health Act. In the letter, he said:

> We will be seeking changes to the Mental Health Act to empower individuals to shape their own care and treatment, providing them with greater choice and influence over their care. We want to improve the Act so that it works to ensure patients receive therapeutic benefit when made to stay in hospital for their mental health. We will also restrict the use of the Act for people with a learning disability and autistic people.[77]

The Queen's Speech in May 2022 included an announcement on draft legislation to reform the Mental Health Act.[78] The briefing notes to the speech stated:

> These are once in a generation reforms to bring the Mental Health Act into the 21st century and give people greater control over their treatment and receive the dignity and respect they deserve.[79]

Initial responses to the announcement of the Draft Bill from mental health charities and stakeholder groups have welcomed the coming changes.[80]

The draft Bill will be subject to pre-legislative scrutiny before it is introduced in Parliament.

77 Rt Hon Sajid Javid MP, Letter to Health and Social Care Committee, 25 February 2022

78 Prime Minister's Office, Queen's Speech 2022, 10 May 2022

79 Prime Minister's Office, Queen's Speech 2022: background briefing notes, 10 May 2022

80 See Mind, Mind responds to Queen's Speech with comments on Mental Health Bill, Conversion 'therapy' ban, Human Rights Act reform, and lack of Employment Bill, 10 May 2022; Mencap Press Release, "Reforms to the Mental Health Act are a vital step in protecting human rights" - Mencap responds to the Queen's Speech, 10 May 2022; Royal College of Psychiatrists, Royal College of Psychiatrists responds to the Queen's speech, 11 May 2022.

5 Further resources

Responses by charitable, professional and health organisations to the reform proposals online include:

Care Quality Commission, Dr Kevin Cleary responds to the Reforming the Mental Health Act White Paper, 26 March 2021

Mental Health Foundation, The Mental Health Foundation's statement on the Reforming the Mental Health Act White Paper, 26 March 2021

MIND, Mental Health Act Review, 26 March 2021

NHS Providers, Reforming the Mental Health Act is more important than ever, 26 March 2021

Rethink Mental Illness, The Mental Health Act White Paper: a big step towards change, 26 March 2021

Royal College of Psychiatrists, Reform of the Mental Health Act in England and Wales, 26 March 2021

SANE, SANE comment on reforming the Mental Health Act ,26 March 2021

Turning Point, Turning Point responds to the publication of the Mental Health Act White Paper, 26 March 2021

See also related documents:

The NHS Long Term Plan, 26 March 2021

The Five Year Forward View for Mental Health, 26 March 2021

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