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Reforming the Mental Health Act

Summary of Government's Response to Reforming the Mental Health Act – July 2021

Chapter	Question	Next Steps
1. Guiding Principles	Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?	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	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. 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 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	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	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	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.	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 statue 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	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.	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	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.	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	We asked if you have any other suggestions on what should be included in a person's advance choice document.	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.
	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.	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	We asked if you have any other suggestions for what should be included in a person's Care and Treatment Plan.	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 patient's right to choose and refuse treatment - Refusal of treatment for those with capacity	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.	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 patient's right to choose and refuse treatment - A new right to challenge a treatment decision at the Tribunal	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.	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	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	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

	MHA Code of Practice to make clear the availability of this right to individuals, and to provide an explanation for your view. 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?	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	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. 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').	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	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. 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.	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	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.	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	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	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.

	• 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	
16. Caring for patients in the Criminal Justice System - Independent role to oversee secure transfers from prison and immigration removal centres (IRCs)	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)	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	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.	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	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. We also proposed that a supervised discharge order for this group of patients would be subject	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

	to annual Tribunal review. Do you agree or disagree with the proposed safeguard? Beyond this, what further safeguards do you think are required?	• 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	We asked you how do you think the role of social supervisor could be strengthened.	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	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. 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.	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	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.	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	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. 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.	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	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.	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	We asked you whether you agree or disagree with the proposal to create a new duty on local	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

– Duties on local commissioners	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. 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.	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	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.	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	We asked you how could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers.	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)	No consultation questions asked.	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	Based on consensus, post Devon Partnership, the presence of professionals in the room is required so the Government will not be seeking to amend the Act to allow for the use of remote assessments.
29. Section 117	Proposals are being developed in close liaison with Local Govt and NHS E/I to make it more straightforward to establish which area is responsible for the aftercare, particularly in more complicated personal histories, which have included out of area placements.
30. Impact Assessment	

Get in touch

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