**Mental Health Bill Committee Stage**
Briefing for Peers
The British Association of Social Workers (BASW) and the Association of Directors of Adult Social Services (ADASS)

## Social workers and the Mental Health Bill

BASW and ADASS are uniquely well positioned to comment on the Mental Health Bill.

'*AMHPs (Approved Mental Health Professionals) are responsible for setting up and coordinating assessments under the Mental Health Act, and, if necessary, making applications to detain ('section') people in hospital for assessment and treatment of their mental health needs*.'[i] They are approved and authorised to undertake their role by Directors of Adult Social Services. Each local authority in England and Wales has a Director of Adult Social Services who is responsible for the provision of social work mental health services including AMHPs'.

Although a range of professionals can be accredited as AMHPs, 95% of all AMHPs are social workers[ii].

Social workers in other roles (for example, working in child safeguarding or adult care assessment and review) also come across those with severe enough mental health issues that impact on a range of other statutory responsibilities.

For this briefing, we worked with a number of other organisations. We have indicated alongside each amendment the organisations that share BASW's position. This includes ADASS with whom we have partnered on this occasion. The absence of an organisation being mentioned should not be interpreted as them not supporting our position, but rather that they simply have not taken a position.

## About BASW

BASW – the British Association of Social Workers – represents under 22,000 social workers across the UK. This briefing reflects both specialist expertise from our members who are AMHPs as well as consultation with our wider membership.

## About ADASS

The Association of Directors of Adult Social Services (ADASS) is a charity. Our members are current and former members are Directors of adult care or social services and their senior staff, including principal social workers. Our objectives include:

- Furthering comprehensive, equitable, social policies and plans which reflect and shape the economic and social environment of the time
- Furthering the interests of those who need social care services, regardless of their backgrounds and status, and
- Promoting high standards of social care services.

**Contents**



## Laid amendments

### Communication needs

· *Clause 4, page 7, line 12, at end insert— "(v) ensuring communication needs are met where the patient may have additional or alternative communication needs" (Baroness Tyler of Enfield)*

**The Interpreter-mediated Mental Health Act Assessments (INFoRMHAA) Project and BASW believe that this amendment should be reworded with 'communication needs' replaced with 'communication requirements'.** As this is legal provision referring to equality, then it is more appropriate to specify requirements, not needs because both the individual patient and those who have contact with them in whatever capacity require an interpreter – they cannot communicate adequately otherwise. The use of requirement rather than need emphasises this point. The members explanatory statement should also reflect this change, and also be edited to say '…the communication requirements of patients are considered and met at all stages...". Effective assessment under the MHA cannot take place without interpreter provision for those for whom spoken English is not a fluent or preferred means of communication.

*Young, A., Napier, J., Vicary, S., Tipton, R., Rodríguez Vicente, N., Hulme, C. (2024). INforMHAA: Interpreter-mediated Mental Health Act Assessments: Best practices for*

*Approved Mental Health Professionals and Interpreters working together. DOI https://doi.org/10.48420/25634664*

## Autistic people and people with learning disabilities

- *Clause 4, page 5, line 23, at end insert— "(v) the patient, (vi) the patient's nominated person, and (vii) the patient's independent mental health advocate." (Lord Scriven)* ***AND*** *Clause 4, page 4, line 41, at end insert— "(iv) housing" (Baroness Barker)* ***AND*** *Clause 4, page 9, line 17, leave out "regard to" and insert "a duty to consider" (Lord Scriven)* ***AND*** *Clause 4, page 9, line 20, leave out "seek" and insert "have a duty" (Lord Scriven)* ***AND*** *Clause 4, page 9, line 24, leave out "regard to" and insert "a duty to consider" (Lord Scriven)* ***AND*** *Clause 4, page 9, line 26, leave out "seek" and insert "have a duty" (Lord Scriven)* ***AND*** *Clause 4, page 9, line 27, leave out "under Part 2 of this Act" and insert "unless there is a compelling reason for why this is not possible" (Lord Scriven)* ***AND*** *Clause 4, page 9, line 40, at end insert— "125FA Report: sufficient commissioning services for people with autism or learning disabilities (Lord Scriven)*

**BASW supports the above amendments** on autistic people and/or people with a learning disability.

- *Clause 4, page 8, line 30, at end insert— "(1A) Each local authority must take reasonable steps to assist the integrated care boards in its duties set out in subsection (Lord Scriven)*

**BASW supports the above amendment** but would suggest this also needs to reference the dynamic support register (DSR) in order to promote a joined-up approach. The DSR contains information about local population needs: https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/

- *Clause 4, page 9, line 40, at end insert— "125FA Mandatory training in diagnosis of autism and learning disabilities (Baroness Barker)*

**BASW <u>does not</u> support the above amendment**. Autism and learning disabilities are not treatable as conditions, hence the call to remove them from the new Act as the sole reason for detention. We would support mandatory training in terms of diagnosis of autism and learning disabilities, but we would suggest mandatory training about therapeutic interventions, reasonable adjustments and support strategies as opposed to treatment.

We would support mandatory training for those clinicians undertaking autism assessments, and mandatory training for those who are involved in assessment,

care planning, directly supporting and signposting/referral activity with autistic people.

- *Clause 11, page 17, line 6, at end insert— "(aa) consider whether non-drug-based interventions may be more appropriate in place of, or in addition to, drug-based therapies for patients who are diagnosed with autism or a learning disability, or where autism or a learning disability is suspected, who are— (i) hospitalised under the relevant sections in Part 3 of this Act, and (ii) do not have a co-existing psychiatric disorder." (Baroness Tyler)* ***AND*** *Clause 11, page 17, line 6, at end insert "including the full range of non-drug-based interventions" (Baroness Tyler)*

**BASW supports the above amendments** on autistic people and/or people with a learning disability.

- *New Clause "Cost and implementation reporting" (Lord Scriven)*

**BASW supports the above amendment** on autistic people and/or people with a learning disability.

## Racial disparities and other inequalities

- *New Clause: Reporting: racial disparities relating to Community Treatment Orders (Baroness Tyler of Enfield)* ***AND*** *New Clause X "Addressing and reporting on racial disparities and other inequalities in the use of the Mental Health Act 1983" (Baroness Tyler)*

**BASW supports the above amendments**. It is clear that Community Treatment Orders (CTOs) have been used more widely than anticipated – and disproportionately on individuals from particular ethnic backgrounds, notably those who are Black or Black British. The impact of these measures must be monitored to ensure they tackle this disproportionately in use, not just reduce the overall number of CTOs.

There is also the challenge of facing conscious and unconscious bias in decision-making throughout the mental health system. People from these backgrounds may also be reluctant to seek help from formal services based on previous negative experiences[iii]. Some may also have to deal with social stigmas attached to mental health issues within their own community, making it difficult to acknowledge their mental health problems to themselves and to others.

The implementation of the Government's proposed reforms must be carefully monitored with respect to their impact on people from Black and/or ethnic minority backgrounds. This includes collecting evidence on the effectiveness of NHS England's Patient and Carer Race Equality Framework approach to reducing over-

representation of people from Black or minority ethnic backgrounds who are made subject to the powers in the MHA. The creation of a national dashboard of performance indicators would assist, and service users and carers should be involved in defining the outcomes that are important to them. The outcomes for people who are of a Black or ethnic minority background should be particularly considered in any system that is considered.

## New Amendments

Below are suggested amendments that we would encourage members of the House of Lords to lay ahead of Committee Stage.

### 1. New Clause - Power to promote mental health prevention

To move the following Clause -

Powers to promote mental health prevention

1. Relevant local and health authorities will have the power to undertake the promotion of mental health prevention, specific to the needs of the local community that those authorities serve.

*Members explanatory statement: This new clause would give 'relevant bodies' (for example, ICBs, Public Health bodies and Local Health Boards (Wales)) the power to undertake the promotion of good mental health. This would make it explicit that relevant bodies have a power to support those already undertaking work in this field while giving permission to those bodies who wish to undertake this work.*

**Reasons for the amendment:**

The causes of mental health issues are complex and can be as much around social and societal issues (e.g. unemployment, housing, poverty) as clinical issues. This is recognised in the AMHP role which recognises that while a clinical perspective is appropriate other perspectives are equally valuable.

Consequently, the prevention of mental health problems, or the maintenance of an acceptable level of mental health, can be as much around social and societal issues, as any clinical intervention. For example, there is considerable evidence to suggest that physical exercise, undertaken in green space, can reduce or prevent mental health issues[iv]. Promotion of good mental health can thus cover a wide spectrum of interventions (e.g. public information promoting exercise in the outdoors) some of which can be relatively modest in cost.

The Health and Social Care Secretary has spoken about the importance of a shift from hospital to community, and from sickness to prevention[v], but unfortunately, we do not see this reflected in the Bill. We propose this or a similar simple amendment

that would empower relevant authorities while being realistic about current financial realities.

## 2. Nominated persons: 16- and 17-year-olds (Amendments suggested by Children and Young People Mental Health Alliance – supported by BASW)

a. Schedule 2, part 1, page 76, line 27, for “16” substitute “18”

1. Explanatory statement: This amends Clause 9 so the process for appointing a nominated person in that clause only applies to adults who lack capacity to do so.

b. Schedule 2, part 1, page 77, line 3, for Clause 10, substitute:

“10 (1) This paragraph applies where an approved mental health professional is deciding who to appoint as a nominated person for a relevant patient who is aged under 18.

(2) Where—

(a) the relevant patient is in the care of a local authority by virtue of a care order within the meaning of the Children Act 1989; or—

(b) the rights and powers of a parent of the relevant patient are vested in a local authority by virtue of section 16 of the Social Work (Scotland) Act 1968,

the authority shall be deemed to be the nominated person of the patient in preference to any person

(3) Where 2(a) or (b) do not apply and where a person within the following list is willing to act as the nominated person, the approved mental health professional must appoint such a person (giving preference to those mentioned first in the list):

(a) a guardian who has been appointed for the relevant patient; or

(b) a person who is named in a child arrangements order (as defined by section 8 of the Children Act 1989) as a person with whom the relevant patient is to live, or

(c) a person who has parental responsibility for the relevant patient

(4) In this paragraph ‘guardian’ includes a special guardian within the meaning of the Children Act 1989 but does not include a guardian under section 7 of the Act.

(5) Where there is more than one person in 3(a), (b) or (c) then the approved mental health professional must in deciding who to appoint as nominated person,

(a) take into account the relevant patient’s past and present wishes and feelings so far as reasonably ascertainable; or

(b) (where it has not been possible to ascertain the relevant patient’s past and present wishes), preference must be given to the eldest person.

(6) In any other case, the approved mental health professional must, in deciding who to appoint, take into account the relevant patient's past and present wishes and feelings so far as reasonably ascertainable

*Members explanatory statement: This amends Clause 10 so the process for appointing a nominated person for all children and young people under 18 is consistent and provides a clear framework to AMHPs for who should be appointed where a child or young person lacks competence or capacity to do so.*

**Reasons for the amendment:**

The current clauses for appointing a nominated person treats 16/17 years old as if they were adults and ignores the fact that Children Act 1989 provisions might be relevant e.g. the young person might be subject to a care order/ interim care order; special guardianship order. The proposals for under 16s ignores the complexities of Children Act 1989 provisions and that more than one person may have parental responsibility (e.g. mother & father; people having PR through a court order e.g. special guardianship order; child arrangement order) and provides no guidance to AMHPs on how they should choose between differing people with PR. These clauses are likely to give rise to confusion in practice and could lead to the AMHP choosing a parent where, for example, a Local Authority has Parental Responsibility. This could lead to safeguarding concerns.

## 3. Including AMHPs in s3 renewals (supported by BASW and ADASS)

Clause 28, page 37, after line 31 insert –

'(aa) in subsection (5A) omit paragraphs (a) and (b) and insert "who is an approved mental health professional states in writing that he has interviewed the patient in a suitable manner, consulted the patient's nominated person (unless it appeared to the professional that in the circumstances such consultation was not reasonably practicable or would involve unreasonable delay) and agrees that the conditions set out in subsection (4) above are satisfied." '

*Members explanatory statement: This amendment would mean that those put on s3 have access to an independent enough check, such as an AMHP in addition to the Responsible Clinician, to decide whether their situation warrants extending their s3.*

**Reasons for the amendment:**

This is to ensure that there is a balance of opinions when a decision to extend a s3 for either 3 or 6 months is considered.

Currently, this is covered by s20 of the mental health act, where under s20(5A) the responsible clinician (RC) is required to get the written agreement of someone from another profession who is involved with the patient's care before s/he can extend the order. Our contention is that this is insufficiently independent, and in a system where medical power and control is significant, it would be a challenge for the second professional to stand up and provide an opinion different from the RC. In most cases, the other professional will be likely to be junior to the RC.

We are unclear how often this second professional does not agree to renewal. In contrast, where someone has been moved onto a Community Treatment Order and an AMHP is involved in the decision we have data (2017 ADASS & NHS digital benchmarking report) that shows that 10% of requests to extend are refused.

We know the percentage of black/non white men detained increases with the tariff (ie black men are disproportionately detained longer than their white counterparts). Having an AMHP who brings a social perspective and knowledge of community alternatives to the decision could also help to address this discrimination.

## 4. Mental Capacity Act – Schedule 1A (supported by BASW and ADASS)

### Part 1 - Application of the Act

Delete the current section 1(2)

1. (1) This part applies if the following conditions are met.

(2) The first condition is that the person (P) is detained in a care home or hospital - for the purposes of being given care or treatment- in circumstances that amount to a deprivation of Liberty.

In Section 1(2) of Schedule 1A of the Mental Capacity Act, the above s2

and replace with:

(2) The first condition is that the person (P) is detained anywhere except a psychiatric hospital - for the purposes of being given care or treatment- in circumstances that amount to a deprivation of Liberty.

*Members explanatory statement: The amendment attempts to make the current Deprivation of Liberty Safeguards (DoLS) scheme more proportionate and practical to apply,. It would mean local authorities and trusts would no longer need to go to the Court of Protection for non contentious Community cases. This would save Court time and the local authority money. They mirror the anticipated changes that the Liberty Protection Safeguards (LPS) regime would have brought in.*

In addition, it would be necessary to make relevant changes in schedule 1AA

- in definitions remove the definition of a care home
- Amend the definition of a hospital to include a definition of a Psychiatric Hospital
- change the wording to say ‘detained person’ rather than ‘detained resident’ to reflect the wider number of places in which the person may be living.

**5. Length of orders (supported by BASW and ADASS)**

Amend under MCA Best Interest subsection 2(b) to read ‘3 years maximum’ and use the regulatory power to state the circumstances where the maximum 3 yr period would be appropriate, and what safeguards would need to be in place.

*42(1) The assessor must state in the assessment the maximum authorisation period.*
*(2)The maximum authorisation period is the shorter of these periods—*
*(a)the period which, in the assessor's opinion, would be the appropriate maximum period for the relevant person to be a detained person under the standard authorisation that has been requested;*
*(b)3 years, or such shorter period as may be prescribed in regulations.*

*Members explanatory statement: This amendment makes the current DoLS scheme more proportionate and practical to apply, so that more people entitled to legal protections can see assessed and are supported by a legal framework. They mirror the anticipated changes that the LPS regime would have brought in.*

**6. Equivalent assessments (supported by BASW and ADASS)**

Delete s49 (4) as follows so that there is no requirement for assessments to be less than 12 months old. Replace with a requirement that a BIA assessment must be repeated on each occasion when the order is extended.

(3) The second condition is that the existing assessment complies with all requirements under this Schedule with which the required assessment would have to comply (if it were carried out).

(4) The third condition is that the Best Interest Assessment must be undertaken prior to each decision to extend an order.

*Members explanatory statement: This amendment is intended to make it possible to use equivalent assessments more widely, if no other circumstances have changed- particularly in relation to medical assessments.*

**Reasons for amendments 4,5, and 6:**

There have been concerns about the DoLS system for many years. This led to the development of its replacement the Liberty Protection Safeguards which passed through Parliament in 2019. Its implementation was initially delayed by Covid before being delayed again in 2022 and 2023.

Currently it is unclear whether or when the current Government will implement this Act.

On 31st March 2024, over 3000 people were waiting for DoLS assessments, over half of those people had waited for more than 6 months already. Our amendments are intended to address these waiting lists and ensure more people are protected.

We also intend that uncontentious community based cases no longer need to come before the Court of Protection, but can instead be dealt with via the DoLS processes. We estimate this will save councils somewhere in the region of £6 million pounds annually.

The purpose of these amendments would be to make the current system more workable and proportionate whilst the government decides whether or when it will implement LPS. For example, LPS allowed for orders to last for up to 3 years (within otherwise stable and appropriate placements) this would have allowed for resources to be redeployed to others waiting for assessment. Our amendments will seek to replicate the changes already agreed for LPS so that they apply now.

## 7. 5/2 in A&E (supported by BASW and ADASS)

Clause 5, page 11, after line 38 insert –

"5A Admission for assessment in cases of emergency of persons attending hospital Accident and Emergency departments or other places of safety

(1) Where it appears to a registered medical practitioner who is on duty in a hospital or any other place of safety that a person who is present in that place and has attended there for assessment or treatment and is exhibiting behaviour which causes the registered medical practitioner to believe that the person might be suffering from mental disorder to such a degree that it is necessary for the person's health or safety or for the protection of others for the person to be immediately restrained from leaving that place and that calling a constable to attend the scene to exercise police powers under section 136 of this Act would involve undesirable delay, the registered medical practitioner may record those facts in writing; and in that event the person may be detained in that place, or removed to another place of safety under section 135 of this Act, for assessment for a period of up to 24 hours from the time when that fact is so recorded.

(2) A nurse of the prescribed class may exercise the powers of a registered medical practitioner in subsection (1) above where it appears to the nurse that it is not practicable to secure the immediate attendance of a registered medical practitioner."

*Members explanatory statement: This amendment makes it possible to hold someone in A&E or a health-based place of safety legally whilst an assessment is organised and the resources put in place as needed.*

**Reasons for the amendment:** Extending section 5 of the MHA so that it also applies to A&E locations or other places of safety will make it easier for clinicians, and other health professionals, to care legally for individuals in crisis who have presented in A&E or other places of safety without requiring the presence of the police to try and resolve the situation by using s136 powers. This addresses the current situation where people are being held illegally in A&E and health based places of safety having presented informally (or where their s136 has expired prior to beds being located) whilst they wait for beds to be available to which they can be detained. The changes will protect both patients and staff, and make it easier to monitor people waiting for long periods due to lack of suitable inpatient beds. We would therefore support the proposal to extend section 5 so that it also covers the venue of A&E departments and other Health based places of safety.

Contact officer: Kerri.Prince@basw.co.uk (please send queries to Luke.Geoghegan@basw.co.uk after 20th December 2024)

---

[i] p 4. DHSC/Skills for Care/Workforce Intelligence (May 2024) *The AMHP Workforce in the Social Care Sector*. London: DHSC.

[ii] p 6. DHSC/Skills for Care/Workforce Intelligence (May 2024) *The AMHP Workforce in the Social Care Sector*. London: DHSC.

[iii] Memom, A; Taylor, K; Mokebati, LM et al: "Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities in South East England", (*BMJ Open*, 2016: 6): pp5-6 (doi:10.1136/bmjopen-2016-102337)

[iv] See, for example: Singh et al (2023) *Effectiveness of physical activity interventions for improving depression, anxiety and distress: an overview of systematic reviews*. British Journal of Sports Med 2023: 57 1203-1209, and Coventry et al (2021) *Nature based outdoor activities for mental and physical health: systematic review and meta-analysis*. SSM-

Population Health 16 (2021). We are grateful to Brett Smith, University of Durham, for sourcing these resources.

[v] https://www.gov.uk/government/speeches/secretary-of-state-for-health-and-social-cares-address-to-ippr