21 November 2024

Mental Health Bill 2025

House of Lords, Second Reading, 25 November

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in England in voluntary membership, collectively accounting for £124bn of annual expenditure and employing 1.5 million people.

Our briefing covers the following areas of concern:

1) Learning disabilities and autism
2) Distinction between Parts 2 and 3 of the Act
3) Children and young people
4) Addressing racial disparities
5) Implementation
6) Nominated person
7) Mental Capacity Act
8) Transfers from prison to hospital
9) Hospital managers
10) Non-legislative programmes to improve patient safety and quality

Please contact publicaffairs@nhsproviders.org if you would like any further information.

Key points

- We welcome the publication of the Mental Health Bill and look forward to the government passing this legislation and taking the necessary, broader steps required to improve how and where people from all backgrounds access high quality mental health and care services.
- We support proposals to simplify the Mental Health Act 1983 (MHA) and make changes that maintain appropriate safeguards, while enabling greater individual rights and liberties and service users to have a more active role in their care planning with a focus on recovery. Putting patients at the heart of how they access care and treatment is vital to high quality care. Good practice needs to be shared, and its implementation supported, in a systematic and coordinated way.

- However, reform of the MHA alone will not be enough to improve how and where good quality mental health services are accessed. We welcomed the acknowledgement of this in the 2021 white paper and the paper's further proposals, as well as planned and ongoing work, to reform policy and practice more broadly.
- The proposed reforms will require additional funding and expansion of the workforce, over and above current commitments. Sufficient funding and investment in mental health services are crucial to addressing the underlying issues driving the pressures on services and compounding the rising severity and complexity of people's needs. Longstanding system and financial pressures on providers, combined with inconsistent investment in mental health services at local levels, continue to exacerbate bed capacity pressures and increase the likelihood that a person may reach a crisis point and need to be detained under the MHA.
- Full funding, on a sustainable basis, of the expansion of community-based specialist mental health, learning disability and autism care capacity is required to meet the demand for services and to ensure these services meet the needs of their local populations. We know this investment is key to reducing the need to detain under the MHA and providing the most appropriate, high quality care in the least restrictive setting.
- Adequate investment to maintain and build on the steps being taken to grow the mental health, learning disability and autism workforce, and the sector receiving its fair share of capital funding, are both also crucial. Public health and social care also need additional support given the crucial role these services play in providing people with the wider care and support they need and helping many avoid reaching a crisis point.
- We welcome the engagement on the Bill to date, and look forward to continuing to work with parliamentarians and the government to ensure the impact of reforms on the system is fully understood and a robust and achievable plan for implementation is developed.

Areas for further consideration

1) Learning disabilities and autism

Safeguarding considerations and unintended consequences

We support the principle of the provisions in clause 3 that change how people with a learning disability or autistic people are treated under the MHA. Changing the Act to make it clear someone with a learning disability or an autistic person will not be detained unless they also have a mental illness is a long overdue step.

However, a concern has been raised by a number of trusts that an unintended consequence of the proposed changes might be these groups of individuals staying in hospital for long periods of time but held under the Mental Capacity Act, which will provide them with fewer legal safeguards. Trusts have also highlighted patients with a learning disability and autistic people not being subject to section 3 would impact section 117 aftercare and potentially make finding community placements more complicated than it is currently. Trusts have highlighted, with respect to clause 4, section 125B, that there can be difficulties with determining within 28 days whether a person's challenging behaviour is due to a mental illness or social and/or environmental factors, given the complex inter-relationship of biological, psychological and social factors in a patient's condition. This is especially true for many clinical presentations that meet the criteria for detention under the Mental Health Act.

Trusts are also concerned that by prohibiting detention beyond 28 days in Part 2 settings, as per clause 4, section 125B, but retaining the option of long-term detention in Part 3 settings, the proposed changes might have the unintended consequence of driving individuals into the criminal justice system or lead to increased use of medication in the community. Trusts have concerns that these proposals presuppose that patients detained under Part 3 are inherently more risky than patients detained under Part 2, which is not necessarily the case.

More broadly, trusts are concerned at the creation of two very differently described Acts, depending on whether the patient has come via a civil or forensic route. This is a particular concern given the potential vulnerabilities of people with a learning disability and autistic people and we should be mindful they may have entered the criminal justice system as a consequence of inequalities in access to care and support at an earlier stage. The Care Quality Commission (CQC) has previously found that opportunities were missed early in the lives of people with a learning disability and autistic people to prevent their admission to hospital and the 'system of care' for these groups of individuals is not fit for purpose.

Risk registers and community provision

We welcome, via clause 4, section 125D, the introduction of a duty on integrated care boards (ICBs) to establish and maintain a register of people the ICB considers to be autistic or have a learning disability and who are at risk of detention under Part 2 of the 1983 Act. Trusts would welcome clarity on how the government envisages local registers being resourced, supported and monitored.

We also welcome the new provision in clause 4, section 125E that ICBs and local authorities must have regard to the information on the register when fulfilling their commissioning functions, and would add

the importance of improving funding mechanisms and transparency. Greater transparency would help ensure that funding reaches frontline services and people with a learning disability and autistic people, and is invested in establishing the full range of high-quality services needed. Prioritising the NHS long term plan's ambition to give people a personal health budget where possible, with the appropriate governance and safeguards, is also important so that funding follows service users and the bespoke packages of care required can be created.

Care, education and treatment reviews (CETRs)

We support in principle clause 4, section 125A. 125B and 125C placing duties on the responsible commissioner to make arrangements for ensuring CETR review meetings take place and key bodies and individuals to have regard to the recommendations arising from these reviews. A common theme that emerged from our conversations with trust leaders about the features of high-quality care for people with learning disability and autistic people is, if inpatient care is required, it should be specialist, short-term and focused on people's return to recovery, supported by high-quality, robust and regular care and treatment reviews. Our report highlighted one trust's work to establish new teams and services to help ensure rigorous, frequent care and treatment reviews take place.

2) Distinction between Parts 2 and 3 of the Act

Part 2 of the Act concerns patients who are detained in hospital but have no criminal proceedings against them. Part 3 of the Act, concerns patients that have been involved in criminal proceedings. We are concerned that the proposed distinction between Parts 2 and 3 of a reformed Act in relation to the detention criteria as set out in clause 5 may cause some confusion: it is not necessarily the case that patients detained under Part 3 of the Act are inherently more risky than patients detained under Part 2. The proposal to tighten Part 2 criteria may also risk inadvertently pushing people into the criminal justice system, as well as potentially raising the access threshold, with people who are a significant risk to themselves or others needing to be more acutely unwell in order to access care and treatment. Trusts have raised particular concerns that as forensic services provide care for people under Part 2 and Part 3 of the 1983 Act, they will be required to operate under two different criteria for detention.

We need to ensure that people who may be slowly deteriorating at home, but not posing any obvious significant risk in the short term, are able to access care and support that meets their needs as soon as possible. This is about investing in community-based mental health support, including crisis care, which is delivered in a way that meets the needs of local populations, and particularly those groups of individuals who have been historically under-served. We must also address the

underlying issues driving the pressures on services and the rising severity and complexity of people's needs at the point at which they present to services.

Trusts have also told us that the inequitable arrangements for patients in the criminal justice system compared with others assessed under the 1983 Act is a key issue for reform. Trusts have expressed support for equivalence of care for restricted patients and those in the community; shortening timescales from assessment to hospital admission; and making return to custody easier.

Trusts have highlighted the importance of monitoring whether there are more adverse outcomes following assessments under the reformed Act that do not result in detention and taking this fully into account when incidents are investigated or reviewed.

3) Children and young people

Trusts are keen to ensure reform of the 1983 Act considers the impact on children and young people alongside that on adults. We broadly welcome proposals that all legislative changes will be available to children and young people, and that care and treatment plans are provided to all children and young people receiving inpatient mental health care. Trusts have stressed the importance of taking into account recent case law regarding parental consent, and that robust guidance is required regarding the appointment of a nominated person (clause 23) for children under the age of 16.

There are also broader key issues here that need to be addressed, including: shortfalls in child and adolescent mental health services (CAMHS); increasing demand for mental health services and support for children and young people; lack of access to specialist CAMHS Tier 4 beds; and often protracted waits for children and young people in suboptimal areas in general hospitals. These issues are worsening, and trust leaders are clear that the need to prioritise children and young people and for a more effective model of care for children and young people is greater than ever.

4) Addressing racial disparities

The inequalities in experiences of people from black, Asian and minority ethnic backgrounds is a significant source of concern for trust leaders, and we welcome steps to address these within the reforms. Trust leaders recognise the importance of culturally competent advocacy for detained patients and have stressed the importance of building on the learning from pilot schemes and having access to appropriate funding and resources in order to deliver in practice. There is a need more broadly for investment and additional training to deliver the expanded role proposed for independent mental health advocates (IMHAs) (clause 38), and address the variation in advocacy services more

broadly. Drawing a clear distinction between IMHAs and the role of the legal representative has also been raised by trusts as important.

One trust leader had also previously suggested that the Bill should include a previous proposal to time-limit or remove Community Treatment Orders (CTOs) from statute to help tackle black, Asian and minority ethnic patients being disproportionately treated via CTOs. More broadly, it will be important for the government to monitor the effects of changes to CTOs, particularly the impact of increasing evidence requirements (clause 6 and clause 22).

Advance choice documents

The Bill's introduction of duties in clause 42 on ICBs to arrange for people at risk of detention to be informed of their ability to make an advance choice document, and (if they accept) supported to make one is a welcome update, particularly in light of research showing this type of measure reduces detentions for black people, and is also most cost effective for this group compared to those of other ethnic backgrounds. However, we would welcome further clarity to understand how this would work in practice, for example, how will those at risk of detention be effectively and equitably identified.

Previous questions trusts have raised regarding advance choice documents we would welcome further engagement with the government on when the code of practice is developed include, what their obligation would be to accept a patient in situations where they had not been involved in developing the advance choice document. We have also stressed previously the importance of making sure the language used in matters regarding advance decision making is consistent (e.g. with the Mental Capacity Act and National Institute for Health and Care Excellence [NICE] guidelines and quality standards) to ensure clarity for service users and clinical staff. Consistency will also provide stronger safeguards and protection from misuse: advance decision-making options are supported by quality standards for which compliance can be audited.

Broader action

We know there is more that needs to be done beyond changes to legislation to tackle racial disparities. During the development of proposals for the draft Bill, the government rightly emphasised that a targeted, multipronged approach is crucial to improving people from black, Asian and minority ethnic backgrounds' experience, care and treatment under the Act, as well as their earlier interactions with the mental health system more broadly. We need to see sustained support for local health systems to better address inequalities in access, experience and outcomes of mental healthcare.

Trusts have also told us they would welcome national support to take effective action on race equality by providing challenge, sharing best practice resources and holding boards to account.

Trust leaders agree that more must be done to tackle structural racism, bias and discrimination and they are committed to doing all they can to address systemic inequality. They have also emphasised the need to consider wider inequalities experienced by the communities they serve, including in housing, employment, public health and other areas that have a profound effect on life chances and mental health.

5) Implementation

Workforce

The previous government acknowledged that reforming the Act will require an expansion of the workforce, over and above commitments in the NHS Mental Health Implementation Plan 2019/20 – 2023/24. We must see the implementation of the NHS Long Term Workforce Plan (LTWP), which must be fully funded and delivered. The LTWP is due its first update in summer 2025, providing a window of opportunity to address existing concerns and ensure it aligns with, and will fully support the delivery of, the reformed Mental Health Act and reforms to wider policy and practice planned for and underway in the mental health sector.

Trusts have told us there will be a significant impact on their multidisciplinary teams across all services, particularly because of the significant increase in tribunal activity. Even if the proposed changes (via clause 3 and clause 5) to section 3 admissions result in shorter periods of detention, the overall throughput of admissions is unlikely to reduce so tribunals will become a much more common feature of life in acute wards which will need to be resourced accordingly for the requirements to be workable.

More broadly, despite growth in the mental health workforce in recent years, there remain significant shortfalls in both the number and skill mix of staff. The number of mental health nurses has only recently (2023- 24) returned to 2009-10 levels. It is important to emphasise that staff with the right skills in the right place are just as important as an increase in the number of staff: effective mental health services depend on multi-disciplinary teams with the right levels of expertise, skills and experience to meet individuals' care and treatment needs. Half of trusts leaders have told us they are worried or very worried (50%) about whether their trust has the right numbers, quality and mix of staff to deliver high quality health care.

Focus is also needed on retention and making the NHS a great place to work, alongside ensuring compassionate, courageous and inclusive leadership at all levels. Capital investment to make inpatient and community mental health settings better places to work would also help with staff morale, recruitment and retention.

Funding

The proposals set out in the Bill will require additional funding over and above current commitments. Funding will be needed for training to enable compliance with a new Act, as well as to deliver specific proposals, for example expanding and improving advocacy services (clause 38), making them culturally competent, and removing police stations as designated places of safety (clause 46). Additional, sustained funding for community-based specialist care will also be crucial to mitigating the potential unintended consequences of some proposals. For example, caring for people who will not meet the new criteria for detention (clause 5), and in particular specific vulnerable groups of individuals such as people with learning disability and autistic people (clause 3). All changes to the Act and associated regulations and guidance that will result in increased costs to providers need to be fully and promptly funded, on a sustainable basis, to ensure that they can be appropriately taken forward.

Mental health trusts also need capital investment, allocated quickly, fairly and transparently. Mental health services are being delivered in some of the oldest parts of the NHS estate and, in many instances, the sector has lacked the investment in modernisation and development available to other parts of the NHS despite best practice for mental health care having progressed significantly in recent years. Mental health trust leaders have highlighted how poor physical environments uniquely affects the rehabilitation and recovery of people using mental health services, given they are often accessing services at their most vulnerable and typically stay for longer than patients in other types of services. Having a high-quality physical environment is also important for staff morale and patient safety: large wards create a cramped and noisy environment and impact on staff's ability to support patients safely.

Funding and investment are also fundamental to addressing the underlying issues driving the pressures on services and compounding the rising severity and complexity of people's needs. Longstanding pressures on providers, combined with inconsistent investment in mental health services at local levels, continue to exacerbate capacity pressures and increase the likelihood that a person may reach crisis point necessitating use of the Act to admit. There must also be increased

support for public health and social care given the vital role these services play in providing people with the wider care and support they need and helping many avoid reaching crisis point.

Data and digital

There is a need for better data collection and quality to ensure a clear understanding of mental health activity, access and outcomes, and in turn enable better and more equitable commissioning and delivery of services. The scale of unmet need for mental health services is still not fully understood; prevalence data for mental ill health among adults in England is from 2014. Investment in the skills required to analyse and act on population-based trends is also needed.

The digital fundamentals also need to be in place for trusts, for example, strong digital infrastructure (e.g. reliable wi-fi) and effective electronic patient record systems and shared care records to help staff deliver safer care, improve patient and staff experience and enable data-driven decision making. A broader approach needs to be taken to digital funding, with clarity provided to trusts about how they can expect to make longer term, sustainable investments in digital ways of working, that recognises both the revenue and capital implications. Trust leaders themselves will be best placed to make investment decisions.

Implementation plan, monitoring and reporting

We welcomed the previous government's commitment to working with the sector to understand the impact of reform and to develop a robust and achievable plan for implementation. It is right to recognise that other demands placed on the system, and the capacity of health and care staff to deliver what is required, need to be carefully considered as this work progresses. During the passage of the bill it would be worth debating whether or not the government should report annually on progress to implement the reformed Mental Health Act and on the impact of the reforms. This would have the benefit of being able to track progress on implementation and impact but does risk creating additional reporting burdens and duplicating the existing monitoring powers of the CQC.

It will be important for the government to prioritise decisions around funding and required changes to data monitoring and national documentation, and provide that clarity to trusts as early as possible. This is vital to assisting the preparations trusts will need to make, and the consistency of recording, data monitoring and reporting on the use of the Act, as well as implementation of reform more broadly going forwards.

Discharge and after care

Trusts having enough staff with the right mix of skills, experience and expertise is critical to delivering the new proposal (clause 32) requiring the Responsible Clinician to consult another professional from another discipline involved in a patient's care before taking the decision to discharge in an effective and timely way. Adequate resources for ICBs and local authorities to be able to provide aftercare services as recommended by the Tribunal is also vital.

For some people, especially those who have complex needs, there is often very limited appropriate out of hospital provision to discharge to. We also understand housing is one of the main reasons for delayed discharges from mental health services nationally, although this varies at regional level. Partnership working, alongside sufficient provision of the right out-of-hospital services, is key to successfully discharging individuals and avoiding inappropriate readmissions.

In supporting patients who will not meet the criteria for detention (clause 5) under a reformed Act and when using least restrictive approaches, trusts have highlighted that there will be a particular need for improved collaborative working with community partners and multi specialist agencies. This will help to ensure referral pathways back into community providers and safety plans are clear, robust and effective.

6) Nominated person

We support updating the nearest relative provisions and, broadly, the proposed additional powers of the nominated person (clauses 23, 24, 25, 26, 27). However, trust leaders have highlighted to us that the proposals are not straightforward and they may not be able to meet all of the new requirements due to the complexity of the arrangements – which appear even more complicated for those under 18 – and resources for delivering these arrangements are potentially being underestimated.

Trusts have previously raised concerns that there may be a risk that legislating so that the nominated person's objection to admission can be temporarily overruled, as opposed to them being removed or displaced, might give rise to a need for serial proceedings to overrule every single decision (clause 24). One trust has also said that, while they support moves to maximise the nominated person's participation by consulting them at junctures other than when considering making an application under the Act, the ability to waive this due to non-practicability should be made clearer in the Bill (clause 24, 25, 26 and 27). When revoking or assuming the role of a nominated person, trusts also told us that the direct involvement of an approved mental health professional risks placing an unnecessary strain on their resources (clause 24). They have suggested such matters could be dealt

with via a delegated representative with an obligation to update the local authority on any material change in the patient's circumstances.

Some trusts have also told us previously they anticipate that the mental health tribunal will have a key role to play in making further determinations if a person's choice is potentially inappropriate or harmful (clause 23). Trusts have also highlighted that it will be important to work through who determines what the patient's best interests are if the nominated person is objecting to a CTO (clause 26, section 17AA), and other practical issues, such as how and when people can change their mind regarding who their nominated person is and who should keep track of this. Trusts have also highlighted to us that new duties (clause 24, section 20) for the responsible clinician to consult with the nominated person at the point of the renewal of a detention will also need to be carefully managed to ensure this is a meaningful safeguard.

7) Mental Capacity Act

The lack of clarity around the interface between the MHA and the Mental Capacity Act 2005 has been a longstanding cause for concern for trusts. A number of trusts have previously suggested the demarcation between the two Acts should be based on the nature and purpose of the detention, so that all those being detained in hospital for assessment or treatment for a mental disorder receive MHA safeguards. One trust believed that the existing nuanced case law position would ensure more appropriate options for patients than an unsuitable, artificial simplification.

The previous government planned to assess the impact of Liberty Protection Safeguards (LPS), introduced in the Mental Capacity (Amendment) Act 2019, before introducing reforms to the MHA to ensure that any gaps can be addressed. The current government needs to provide an update on its approach given LPS have yet to be implemented. Trust leaders have stressed the importance of the codes of practice for each Act providing clear guidance and case studies, including flow charts, to assist in practitioners' decision-making regarding which legal framework would be most appropriate.

8) Transfers from prison to hospital

Trust leaders agree with the principle of the 28-day limit on transfers from prison or immigration removal centres to a secure hospital (clause 35), but have highlighted its successful delivery depends on the number of patient beds available, as well as means of transport and the location of a secure hospital. We need to ensure there is enough fit for purpose capacity to provide care and treatment according to legislative requirements in an inpatient setting for people in the criminal justice system who require it.

We welcomed the previous government acknowledging these concerns and clarification that requirements will only commence once NHS England guidance on transfer and remissions has been fully embedded. We also welcomed the previous government committing to producing an action plan for how services will achieve the statutory 28-day deadline: we would welcome this being re-committed to by the current government and stress this needs to be independently assessed as delivered before the 28-day limit is commenced. We would also want the government to monitor and report on delivery and impact.

9) Hospital managers

Trust leaders would welcome clarification in respect of the current hospital managers role and how this will look going forward. While some support the removal of manager panels, their removal needs to happen alongside an increase in tribunal powers and providing adequate resource to tribunals so patients' rights and access to timely reviews are not affected. Previously trust leaders also highlighted there was a need for further clarity regarding hospital managers' discharge powers being used and their role in renewals decisions. More broadly, the government must ensure trusts are resourced to deliver changes and/or additional duties the reformed Act places on hospital managers.

10) Non-legislative programmes to improve patient safety and quality

We welcome ongoing work to bring about a cultural change within mental health services, including through the national quality improvement programme looking specifically at care under the Act to enable and support this system-wide drive for change. This work will need to be sustained and requires additional resources – for example, training for inpatient staff – as well as monitored. The forthcoming refresh of the patient safety strategy also offers an important opportunity to support trusts through training, expertise and resources to fully embed an effective safety culture.

However, we remain concerned that quality of care and patient safety is at increasing risk due to the mismatch between demand for services and the overall funding, capital and workforce available. In NHS Providers State of the Sector report 2024, only 32% of trust leaders predicted that the quality of healthcare provided by their local area in the coming year would be very high (1%) or high (31%). Almost half (48%) said the quality would be average, 12% said low, and 2% said very low. Trusts are working hard to provide high-quality mental health services and manage risks to patient safety – but their ability to do so comes against a backdrop of soaring demand, resource pressures and the poor condition of the mental health estate, much of which isn't fit for purpose.

Finally, we would note that it takes a whole board and whole organisation approach to embed a just culture. Despite progress and commitment from providers, a blame culture arguably still exists within the NHS. Compassionate and inclusive leadership from provider boards remains fundamental in addressing this, but positive behaviours must also be modelled at all levels of the system including by national and regional bodies. Clarity and alignment on what systems and processes support compassionate and inclusive leadership is also crucial.

Further background

NHS Providers has commented extensively on reforming the Mental Health Act 1983 since the government published the Mental Health Act White Paper consultation in 2021.

Our written evidence to date can be found here:

- Written submission to the Joint Committee on the Draft Mental Health Bill (September 2022)
- Written submission to the Department for Health and Social Care on Reforming the Mental Health Act White Paper (April 2021)

Further relevant NHS Providers briefings can be found here:

- Government response to the Joint Committee on the draft Mental Health Bill pp.4-11 (March 2024)
- Joint committee on the Draft Mental Health Bill 2022 report (January 2023)
- Draft Mental Health Bill 2022 (June 2022)
- Care Quality Commission Monitoring the Mental Health Act 2020/21 (February 2022)
- Reforming the Mental Health Act White Paper: Government response to the consultation (June 2021)
- Westminster Hall debate – Reforming the Mental Health Act White Paper (June 2021)
- Reforming the Mental Health Act White Paper (January 2021)