

Briefing on MHA White Paper

February 2021



Context

It is over two years since Professor Sir Simon Wessely delivered his landmark Independent Review of the Mental Health Act. This set out what needs to change in both law and practice in order to deliver a modern mental health service that respects the patient's voice and empowers individuals to shape their own care and treatment. It also made recommendations on how to address the disparities in how the Act affects people from Black and Minority Ethnic minority backgrounds.

The Government has accepted and will take forward the vast majority of its recommendations for change, though there are some departures, including on Intellectual Disability and Autism.

Summary

This brief summarises the key parts of the White Paper, including all consultation questions. The White Paper is structured in three parts. The first part focusses on proposed changes to the MHA legislation. The second details how the Government and the NHS will work, along with other partners, to bring about an overall culture change within mental health services, so that people have a far better experience of care under the Act. The third part is the Government's response to the Wessely Review, which this brief does not tackle.

The White Paper includes 36 consultation questions and sets out the Government's plans for:

- New guiding principles
- Stronger detention criteria
- Giving patients more rights to challenge detention
- Strengthening the patient's right to choose
- Improving the support for people who are detained
- CTOs
- The MHA MCA interface
- Caring for patients in the criminal justice system
- People with Intellectual Disability and Autism
- Children and Young People
- The experiences of people from BAME communities

PART 1: Proposals for reform of the Mental Health Act

1. New guiding principles

The White Paper sets out four guiding principles for the MHA, aiming to 'drive a more person-centred system, in which the choices made by patients have weight and influence, where care must have a therapeutic benefit for the patient, and where the powers of the Act are only used when absolutely necessary':

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

Also set out is the way in which the Government hope to embed these principles in the Act:

- **Choice and autonomy:** Service users' views and choices will be represented in Advance Choice Documents and through their involvement in Care and Treatment Plans, and through enhanced opportunities to challenge treatment decisions.
- **Least restriction:** Ensuring the Act's powers are used in the least restrictive way, by strengthening and clarifying the criteria that must be satisfied before a person is detained and treated.
- **Therapeutic benefit:** Supporting patients to get better, so they can be discharged from the Act, and that therapeutic benefit is a requirement of detention.
- **The person as an individual:** Treating patients as rounded individuals, supported by enhanced rights to Independent Mental Health Advocates, and through a Patient and Carer Race Equality Framework (PCREF) with the goal of improving access, experience and outcomes for people from black, Asian and minority ethnic backgrounds.

Consultation question 1:

We propose embedding the principles in the MHA and the MHA code of practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?

Your answer can be up to 500 words.

2. Clearer, stronger detention criteria

In the context of rising rates of detention that led to commissioning of the Wessely Review, the White Paper sets out how the Government will revise, strengthen and clarify the detention criteria to ensure that, in the future, detention only takes place when it is absolutely appropriate. This is delivered through two principles:

- i. Therapeutic benefit** - greater consideration must be given to whether, and if so how, detention and interventions provided under the Act are or would be beneficial to a person's health and recovery
- ii. Least restriction/ Substantial likelihood of significant harm** - ensuring a person is only detained where it is absolutely necessary, where not detaining poses a substantial risk of significant harm being caused to themselves or others

Therapeutic benefit

Currently, the Act states that detention should be "necessary for the health or safety of the patient" and that "appropriate medical treatment is available", neither of which expressly provides for a requirement that the patient should benefit from the treatment allowed for by the detention. Proposed to amend the detention criteria in section 3 of the Act, and elsewhere, to more clearly stipulate that in order for someone to be detained, it must be demonstrated that:

- The purpose of care and treatment is to bring about a therapeutic benefit
- Care and treatment cannot be delivered to the individual without their detention
- Appropriate care and treatment is available.

Decisions about when and whether to discharge a patient should also include an assessment about whether the hospital or an alternative community setting provides the most therapeutic package of care. The presumption should always be that care is delivered in the least restrictive setting possible.

Least restriction/ Substantial likelihood of significant harm

Proposed to amend the detention criteria for sections 2 and 3 of the Act, and elsewhere, to clearly stipulate that in order for someone to be detained, it must be demonstrated that:

- There is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person.

This is in order to make it harder to detain people in a way that is more in keeping with the gravity of the removal of their liberty.

Applying the new detention criteria

The new detention criteria will apply when detaining an individual under sections 2 and 3 of the Act, and when using a CTO. No proposal to change the criteria for detention under Part III of the Act (nor was this proposed by the Review).

Consultation question 2:

We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 2a:

Please give reasons for your answer (up to 500 words).

Consultation question 3:

We also want 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. Do you agree or disagree with this change?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 3a:

Please give reasons for your answer (up to 500 words).

3. Giving patients more rights to challenge detention

More frequent review of the case for detention

For patients under section 3 of the Act, proposal for their detention to be reviewed to assess whether it is still justified three times within the first year, as opposed to current policy and practice which states this needs to happen just two times.

Greater access to the Mental Health Tribunal so detention can be scrutinised

Proposal to extend 14-day time limit on patients detained under section 2 of the Act, making an application for discharge to the Tribunal to 21 days, to give patients (or their representative) greater

opportunity to appeal their detention. Whilst allowing enough time (seven days) for the hearing to take place before the section expires, after which the patient must be discharged or transferred to section 3 of the Act.

Proposal to increase opportunities for patients detained under section 3 of the Act, to appeal to the Tribunal in the first 12 months of detention, to three (up from the current two).

Proposal to create a new statutory power for Independent Mental Health Advocates (IMHAs) to apply to the Tribunal to challenge the patient's detention on their behalf. This will be in addition to the Nominated Person who can also apply to the Tribunal in certain circumstances, in line with the current powers of the Nearest Relative.

As part of its assessment of whether the detention continues to be justified, the Tribunal will take into consideration the new statutory Care and Treatment Plan, which will set the Responsible Clinician's justification as to why the patient continues to meet the detention criteria. As the Tribunal is a judicial body, rather than a clinical body, the tribunal will not comment or rule on the specific details of the plan or the treatments being provided, as part of applications for discharge, but will be able to consider the strength of evidence set out that the patient continues to meet the detention criteria.

Automatic referral to the Tribunal

Where a patient (or their NR or IMHA) does not request a Tribunal, the Government is considering increasing how frequently patients are automatically referred to the Tribunal. Increasing the frequency of automatic referrals to the Tribunal, as recommended by the Review, would ensure that detentions under the Act are more regularly scrutinised but will also place additional demand on the Tribunal. The White Paper asks the following question to help it make this decision:

Consultation question 4:

Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal (see [table 1](#) for details)?

1) Patients on a section 3

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

2) Patients on a community treatment order (CTO)

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

3) Patients subject to part 3

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

4) Patients on a conditional discharge

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 4a:

Please give reasons for your answer (up to 500 words).

Table 1 – Frequency of automatic referrals - Current and future proposals

Patient Group	Current system	Proposed system
Patients subject to section 3	<p>Referral 6 months after the detention started, if the Tribunal has not considered the case in the first 6 months (e.g. if the patient had not made an appeal).</p> <p>Following that, referral takes place if more than 3 years have elapsed since the case was last considered by the Tribunal.</p> <p>Or, if the patient is under the age of 18, the case is referred to the Tribunal annually.</p>	<p>Referral would instead take place 4 months after the detention started, if the Tribunal has not considered the case in the first 4 months.</p> <p>Thereafter, referral would take place 12 months after the detention started, if the Tribunal has not considered the case in the intervening months.</p> <p>After the first 12 months of detention, referral would take place annually.</p>
Patients on a CTO	<p>During the CTO, referral takes place 6 months after their detention began, so long as the Tribunal has not considered the case in the first 6 months.</p> <p>Following that, referral takes place if more than 3 years (or 1 year in the case of a patient under 18) have elapsed since the case was last considered by the Tribunal.</p> <p>If the CTO is revoked, referral to the tribunal takes place as soon as possible after that point.</p>	<p>Referral would take place 6 months after the patient was put on the CTO, if the Tribunal has not considered the case in the first 6 months.</p> <p>However, thereafter, referral would take place 12 months after the patient was put on the CTO, if the Tribunal has not considered the case in the intervening months.</p> <p>After the first 12 months of detention, referral would take place annually.</p>
Patients subject to Part III	Referral takes place if the Tribunal has not considered the patient's case in the last 3 years.	Every 12 months.
Patients on a Conditional Discharge (restricted, part III patients only)	These patients have no right to an automatic referral.	<p>Referral would take place 24 months following receipt of the conditional discharge by the patient.</p> <p>Thereafter, referral would take place every 4 years.</p>

Removing the Tribunal's role when revoking CTOs

Proposal to remove the automatic referral to a Tribunal when a CTO is revoked.

Consultation question 5:

We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 5a:

Please give reasons for your answer (up to 500 words).

Giving the Tribunal more power to grant leave, transfers and community services

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Proposal to extend the role of the Tribunal, when considering applications for discharge, to give it the power to grant leave, transfer patients, for example to a less secure hospital, and to direct services in the community.

Proposal that there should be an obligation in legislation on health and Local Authorities to take all reasonable steps to follow the Tribunal's decision. If the authority is not able to give effect to the Tribunals' decision, it must provide an explanation to the Tribunal, setting out the steps it took and why it was not possible to follow the decision.

These powers would only apply for patients who are not subject to restriction orders (unrestricted patients) and would only be considered as part of an appeal for discharge. Patients will not be able to appeal directly to the tribunal to be granted leave or transfer.

It is acknowledged that there are practical implications to implementing this recommendation. For example, if the Tribunal grants the transfer of a patient to a hospital in a different location or with a lower level of security, bed availability may mean it is not possible to give effect to the transfer immediately. It is therefore proposed that healthcare bodies and Local Authorities should be given a period of five weeks to take reasonable steps to deliver the Tribunal's direction and to respond to the Tribunal if they are unable to give effect to the direction.

Consultation question 6:

We want to give the Mental Health Tribunal more power to grant leave, transfers and **community services**.

We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 6a:

Please give reasons for your answer (up to 500 words).

Hospital managers' hearings

The Review recommended removing the role of the managers' panel in discharging patients, based on concerns around the effectiveness of this safeguard and the lack of formality surrounding panel hearings. The Government agrees that the Tribunal is better placed to assess whether a patient continues to meet the criteria for detention but has heard mixed views from stakeholders on the effectiveness of managers' hearings, with some Trusts reporting to us that the managers' panel provides an effective means of identifying when a patient is ready for discharge. The Government therefore wishes to consult on this issue prior to taking a final decision on whether or not to remove the hospital manager hearing.

Consultation question 7:

Do 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?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 7a:

Please give reasons for your answer (up to 500 words).

4. Strengthening the patient's right to choose and refuse treatment

To ensure that patients can specify what they want and have their voice will be heard and respected and that they will have the opportunity to challenge when it is not, the government proposes the following:

- Advance Choice Documents (ACDs)
- Care and Treatment Plans:

- A revised Part IV:
- Enhanced role of the Mental Health Tribunal (MHT):

Advance Choice Documents

Currently if a patient has a valid and applicable advance statement which sets out their preference of one antipsychotic drug over another, while the Responsible Clinician is professionally obliged to act in the best interests of the patient, they are not legally obliged to take this into account. The Government proposes a legal requirement on clinicians to consider the contents of an individual's Advance Choice Document while they are detained under the Act.

To ensure that service users' Advance Choice Documents can be readily accessed by health and social care professionals, where necessary, the Government will seek to ensure that these important documents are available via a secure digital database.

Advance Choice Documents will follow a standard format and approach, and should include the following information about an individual's preferences, including on treatment and non-medical therapeutic approaches, as well as any other information deemed relevant by the individual:

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

Consultation question 8:

Do you have any other suggestions for what should be included in a person's advance choice document?

Your answer can be up to 500 words.

Under the reformed Act, decisions made by people when they have the relevant capacity to make them will have a real power and influence over decisions and appeals regarding care and treatment. Any statements of preference in an Advance Choice Document will, in most cases, be considered as equivalent to those made in real time by a patient with the relevant capacity.

Though the Review recommended that service users should seek to have their documents authenticated by a health professional, the Government proposes that formal authentication should be necessary for the Advance Choice Document to be valid. Instead, for an Advance Choice

Document to be valid and have legal effect, it must have been made by someone who had the relevant capacity and apply to the treatment in question. This is the same approach as under the MCA. Authentication would be one way that an individual could seek to ensure that there is no doubt later about whether the statements were made with capacity. Otherwise, it would be for those concerned with the patient's care and treatment to consider whether the statements were made with capacity, at the point when decisions need to be made.

Do 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?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 9a:

Please give reasons for your answer (up to 500 words).

Statutory Care and Treatment Plans

For the first time, the Act will require that all patients subject to detention must have a Care and Treatment Plan, with clear expectations about how and when this should be developed with the patient. In practice this will mean clinicians setting out in detail their assessment and plan for a patient's care and treatment, including how their wishes and preferences have been accounted for and what the intended route is towards discharge.

It will be for the patient's Responsible Clinician (RC), working with all others involved in the patient's care, to complete and maintain the Care and Treatment Plan. The Plan should reflect the patient's preferences, as far as possible, even when the patient lacks the relevant capacity to make decisions about their care and treatment. It should also recognise that capacity can fluctuate, and that an individual may lose capacity for some decisions but not others and ensure that capacitous decisions are followed wherever possible.

Where a patient lacks the relevant capacity, their Advance Choice Document – where one exists – should be used to inform the development of the Care and Treatment Plan. Where a patient lacks the relevant capacity and does not have an Advance Choice Document, clinicians must still support the individual to express wishes and preferences, through supported decision making and consultation with the patient's Nominated Person, family and carers.

If decisions depart from the patient's wishes and preferences, however they are expressed and ascertained, the justification must be explained to patients and recorded. Where treatment refusals have been overruled, the Care and Treatment Plan should document how the necessary procedures have been followed (see following section).

Where a patient has a learning disability or is an autistic person, or both, the Responsible Clinician will also be required to take into account the findings and recommendations made as part of a Care and Treatment Review (CTR) or Care Education and Treatment Review (C(E)TR) for children and young people), in the patient's statutory Care and Treatment Plan. C(E)TRs are part of the

Government and NHSEI's commitment to transform services for people with a learning disability and autistic people and are designed to overcome barriers to the patient's progress. They are jointly produced with the local authority and education services. Where the Responsible Clinician has not followed all the findings and recommendations of the C(E)TR, they will again have to explain their rationale in the Care and Treatment Plan.

A Care and Treatment Plan should include the following information:

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

Consultation question 10:

Do you have any other suggestions for what should be included in a person's care and treatment plans?

Your answer can be up to 500 words.

A new legal framework for patient consent and refusal of medical treatment

Currently Part IV of the Act allows for most medical treatments to be given to an individual without their consent (even where they have the relevant capacity) for a period of three months, at which point a second clinical opinion is required from the Care Quality Commission's Second Opinion Appointed Doctor (SOAD) service.

Medical treatment for mental disorders, as regulated by the Act, covers a wide range of interventions, from the extremely invasive (e.g. neurosurgery) to more routine medical treatment given under the direction of an Approved Clinician.

The Government proposes different requirements and safeguards depending on the nature or invasiveness of the treatment. These can be broken down into three categories:

Category 1: The most invasive treatments (e.g. neurosurgery)

Category 2: Invasive treatments (e.g. electro-convulsive treatment)

Category 3. All other medical treatment for mental disorder

Category 1 Treatments: most invasive

The provisions within section 57 of the current Act, which relate to the administration of invasive treatments, such as neurosurgery, will apply in the case of Category 1 treatments.

Category 2: Invasive treatments (e.g. electro-convulsive treatment)

This Category will include electro-convulsive therapy (ECT) and other similarly invasive treatments. As is now the case with ECT, treatments in this category will not be able to be given if the patient has the relevant capacity and is refusing.

People who lack the relevant capacity to express their wishes, but who have refused treatment in a valid Advance Choice Document, should also have access to this important safeguard.

In both cases, the Responsible Clinician will only be able to override the patient's refusal for treatment if it is considered urgent, meaning it is necessary to save the patient's life or prevent a serious deterioration of their condition.

The Government proposes to strengthen this safeguard so that where the urgent criteria are met, then the Responsible Clinician should be required to seek approval from court before overriding the patient's refusal. The Responsible Clinician should also have to secure two medical opinions to support their application.

If the patient lacks the relevant capacity to consent but has not refused the treatment via a valid Advance Choice Document, the current requirement for ECT would stand, in that the treatment could only be administered once a SOAD has certified that it is clinically appropriate and that it should be given.

For these individuals, if the treatment is considered to meet the urgent criteria set out above, it can be administered without SOAD certification, but the Care Quality Commission should in future be informed of the decision and provided with the clinician's records for scrutiny.

Category 3 Treatments: all other medication

At the moment, the medical treatments in this category, which represent the vast majority, can be administered for a period of three months without the need for consent. This is even the case for patients who have the relevant capacity to refuse treatment. The Government proposes to change this so that the administration of these treatments is subject to far greater control. The Government will also seek to rebalance the system to be more responsive to the wishes and preferences of the patient.

Most crucially, where a patient is refusing treatment, and the Responsible Clinician wishes to overrule their refusal, the Government will seek to bring forward the point at which a SOAD must certify a patient's treatment from 3 months to day 14 of detention, when their Care and Treatment Plan has been signed off by the Clinical or Medical Director.

This will apply both to people who have the relevant capacity, at the time, and are refusing treatment and to people without the relevant capacity who have refused treatment in a valid Advance Choice Document.

The Government will also seek to bring forward the point at which the SOAD has to certify treatment for patients who lack the relevant capacity to consent to treatment and who do not have an Advance Choice Document. The intention is that this certification will take place at two months, rather than the current three.

Again, where a SOAD is required to certify treatment they should, as part of deciding whether the treatment should be given, ascertain as far as possible the wishes and preferences of the individual and consult with the appropriate people, ensuring the treatment is in the patient's best interests. Where the patient is refusing treatment, the SOAD will also be required to certify that there is no other clinically appropriate treatment available that is more acceptable to the patient.

Where treatment is considered urgent, the Government proposes the criteria for administering treatment against someone's wishes should differ depending on whether the individual has the relevant capacity to refuse treatment at the time, versus if they lack capacity but have refused treatment in a valid Advance Choice Document. In both cases, the Responsible Clinician should be able to overrule the patient's refusal and administer the treatment, without the certification of a SOAD, if it is considered immediately necessary to save the patient's life, to prevent a serious deterioration of their condition, or to prevent the patient from behaving violently or being a danger to themselves or others. However, the Government proposes that the fourth requirement, which is that the treatment is needed to alleviate serious suffering (as described in section 62(1) (c)), should only apply in the case of patients who lack the relevant capacity to refuse treatment at the time. The Government discuss the proposed changes to the urgent criteria and consult on this issue below.

The right to choose to suffer

The Government is consulting on the proposal to remove section 62(1)(c) meaning that urgent treatment could no longer be given to patients with the relevant capacity, against their wishes, on the basis of the alleviation of serious suffering.

Consultation question 11:

Do 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?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 11a:

Please give reasons for your answer (up to 500 words).

Absolute refusal of medical treatment

The new framework for patient consent and refusal will support our ambition of giving patients more choice and autonomy over their treatment but the framework will not allow someone to refuse treatment altogether.

A new right to challenge a treatment decision at the Tribunal

Currently, a patient has limited ability to challenge their treatment under the Act. Should a patient with capacity wish to challenge the decision of the Responsible Clinician and SOAD, they only have a right to do so by way of judicial review.

The Government proposes to introduce the ability for patients to challenge a specific treatment through the Tribunal. The challenge may be brought by a patient who has the relevant capacity to

refuse a specific treatment at the time. Alternatively, if the patient lacks the relevant capacity, their IMHA or Nominated Person (NP) would be able to bring the challenge on their behalf, providing they have an Advance Choice Document stating their refusal to receive a specific treatment. Before a case is able to proceed to a full Tribunal hearing, a judge sitting alone would carry out a preliminary review of the case in a 'permission to appeal' stage.

The Government proposes that the preconditions for permission are:

- i. The Responsible Clinician and SOAD have confirmed that the treatment should be given and have set out the reasons for overruling the patient's refusal;
- ii. The patient, or their NP or IMHA, has set out the treatment refusal and rationale for it;
- iii. The application applies to a specific disagreement about an individual treatment decision, rather than a general desire not to be detained, or to not receive treatment; and
- iv. Any repeat application shows a material change in circumstances.

If permission is granted for a full hearing, this would be carried out by a single judge sitting alone.

During the hearing, the judge would be responsible for determining whether the appropriate processes have been taken by the Responsible Clinician in overruling the patient's treatment refusal and therefore whether or not the decision to overrule the patient is sufficiently justified and appropriate.

The judge would not take any role in clinical decision-making and they would not be able to authorise the use of a specific treatment. However, the judge would be able to make a finding that

Consultation question 12:

Do 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?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 12a:

Please give reasons for your answer (up to 500 words).

the Responsible Clinician should reconsider their treatment decision. The Review also recommended that the Tribunal should be able to order that a specific treatment is not given if it is found to disproportionately interfere with a patient's rights. The Government wishes to consult on this point.

5. Improving the support for people who are detained

Nominated Person

Choosing the Nominated Person (NP)

As part of an assessment under the Act, an individual will be asked to identify their Nominated Person. They will also be able to identify and record their Nominated Person before detention, through their Advance Choice Document.

If someone lacks the relevant capacity to make a nomination at the point of detention, and has not previously nominated anyone, an Interim Nominated Person will be appointed by an AMHP. People with the relevant capacity will have the right to opt out and not have a Nominated Person, if that is their preference.

In addition to being able to identify someone to take on the formal role of Nominated Person, patients will also be able to identify other individuals who can receive information about their care and treatment, either by expressing their wishes and preferences while detained or in their Advance Choice Document.

What roles and powers will a Nominated Person have?

The new Nominated Person will have the same rights and powers to act in the best interests of the patient as Nearest Relatives have now. These include rights to:

- Object to the patient being made subject to the Act;
- Apply for the patient's discharge;
- Appeal to the Tribunal if this application for discharge is denied;
- Apply for the patient to be detained under the Act;
- Receive information from the hospital about the patient's care, detention or CTO, unless the patient objects to this.

In addition to the powers currently held by the Nearest Relative, The Government propose that the Nominated Person should also:

- Have the right to be consulted on statutory Care and Treatment Plans, to ensure they can provide information on the patient's wishes and preferences;
- Be consulted, rather than just notified, as is the case now, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO;
- Be able to appeal clinical treatment decisions at the Tribunal, if the patient lacks the relevant capacity to do so themselves and the appeal criteria are met;
- Have the power to object to the use of a CTO if it is in the best interests of the patient.

To support Nominated Persons to access and exercise these enhanced powers the Government will provide clear, detailed guidance on the powers of the Nominated Person role.

Consultation question 13:

Do you agree or disagree with the proposed additional powers of the nominated person?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 13a:

Please give reasons for your answer (up to 500 words).

Improving support for patients in the criminal justice system

The Government proposes to introduce the Nominated Person for forensic patients, with powers limited to care and treatment planning.

Children and young people's right to choose a Nominated Person

For young people aged 16 or 17, the Government propose that they should have the same right to choose a Nominated Person as an adult, where they have the relevant capacity to make this decision. As with adults, where someone aged 16 or 17 does not nominate anyone, the AMHP would nominate the Interim Nominated Person (INP). In this case, the Government will advise in guidance that the first choice of INP should be the parent or guardian, where appropriate.

For children under 16 established as "Gillick competent", a child should be able to choose a Nominated Person. However, the patient's right to choose a NP should not undermine the rights of parents, guardians, carers, or other individuals with parental responsibility over the child. If a child were to choose a NP who is not a parent, guardian, carer or person with parental responsibility, then this would not be to the detriment of the usual rights, outside of the Act, that such people would expect to have in order to support their child, including rights to information and to be consulted about decisions about their care.

Consultation question 14:

Do 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')?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 14a:

Please give reasons for your answer (up to 500 words).

Overruling the Nominated Person: role of the Mental Health Tribunal

The Government seeks to legislate so that the NP's objection to admission can be temporarily overruled, as opposed to the NP being removed or displaced, to ensure that they continue to have a role in the patient's care and treatment while they are detained.

Currently, the power to displace the Nearest Relative sits with the County Court but the Government is exploring whether the power to overrule or displace a NP should instead sit within the Tribunal Service's remit, which is potentially better equipped to make these kinds of decisions.

Advocacy

To ensure patients are able to benefit from the reforms to the Act proposed in earlier chapters, the Government proposes to expand the role of IMHAs to include the following additional safeguards:

- Supporting patients to taking part in care planning
- Supporting individuals in preparing Advance Choice Documents
- Power to challenge a particular treatment where they have reason to believe that it is not in the patient's best interests
- Power to appeal to the Tribunal on the patient's behalf.

Consultation question 15:

Do you agree with the proposed additional powers of independent mental health advocates?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 15a:

Please give reasons for your answer (*up to 500 words*).

Advocacy support for informal patients

Though the Government accepts IMHAs are well placed to support informal patients to understand their rights, as was recommended by the Review, as this will create an additional burden for Local Authorities, and advocacy providers, expanding the statutory duty to all inpatients will therefore be subject to future funding decisions.

Consultation question 16:

Do you agree or disagree that advocacy services could be improved by:

1) enhanced standards

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

2) regulation

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

3) enhanced accreditation

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

4) none of the above, but by other means

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sur*

Consultation question 16a:

Please give reasons for your answer (*up to 500 words*).

Culturally appropriate advocacy

The Government have committed to launch a pilot programme of culturally sensitive advocates in partnership with Local Authorities and others, to identify how to respond appropriately to the diverse needs of individuals from black, Asian and minority ethnic backgrounds.

6. Community Treatment Orders (CTOs)

The Government will reform CTOs so that they can only be used where there is a strong justification, they are reviewed more frequently and by more professionals, are time limited, and that people subject to them really need them to receive a genuine therapeutic benefit.

Criteria for use

The Government proposes to revise the criteria for using CTOs, in line with the proposed revised detention criteria for section 3 to ensure that CTOs are used in a more consistent way.

The criteria will be changed so that a CTO can only be used when 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 where a CTO will provide a therapeutic benefit to the patient.

As with assessments for detention, the Government will also strengthen the requirement that the evidence and justification for the use of a CTO, against the new criteria, is clearly documented and regularly reviewed.

Making, renewing and extending CTOs

The Government intends to introduce a third decision maker for CTOs. The initial decision to make a CTO will continue to be the responsibility of the Responsible Clinician and an AMHP. The Government will introduce a requirement for the community supervising clinician who will work with the patient while on a CTO to also be involved in the decision.

Each time a CTO is renewed, this decision should also be agreed by the Responsible Clinician, the community supervising clinician and an AMHP, again to ensure those who are supporting the patient in the community are part of the decision as to whether the restrictions of the CTO are still required. In line with the Review's recommendations, more professionals will be involved in decisions to extend a CTO – currently this is just a matter for the Responsible Clinician, but the Government will seek to legislate so that an AMHP and the patient's community supervising clinician must also agree. Although, if the Tribunal has recently considered a patient's CTO just the AMHP and the patient's community supervising clinician will be required to renew.

The Government will set an expectation that CTOs should end after a period of two years. The patient should be discharged at or before this point, unless they have relapsed or deteriorated during that time. The Government will initially set this out as guidance in the Code of Practice, because they recognise that in some circumstances remaining on the CTO may be beneficial to the patient.

CTOs and the role of the Nominated Person

When putting someone on a CTO, the Nominated Person or Interim Nominated Person should be appropriately consulted, with the Act giving them a new power to object, in line with their existing power in sections 2 and 3. As will be introduced for sections 2 and 3, it will be possible to overrule a Nominated Person's objection to a CTO, without any additional consequence of removing them from that role.

Conditions of CTOs

It is also important that conditions made are set out clearly to the patient, to ensure they understand:

- which conditions constitute advice (for example about lifestyle choices)
- which conditions are required in order for the CTO to be made (for example, about supported living arrangements, or engagement with medicines or other treatment)
- which conditions are statutory grounds for recall to hospital (currently, failure to be available for examination so that the CTO can be reviewed, or for examination so that treatment that requires certification to continue can be so certified. Our proposals to update the recall procedure are described below).

The Mental Health Tribunal's consideration of Community Treatment Orders

When considering applications for discharge from a CTO, the Tribunal will need to consider whether or not the patient continues to meet the revised criteria for use and will have the power to check the Responsible Clinician's justification for the conditions attached to a patient's CTO and recommend that they reconsider any which they believe are overly restrictive. However, the Tribunal will not be able to recommend changes to conditions that would impact on the patient's clinical treatment.

Recalling patients on CTOs to hospital

The Government will revise the criteria for recalling service users to reflect our wider changes around detention criteria, so that recall will only be possible when it is needed because there is otherwise a substantial risk of significant harm.

They also want to broaden the appropriate locations to which a patient may be recalled, allowing for alternatives in cases where treatment in a hospital is not needed.

7. The interface between the Mental Health Act and the Mental Capacity Act

The Review found that within this interface it is not always clear for practitioners whether the MHA or DoLS should be used if a person lacks the relevant capacity and does not appear to be objecting, resulting results in uncertainty, where either the MHA or DoLS may be used.

The Government therefore accepts the finding of the Review that the MHA is still used in cases where it may be preferable to use DoLS, or in future the LPS.

The Review recommended that the solution to these issues is for a clearer dividing line to be introduced in legislation between the two Acts, based on whether or not a patient is clearly objecting to detention or treatment. The effect would be that all patients without the relevant capacity who do not object will receive care and treatment under the DoLS/LPS and not under the MHA.

The Government agrees with the Review that introducing this clearer dividing line could reduce some inappropriate uses of the MHA and could clarify what can be a 'grey' area for patients, their families and for practitioners.

However, given that the new LPS framework is yet to come into effect and may serve to address issues raised by the Review, the Government agrees with the Review that it is important to assess the impact of its implementation, before introducing these reforms to the MCA/MHA interface. In the meantime, the Government are seeking views on how to implement the Review's recommendation on establishing a clearer interface between the two Acts, and on how to address

the complexities that are arising in practice now, so that the Government can implement legislation and guidance which is clear to interpret and use.

Consultation question 17:

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?

Your answer can be up to 500 words.

Prior consent to be admitted as an informal patient

The Review recommended that the Government should consult on whether the MHA should give individuals the right to consent in advance to admission to hospital for treatment for a mental illness. This would mean that, if an individual had given prior consent and they later become unwell and lose the relevant capacity, then they would be admitted as informal or voluntary patients, as opposed to being detained under the MHA or subject to the DoLS/LPS.

As recommended by the Review, the Government wish to seek views about the use of advance consent to informal admission to mental health hospitals.

Consultation question 18:

Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 18a:

Please provide reasons for your answer (up to 500 words).

Consultation question 18b:

If agree, are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

Your answer can be up to 500 words.

Accident and Emergency (A&E)

The Government wishes to improve the powers available 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. Too often, the police must be relied upon to hold individuals who are in crisis and are attempting to leave A&E. Potentially leading to further distress to the individual. This issue is partly to be addressed by the changes to section 4B of the MCA, which are due to come into force in 2022. These will have the effect of enabling health professionals in A&E to take steps to deprive a person of their liberty if it is necessary to provide life-sustaining treatment or to prevent a serious deterioration in their condition.

Given the limitations of section 4B for the purposes of those attending A&E on the basis of mental ill health, the Government wishes to consider extending section 5 of the MHA. This provides powers to hold a person temporarily, while their mental health is assessed, but it cannot currently be applied unless a person is already admitted as an inpatient.

While extension of section 5 was ruled out by the Review as it was considered overly restrictive, the Government believes that extending the existing holding powers in section 5 of the MHA could provide hospitals with a greater ability to ensure the appropriate safeguards are in place in a greater set of circumstances. Chiefly, extending section 5 would provide hospitals with the power to hold a person with the relevant capacity, who wants to leave A&E.

The Government believes that extending the use of section 5 may be more effective in addressing the issues described as it is simply more well established and widely understood by health professionals within hospitals. However, the Government propose that, should section 5 be extended, that the powers should only be available to senior clinicians to ensure that they are only used when it is absolutely appropriate.

The Government is consulting on whether the planned amendments to section 4B are sufficient in providing the necessary safeguards for people who are attending A&E and who may be admitted on the basis of their mental health. Or, whether section 5 of the MHA should be extended to increase the scope of who could be temporarily detained, pending a clinical assessment.

Consultation question 19:

We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do 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)?

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

Consultation question 19a:

Please give reasons for your answer (up to 500 words).

8. Caring for patients in the Criminal Justice System

Some people in contact with the criminal justice system may need to be admitted to hospital for treatment of a mental illness. This could be at the point they enter the criminal justice system, or later on should they become unwell in custody.

In Wales, criminal justice matters are reserved to the UK Parliament meaning, unlike health matters, they remain the responsibility of the UK Government. As such, the proposed changes set out in this chapter have the potential to apply across England and Wales, however, a different approach may still be appropriate between England and Wales.

Court Powers – aligning Magistrate and Crown Courts

The Act provides courts with powers to divert a person accused, or convicted, of criminal offences and in mental health crisis away from the criminal justice system and into hospital for the assessment and/or treatment they require.

The Government is aiming for the Act to support suspects and defendants in accessing the mental health care they need at the earliest possible opportunity, considering the changes proposed by the Review alongside wider reforms suggested by the Law Commission in their ‘Unfitness to Plead’ report.

Secure Transfers

Those individuals who meet the criteria for detention under the Act should not be held in prisons or Immigration and Removal Centres inappropriately. Through ongoing work by health and justice partners and the changes set out below, the Government will ensure that this does not continue and that any prisoner who requires care and treatment under the Act is swiftly transferred to an inpatient setting.

This chapter next discusses the position in England. Those in Wales will also be giving consideration to the proposals as they would affect devolved responsibilities for health and (potentially) local Government.

Statutory Time Limit

To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, the Government will introduce a 28 day time limit, split into two sequential, statutory time limits of 14 days each: first from the point of initial referral to the first psychiatric assessment, and then from the first psychiatric assessment until the transfer takes place.

The government is consulting on whether further safeguards are needed before this statutory timeframe is introduced due to concerns from stakeholders.

Consultation question 20:

To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28-day time limit.

Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?

- *Yes*
- *No*
- *Not sure*

Consultation question 20a:

Please give reasons for your answer (up to 500 words).

Independent Role to Manage Patient Transfer

It will remain for the Secretary of State for Justice formally to approve the transfer of a prisoner to the secure hospital system. However, the Government will establish a new designated role for a person independent of the health or criminal justice systems for the purpose of managing the process of transferring people from prison to hospital when they require inpatient treatment for their mental health.

The Government are consulting on views as to where a new prison/IRC transfers and remissions co-ordinator role might best sit and what their remit should be.

Consultation question 21:

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

Which of the following options do you think is the most effective approach to achieving this?

- *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 to manage the prison or IRC transfer process*
- *an alternative approach (please specify)*

Consultation question 21a:

Please give reasons for your answer (up to 500 words).

Advocacy support for patients waiting to transfer from prison or immigration removal centres

The Government are considering the role of the IMHA and how best to provide advocacy support for individuals awaiting transfer alongside the creation of this new independent role.

Prison as a Place of Safety

In some cases, courts are forced to divert defendants who require care and treatment in an inpatient setting, some of whom may not yet be convicted, to prison as there is no hospital bed available. In these instances, the Government will work with sentencers, health service commissioners and clinicians to ensure that there is a clear, timely pathway in which sentencers have confidence to transfer people directly from court to a healthcare setting where a mental health assessment and treatment can be provided, under the relevant section of the Act.

Conditionally discharged patients

The Government wishes to strengthen and develop the role of social supervisor for restricted patients and are consulting with stakeholders across the sector on how best to achieve this. For example, this could include specifying the professionals that can undertake the role, and the approval, training and qualifications required.

Consultation question 22:

Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?

Your answer can be up to 500 words.

Release of transferred prisoners by the Parole Board

To address the length of time between the Tribunal hearing and Parole Board decision in cases of transferred prisoners, HMPPS has been working with the Parole Board and the Tribunals to streamline processes so that a Parole Board hearing can take place swiftly after a Tribunal hearing for eligible transferred prisoners. A working group has been considering the procedural and operational changes that will be required in order to commence a pilot to test options to substantially reduce the time taken to convene a Parole Board hearing after a Tribunal decision in cases of transferred prisoners. Timelines for the pilot were delayed as a result of COVID-19. Work is currently underway to ensure that the pilot will commence as soon as is practicable.

Giving the Tribunal the power to discharge someone with conditions which restrict freedom in the community

The Government proposes the introduction of a new power of 'supervised discharge' which would enable discharge a restricted patient with conditions amounting to a deprivation of that person's liberty, in order to adequately and appropriately manage the risk they pose. This type of order would be subject to annual review by the Tribunal in line with the Court of Protection decisions on similar cases. The use of this new discharge power would be closely monitored to ensure that conditions amounting to deprivation of liberty were only applied when necessary and proportionate. This supervised discharge would be applicable only to restricted patients, and available irrespective of decision-making capacity. It would be **applicable only where such a patient**:

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

Consultation question 23:

For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty.

Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 23a:

Please give reasons for your answer (up to 500 words).

Consultation question 24:

We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 25:

Beyond this, what further safeguards do you think are required?

Your answer can be up to 500 words.

Victims of unrestricted patients

The Government's Victims' Strategy committed to reviewing and improving the processes by which victims of mentally disordered offenders (MDOs) are given information. The Government are working to address concerns that victims of unrestricted patients do not always receive timely, accurate information about key developments in the offender's case. The government recognise that although the Act's Code of Practice sets out existing responsibilities, the current structure has proved difficult for victims to navigate.

9. People with a learning disability and autistic people

Detention under the Mental Health Act

The Government acknowledges considerable concern about admission of people with a learning disability and autistic people to mental health hospitals under the Act, where such an admission could become protracted or may not result in someone receiving an appropriate therapeutic intervention. They propose reforms to ensure that it is a mental illness that is the reason for detention and that neither autism nor a learning disability are grounds for detention in and of themselves.

The Government proposes to revise the Mental Health Act to be clearer that for the purposes of the Act the Government does not consider autism or a learning disability to be mental disorders warranting compulsory treatment under section 3. The proposed revisions would allow for the detention of people with learning disability and autistic people for assessment, under section 2, of the Mental Health Act, when their behaviour is so distressed that there is a substantial risk of significant harm to self or others (as for all detentions) and a probable mental health cause to that behaviour that warrants assessment in hospital. The intention is that this additional behaviour 'qualification' would strengthen and expand the current qualification for learning disability to include an assessment of what is driving abnormally aggressive behaviour or seriously irresponsible conduct.

The assessment process under section 2 should seek to identify the driver of this behaviour, and whether a mental health condition, physical condition or response to environmental or life change, is the driver of this behaviour. If it is identified that a mental health condition is the driver, there may be continued justification for detention under the MHA, and the patient might in such cases follow a treatment pathway under section 3 for the mental health condition. Where the driver of this behaviour is not considered to be a mental health condition, for example due to an unmet support need, unmet social or emotional need, or an unmet physical health need (including untreated pain), grounds for a detention under the MHA would no longer be justified and the detention should cease.

The Government intends to introduce these changes only for civil patients and to ensure that accused people and offenders whom the courts or the Secretary of State might currently divert to an inpatient setting are not forced into the Criminal Justice System, which is not able, or indeed intended, to cater for their needs.

Consultation question 26:

Do 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?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 26a:

Please give reasons for your answer (*up to 500 words*).

Consultation question 27:

Do 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?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 27a:

Please give reasons for your answer (*up to 500 words*).

Consultation question 28:

Do 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?

- *Yes*
- *No*
- *Not sure*

Consultation question 28a:

Please give reasons for your answer (*up to 500 words*).

Consultation question 29:

We think 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. Do you agree or disagree?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 29a:

Please give reasons for your answer (*up to 500 words*).

Consultation question 30:

Do 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 to autistic people?

Your answer can be up to 500 words.

Putting Care, (Education) and Treatment Reviews (CETRs) on a statutory footing

Where someone with learning disability or an autistic person is detained for treatment under the Act, due to co-occurring mental health condition, the Government intends that progressing a patient towards discharge is a priority from day 1 of detention. The introduction of Statutory Care and Treatment Plans will ensure that this is the case.

For people with a learning disability and autistic people, the Government propose that there is a statutory requirement for the Responsible Clinician (RC) to consider the findings and recommendations made as part of Care, (Education) and Treatment Reviews (C(E)TRs) in the patient's Care and Treatment Plan. Any deviation from the recommendations set out by a C(E)TR should be justified and explained by the RC. C(E)TRs are conducted by a multidisciplinary panel and were introduced as part of NHS England's commitment to transform services for this group. They aim to identify the care needs of a patient and provide recommendations on how barriers to their progress can be overcome.

Consultation question 31:

Do 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 required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 31a:

Please give reasons for your answer (up to 200 words).

Ensuring an adequate supply of community services for people with a learning disability and autistic people

Any duty that requires an adequate supply of services to be commissioned for people with a learning disability and autistic people could create new funding requirements if there is not already sufficient supply in place. The Government will undertake a formal new burdens assessment to establish implications for local Government, informed by the consultation responses.

The Government has previously committed to consult on creating a related duty on commissioners that would ensure every local area understands and monitors the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population. The aim would be to enable better planning for provision and to avoid unnecessary admissions to inpatient settings.

Consultation question 32:

We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 32a:

Please give reasons for your answer (up to 500 words).

Consultation question 33:

We propose 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. Do you agree or disagree with this?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 33a:

Please give reasons for your answer (up to 500 words).

Consultation question 34:

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?

Your answer can be up to 500 words.

10. Children and Young People

NHS Long Term Plan commitments to improve support for children and young people

The proposed reforms to the legislation will be supported by improvements to children and young people's mental health services, delivered under the NHS Long Term Plan.

- The NHS will introduce a full crisis care service for children and young people by 2023/24. This will combine crisis assessment, brief response, and intensive home treatment functions, and will be available nationally on a 24/7 basis. Development of this comprehensive offer will build on the establishment of 24/7 crisis lines created at pace during the initial response to COVID-19.
- By 2023/24, there will be 345,000 more children and young people aged 0-25 accessing mental health services, including through some new school and college mental health support teams. A new approach to young adult mental health services for people aged 18-25 will also be put in place to support the transition to adulthood.

Children and Young People – autonomy and decision making

The Review argued that there is a need to reform the current arrangements in legislation and guidance in order to provide clarifications for professionals, for young patients, and for parents and carers. The Government will maintain existing legislation for these matters and will look to make improvements to the guidance.

The earliest opportunity to do this is the revision of the Mental Capacity Act Code of Practice, which is currently ongoing, to take account of the introduction of the new Liberty Protection Safeguards. Specific recommendations made by the Review about children and young people and decision making are considered below.

Young people aged 16 and 17

The Review recommended that the Mental Health Act and its guidance should make clear that the Mental Capacity Act (MCA) should provide the only test of the capacity of 16 and 17 year olds. Although chapter 19 of the Mental Health Act's Code of Practice is already clear that the MCA should provide this test, as it does for adults, it allows for practitioners to consider other circumstances, including that a 16 or 17 year old may be unable to make a decision because they may be overwhelmed by his or her surroundings and situation. The Government is considering this recommendation at present as part of its current work to review and update the Mental Capacity Act's Code of Practice.

Children aged under 16

For children aged under 16, in all matters of clinical decision making, practitioners need to assess whether a child has "Gillick competence", which involves considering whether the child has sufficient understanding, maturity and intelligence to enable him or her to fully understand what is proposed, and to make a decision about consent.

The Government appreciates that there are different opinions about matters to do with children and young people's rights, and for under 16s matters to do with assessing their capacity and competence. These matters are ultimately for the Code of Practice rather than the Act itself and will form a focus for consultation when the Government come to review the Code.

11. The experiences of people from black, Asian and minority ethnic backgrounds

The Government's intention to respond to the level of inequality in the Act is that enhanced patient voice, supported by advocacy, coupled with a greater reliance on evidence, increased scrutiny of decisions and improved patient's right to challenge, will begin to address the disparity in outcomes, and in turn detentions. Black people should not be treated less favourably than people from other groups – whether in mental health services, by the NHS or by public services as a whole. This cannot continue, and the Government and the NHS will prioritise tackling these issues. Although many of the changes set out in this White Paper will have a positive impact on people from black, Asian and minority ethnic groups, the scale of disparity that exists means that specific targeted interventions will also be vital.

Patient and Carer Race Equality Framework

The Patient and Carer Race Equality Framework (PCREF) will support NHS mental healthcare providers and Local Authorities to improve access and engagement with the communities they serve. Service user and carer feedback, alongside an organisational competency framework, will enable organisations to understand what steps they need to take to make improvements in access, experience and outcomes for individuals of diverse ethnic backgrounds.

The PCREF will support organisations to:

- Identify areas for improvement in the experience of patients from ethnic minority backgrounds, especially for people of black African and Caribbean descent. The areas for improvement ('competencies') will apply across all mental health services, including inpatient wards, community mental health services, and IAPT talking therapies.
- Work with communities to identify which competencies should be strengthened, and put in place strategies, interventions and actions to improve them in an iterative manner.
- Provide a recurring feedback loop to the Board, Trustees, stakeholders and the public to keep them informed of progress.

Ahead of national roll-out, and in line with the recommendations of the Review, the PCREF will be tested in different mental health services and settings to ensure the final framework delivers the results The Government should rightly expect.

Culturally appropriate advocacy

The development of culturally appropriate advocacy for people of all ethnic backgrounds and communities, in particular for people of black African and Caribbean descent, will be a major priority in our plans to deliver higher quality services that respond appropriately to the diverse needs of individuals.

The Government has also already announced funding to pilot culturally appropriate advocacy services. Work to scope the requirements for these services has now completed and will inform the commissioning of pilots, which the Government hope to begin next year. Subject to successful learning from the pilots, and subject to appropriate funding, the Government will legislate for culturally competent advocacy to be available to detained patients

Changes in the workforce – longer-term impact

The Review clearly argues that the mental health workforce needs to be more diverse. The Government is fully supportive of this and there are several programmes in place to improve the diversity of the workforce:

- The Preparation for Work scheme across the NHS aims to improve the representation of people from black, Asian and minority ethnic backgrounds through employability programmes, supported internships and traditional work experience programmes.
- The NHS Leadership Academy has also developed a programme, Ready Now, to support leaders from ethnic minorities to rise to senior levels within the NHS.
- The NHS People Plan for 2020/21 also places emphasis on a more inclusive NHS where a diverse and representative workforce are supported to thrive.
- NHSEI's Advancing Mental Health Equalities Taskforce, in collaboration with Health Education England's (HEE) Equalities subgroup, is working to address the workforce priorities outlined in the NHS Long Term Plan, to develop and implement strategies to enable a more diverse and inclusive mental health workforce that is reflective of the population it serves. This includes workstreams to increase fairness of access to, and inclusion in, mental health training programmes.
- HEE is taking action to increase representation and inclusion in mental health professions, starting with clinical psychology. Training in clinical psychology will, from 2021, be commissioned so that courses are held to account on targeted improvements in representation, such as the introduction of contextual recruitment processes and positive action initiatives. These measures aim to remove systemic obstacles to inclusion.

Reduction in the number of CTOs

NHS Digital reports that people included within its data category of black or black British people are over ten times more likely to be given a CTO than white British people compared to their representation in the general population.

A key aim of these reforms will be for the number of CTOs to decrease as well as a reduction in the disparity of their use. The Government intend to reflect the strengthened criteria for detention under section 3 of the Act in the criteria for making a CTO, so that it will be harder to use a CTO unless the patient is likely to genuinely benefit from the structure they provide.

Policing and Ambulances

For people from black, Asian and minority ethnic backgrounds, there have been too many tragic cases in recent years, as recorded in [the 2013 report from the Independent Commission on Mental Health and Policing](#)^[20], which was established to investigate the experiences of black people in particular.

The NHS Long Term Plan outlines the commitment to introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or conveyance by police to accident and emergency. The NHS will also introduce mental health nurses in ambulance control rooms to improve triage and response to mental health calls and increase the mental health competency of ambulance staff through an education and training programme.

Decreasing the duration of detention

Reforms to the detention criteria, which will increase emphasis on therapeutic benefit and make clearer what the Government mean by the risk posed by an individual to warrant detention, will ensure that a person is detained only when it is absolutely necessary. By clarifying and strengthening the criteria used to justify detention and introducing greater scrutiny of decisions around a patient's continued detention, the Government hope to achieve a culture in which less restrictive alternatives to detention are preferred and, when an individual is detained, that they progress towards discharge more quickly. The Government will introduce legislation and wider frameworks to ensure that patients are also able to have greater say over their care and treatment. Where they disagree with decisions, they will be able to more meaningfully make a challenge. The Government hope that these changes will ensure that a person's dignity is respected, their autonomy is preserved and that the experiences and outcomes of patients detained under the Act are improved.

Many of the reforms outlined above aim to decrease the duration of detention and while these changes will apply to all, the Government intends to make sure that these important changes benefit patients of black African and Caribbean descent, whose experiences and outcomes under the Act are persistently poorer than other ethnic groups.

PART 2: Reforming Policy and Practice Around the New Act to Improve Patient Experience

Now set out is how the Government and the NHS will work, along with other partners, to bring about an overall culture change within mental health services, so that people have a far better experience of care under the Act.

These improvements in care and patient experience will be led by staff. There are already examples of excellent practice. The Government need to build on this, and share best practice, to ensure consistent standards across the board.

Transforming mental health services - The NHS Long Term Plan

The NHS Long Term Plan includes ambitions for radical transformation of mental health services, backed by an additional £2.3bn of new investment a year by 2023/24, and with a renewed focus on services for people with severe mental illness. A key ambition of the Long Term Plan is to provide integrated models of mental health care across primary, community and secondary care services and to improve therapeutic services, so that patients have better experiences of inpatient care and better outcomes. It also seeks to reduce lengths of stay in all in adult acute inpatient mental health settings to make sure that everywhere meets the current average of 32 days (or fewer) by 2023/24.

Quality Improvement Programme

To create the best ward cultures to improve patient experience, to ensure everyone is kept safe and receives the best, therapeutic care, a comprehensive implementation support plan will be developed in partnership with NHSEI and HEE. This will include a National Quality Improvement (QI) programme led by NHSEI, which will support the system to address issues around quality, patient experience, leadership and culture.

The scoping phase will identify the specific reforms to the Act which are most likely to benefit from a QI approach. Once developed and tested, the programme will be rolled out nationally to support all mental health providers and local systems.

Inpatient safety and risk

The safety of patients in mental health services, whether detained under the Act, or informal patients, will always be the paramount concern of health services.

NHSEI launched a new [NHS Patient Safety Strategy in 2019](#)^[21] which sets out how the NHS will improve patient safety incident data collection and learning. This includes work to enhance the local response to patient safety incidents including local investigations.

The Review highlighted how decisions focused solely on safety can be at the expense of therapeutic environments and good quality care and can contribute to cold and unwelcoming environments.

Sexual Safety

It is essential that patients feel safe in inpatient settings and that steps are taken to provide protection from sexual and physical assault. Findings from the CQC, [the Women's Mental Health Taskforce](#)^[22] and the Review indicate that this has not always been the case. As part of the MHSIP, the Sexual Safety Collaborative was launched in October 2019. It is working to produce a set of standards around sexual safety for mental health and learning disability inpatient pathways, with a strategy to measure and support quality improvement via a national quality improvement collaborative. This will support inpatient mental health teams in mental health Trusts in England to use QI to improve sexual safety on their wards.

Restrictive Practice

Despite guidance supporting positive and proactive care, designed to avoid these practices, large variation in practice across different units, for people with similar needs, was observed and reported in the 2017 State of Care review of mental health and learning disability services. In recent months, the CQC has raised concerns that the reduced availability of staff to keep people safe may have increased restrictive practice in the context of the COVID-19 pandemic.

The initial phase of targeted work to reduce restrictive practice has demonstrated a number of encouraging improvements. The MHSIP will build on this work to refine the interventions ahead of scale-up across England.

Consultation question 35:

How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?

Your answer can be up to 500 words.

Suicide

Taking a quality improvement approach, the Mental Health Safety Improvement Programme (MHSIP) will focus specifically on reducing AWOL episodes, the risk of suicide of staff working within the healthcare system, and suicide in acute general hospitals. It will also support the adherence to national guidance for ligature anchor point management.

The physical ward environment

Inpatient settings should offer rehabilitative environments that enable the delivery of therapeutic care, and support patient recovery.

The Government and NHSEI have already started to improve the physical environment of hospitals, making them far better places to stay and to work in. The Government has committed to eradicate dormitory provision, ensuring that every person who is admitted to a mental health hospital has the dignity and privacy of their own bedroom with an en suite bathroom. These new facilities will also support our drive to improve infection control on wards. The Government has committed over £400m for this purpose and has identified 1,200 beds that will receive this upgrade over the next four years.

In October 2021, the Prime Minister confirmed that 40 hospitals will be built by 2030 as part of a package worth £3.7 billion. This includes funding for building projects for two mental health hospitals, St Ann's in Poole, Dorset, and Northgate in Morpeth, Northumberland. For many mental health sites, specific investment in a current site is a more suitable clinical option than a full replacement hospital – and The Government have many schemes underway, and completed, to do this.

This funding is in addition to the over £400 million of investment the Government have announced in improving mental health estate since July 2017. This includes £72.3 million for Greater Manchester Mental Health NHS Foundation Trust to develop a new adult mental health inpatient unit and £33 million to Mersey Care NHS Foundation Trust for a 40-bed low secure unit for people with learning disabilities, both of which were included in the £850 million capital funding for 20 hospital upgrades announced by the Prime Minister in August 2019.

In addition, the Department of Health and Social Care spent almost £19 million in capital last year on central programmes to support mental health services. This includes schemes to deliver Perinatal Mental Health Mother and Baby Units to deliver more personalised care to expectant and new mothers with serious mental ill health.

The role of the Care Quality Commission

The Government will work with the CQC and national bodies including NHSEI and Local Authorities to consider how best to extend this role and publish proposals for consultation at a later stage. The Government expect the recommendations to complement the wider work being taken forward to improve the quality and safety of patient care.

[Supporting people in the community](#)

The NHS Long Term Plan commits to expanding services for people with severe mental illnesses, delivered through new models of integrated primary, community and social care, so that by 2023/24, at least 370,000 adults and older adults have greater choice and control over their care and are supported to live well in their communities. The new models will incorporate care for people with eating disorders, mental health rehabilitation needs and those with a diagnosis of a ‘personality disorder’, among other groups.

The [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#)^[24], sets out the detail behind these commitments and how they will be implemented over the next four years, with information about how funding will be spent.

The Government are currently testing the new models of integrated primary and community care for people with severe mental illnesses ahead of national roll-out from April 2021. Over £70 million across 2019- 2021 has been provided to 12 early implementer sites, ahead of over £750 million additional transformation funding becoming available to all STP/ICS areas in England from 2021/22-2023/24. While the majority of planned activities of these early implementer sites had to be paused due to the first phase of COVID-19, the programme is continuing as far as is practicable. The testing of new models also includes testing four week waiting times for generic adult and older adult care in line with the Clinically-led Review of NHS Access Standards. Meanwhile, from 2019/20 onwards, all Clinical Commissioning Groups have been in the process of receiving year on- year increases in baseline funding to bolster community mental health provision and will continue to receive these increases up to and including 2023/24.

NHSEI is monitoring the implementation of the new community models, including their potential impact on detention rates, to generate insights that will inform the delivery of the Long Term Plan commitments in future years and any further policy development that may be necessary ahead of or alongside national roll-out.

[Care planning in the community](#)

The NHS has held a longstanding ambition to support and treat people in the right place, at the right time, shifting more care from acute settings into the community and people’s homes.

To enable this, more planned and personalised packages of care are required that can meet the needs of individuals. High-quality care and support plans are the key to delivering this, as they enable people to stay independent for longer, to have more control and responsibility over their care by setting their own aims and goals and to shape that care in a way that works best for them.

[Section 117 national guidance](#)

The Government will work in close collaboration with Local Authorities, ADASS, ADCS, NHSEI and service users to update national guidance so that there is greater clarity on how budgets and responsibilities should be shared to pay for section 117 aftercare. The Government will also develop a clear statement in the new Code of Practice of the purpose and content of section 117 aftercare.

[Supporting people in a mental health crisis](#)

Work is underway as part of the NHS Long Term Plan to enhance services. To support the COVID-19 response, NHSEI asked all local areas to ensure that urgent mental health advice and support is available to people of all ages through open access NHS 24/7 telephone help lines. This ambition was originally expected to be delivered for adults by March 2021 and children and young people by March 2023/24. As of May 2020, every area had implemented a 24/7, all age urgent NHS mental health telephone service which can be accessed by any member of the public and can be found on a [new NHS.UK service finder](#)^[25]. This means that 2020 will be the first NHS winter campaign, where

there is a national option for people with urgent mental health needs that is not solely to call 999. The wider objective remains that by 2023/24, the whole country will have crisis care support available at all times of the day and night, for people of all ages, fully accessible via NHS 111. Significant progress has also been made towards the NHS Five Year Forward View for mental health ambition on 24/7 Crisis Resolution Home Treatment (CRHT) teams for adults. In 2017, under 50% of services were 24/7 or accessible to people not known to services. Now almost all teams are staffed to high fidelity, open to self-referral and operate 24/7. The ambition is on track for all areas to have 24/7 CRHT by March 2024.

Use of police custody

To help ensure that in future all people in a mental health crisis are taken to a clinical environment, where they can receive the care and support they urgently need, the Government have committed to update sections 135 and 136 to remove police stations as a designated place of safety by 2023/24. However, before the Government can do this, they will have to make sure that the system is ready. This may require new capital funding to be available to provide the estate needed, including health-based places of safety, in those areas that need them.

Ambulance conveyance

The Act's Code of Practice is clear that ambulances or other health transport arranged by the police should be used to convey people after a section 136 detention. The NHS Long Term Plan has committed to a dedicated national investment programme to improve the capacity and capability of the ambulance service to meet mental health demand. This will see £70 million additional revenue investment by 2023/24 for additional mental health professionals to deliver mental health specific initiatives and extra capacity in ambulance services, such as having mental health staff based in 111/999 (integrated urgent care) control rooms to improve telephone triage and support, as well as a national programme to increase mental health training and education of ambulance staff.

The mental health workforce

The reforms to the Mental Health Act will require additional workforce over and above that to be delivered through the NHS Long Term Plan, including the expansion of the Responsible Clinician workforce. The reforms will also create new demands on advocates, Approved Mental Health Professionals, and Second Opinion Appointed Doctors. These estimates are included in our Impact Assessment.

The Government have programmes of work under way to meet the mental health workforce ambitions required to deliver on the NHS Long Term Plan by 2023/24. These include commitments to expand community mental health and crisis services, to prevent admission and where necessary provide more alternatives to admission and improving the availability of therapists and peer support workers in inpatient settings.

The mental health workforce expansion the Government needs to see over the next four years will be challenging for the system to deliver, with past issues exacerbated by the pandemic.

Diversity of the Workforce

The 2020/21 People Plan, along with the NHS COVID-19 phase three recovery guidance, set out the urgency required to intensify efforts across teams and organisations. They require all local areas to take action to identify a named executive board-level lead for tackling inequalities and to publish action plans to set out how their board and senior staff will at least match in proportion the BAME composition of their overall workforce or community, whichever is higher.

In social work, there is also action under way. The Chief Social Worker, Social Work England, the British Association of Social Workers, the Association of Directors of Social Services and the Local

Government Association are committed to implementing improvements to race equality and diversity.

Scoping work is being undertaken by Skills for Care and the Chief Social Worker's office, supported by Local Authorities on a new workforce race equality programme to improve the oversight and leadership of this area in social work and social care. The AMHP workforce plan, new AMHP service standards and the Workforce Race Equality Standard (WRES) guidelines, which have also been published, outline how these ambitions can be met by Local Authorities and Principal Social Workers. Social Work England, the regulator for social workers, is also supportive of incorporating the principles of the PCREF into requirements for AMHP training, as well as the reapproval processes, which it will review in 2021. The PCREF is supported by the National Workforce Plan for AMHPs and the workforce race equality framework for social work that is currently under development.

Improving Staff Morale

The Review highlighted evidence supporting the link between positive staff experience and high-quality patient care and noted that this has not been sufficiently exploited in the mental health setting.

The Government and NHS England agree that improving staff experience can have a significant impact on the quality of patient care, as well as boosting staff morale and retention. This is why improving the health and wellbeing of our staff was a commitment of the NHS Long Term Plan and is central to the 2020/21 NHS People Plan.

The 2020/21 People Plan contains a chapter on staff wellbeing and support, which sets out the support NHS staff can expect from their employers, including safe spaces to rest, psychological support, sickness support and risk assessments for vulnerable staff, including BAME staff.

NHSEI has developed a specific national support offer, which is available at people.nhs.uk^[26] for NHS staff, which includes:

- A dedicated health and care staff support service, including confidential support via phone and text message;
- A specialist bereavement support helpline for those who have sadly lost friends and family – whether from COVID-19 or otherwise;
- A pilot of a specialist relationship counselling service with the charity Relate; and
- A partnership with the Money and Pensions Service (MaPS), to launch a financial wellbeing offer.

A comprehensive mental health offer is also in development, following investment from NHSEI, to strengthen mental health support for healthcare staff in all local areas and ensure rapid access to evidence based mental health services. This includes:

- A centrally commissioned service for people with complex needs: a national support service particularly for critical care staff who research suggests are most vulnerable to severe trauma;
- Mental health and wellbeing hubs: nationwide outreach and assessment services, ensuring staff receive rapid access to evidence based mental health services; and
- The development of [wellbeing and psychological training](#)^[27], set to be rolled out this winter.

Data and digital

The Government and NHSEI have had to consider whether digital and online methods can suffice for medical assessments made for the purposes of the Act. NHSEI [issued guidance](#)^[28] on this matter in May 2020, which included the Department of Health and Social Care's view that the Act may be

interpreted to allow for this. The guidance, did however, state that it is always preferable to carry out a Mental Health Act assessment in person.

There has also been a long-standing desire amongst practitioners and Act administrators to remove the legislative barriers that prevent the greater use of digital means for the completion and communication of the Act's various statutory forms. This requirement was made more acute by the pandemic, when staff have needed to work more flexibly to account for a reduced workforce and public health measures around social distancing and non-essential travel. The Government amended legislation to allow for the electronic communication of forms through the Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 in October 2020, which came into force on 1 December 2020.

The Government anticipates that this change will enable staff to work more efficiently and, in doing so, ensure that patients access the care they need in a more timely manner.

The Government are now working to establish how the Act's pathway may be modernised in other ways. The Government want to investigate service maturity across the Act's pathway, map key information flows, and identify business and technical capability requirements so that The Government can eventually look to deliver a "digital first" approach to processes and procedures, governed by the Act. This work is crucial to ensuring that people under the Act can access the benefits of a modern, world-class health care system.

Improving data is a critical enabler to the wider system changes and ambitions set out in this White Paper. Better data supports transparency and scrutiny and is critical to informing ongoing reform and improvement, and to monitor the impact of change. The NHS Mental Health Implementation Plan 2019/20 – 2023/24 states NHSEI's commitment for substantially improved mental health data quality over the coming years. It will increase the coverage, consistency, quality and breadth of national data. Seeking improvements to Mental Health Act related data is a part of this plan.

[Impact Assessment](#)

Alongside the White Paper the Government has produced an [impact assessment](#) in which they have estimated likely costs and benefits of implementing the proposed changes to the act.

Consultation question 36:

In the [impact assessment](#) we have estimated likely costs and benefits of implementing the proposed changes to the act. We would be grateful for any further data or evidence that you think would assist the departments in improving the methods used and the resulting estimates.

We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following:

- different professional groups, in particular:
 - how the proposals may affect the current workloads for clinical and non-clinical staff, independent mental health advocates, approved mental health professionals, Mental Health Tribunals, SOADs etc
 - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
- service users, their families and friends, in particular:
 - how the proposal may affect health outcomes
 - ability to return to work or effects on any other daily activity
 - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
 - any other impacts on the health and social care system and the justice system more broadly

Please provide information (up to 500 words). You can also upload files when you [respond to the consultation](#).