Written Evidence: Draft Mental Health Bill Pre-Legislative Scrutiny
Joint Committee on the Draft Mental Health Bill

Submission by: British Association of Social Workers (BASW)

Executive Summary

The Approved Mental Health Practitioner (AMHP) role is one of the most important in the application of the mental health statutory framework. AMHPs have the power to apply for a person to be detained under the mental health legislation if the legal criteria are met. AMHPs are also responsible for coordinating assessments and admissions under the mental health legislation, as well as working to identify alternatives to compulsory detention. 95% of AMHPs are social workers[i] and the British Association of Social Workers (BASW) is the professional association for social workers.

BASW drew on the perspectives of our members who are AMHPs, as well as social workers who come across mental health issues in the course of their work more generally, in making this submission. While agreeing with the principles of the draft legislation (for example, reducing detentions, therapeutic benefit, increasing CTOs) our response addresses the practical challenges in making the legislation effective, for example, the importance of the social model in mental health support, early intervention preventing admission in the first place, inequalities impacting on services, the interface of the mental health and mental capacity legislation and workforce issues.

Tightening the criteria for detention cannot reduce the number of detentions by itself – it requires significant funding and resource, especially in preventative services. We expand on and evidence this material below.

1. About The British Association of Social Workers (BASW)

1.1 BASW is the professional association for social work and social workers in the UK with offices in England, Northern Ireland, Scotland and Wales.

1.2 We are the independent voice of social work. We champion social work and help members achieve the highest professional standards of practice. With over 22 000 members we exist to promote the best possible social work services for all people who may need them, whilst also securing the well-being of social workers working in all health, social care and youth justice settings.

1.3 We have many Approved Mental Health Professionals (AMHPs) among our members. Although the Mental Health Act 2007 allowed other professionals to train as AMHPs, 95% of AMHPs are social workers[ii], meaning social workers are central to the delivery of the Mental Health Act 1983 (MHA). Front-line social workers, whether specialising in mental health or not, frequently encounter people experiencing mental health issues in their work supporting society's most vulnerable. Widespread consultation amongst BASW members has informed this response.

1.4 In this submission, we focus on the social work aspect relating to the Committee's questions and primarily the role of the AMHP.

2 Social work and mental health services

2.1 One in four people face mental health challenges. There are those who manage their conditions themselves, often with the help of family and friends, those who access help via their GP, people

who need more significant help and those who are admitted for compulsory treatment because their condition is severe.

2.2 The AMHP role is one of the most important in the application of the statutory framework. They have the power to apply for a person to be detained under the MHA if the legal criteria are met. AMHPs are also responsible for coordinating assessments and admissions under the Act, as well as working to identify alternatives to compulsory detention. In 2021-22, there were 53 329 applications for compulsory detention in England[iii]. In 2019-20, Wales saw 1965 formal admissions to mental health facilities[iv].

2.3 A number of those who require significant levels of help with their mental health may also trigger other forms of social work intervention, for example child safeguarding.

2.4 The central role of the AMHP in applying the MHA in practice emphasises both the social and community aspects of mental health. This is sometimes described as the 'social model' approach and contrasts with the 'medical model' approach which focuses upon diagnosis, treatment and medication to 'cure' what is 'wrong' rather than focusing upon what the person may need. The 'social model' of mental health recognises the social factors that contribute to mental health distress. The social model approach adopts a strengths-based approach to social inclusion and focuses more on the principles of personal recovery whilst acknowledging that clinical recovery may also have a role.

2.5 BASW believes this broader approach accepting the impact of non-medical factors on a person's mental health should be more clearly recognised within the draft Bill and in funding the subsequent implementation of the Act.

3 Reform of the Mental Health Act

3.1 We welcome the move towards an approach based upon principles relating to least restrictive intervention and therapeutic benefit.

3.2 We remain concerned the approach taken in the draft Bill over-medicalises issues where societal factors are contributing, in some cases significantly, to mental health distress.

3.3 We recognise the Government's intention to drive down rates of detention and the use of Community Treatment Orders (CTOs) under the MHA to ensure this restriction of liberty is used as a last resort for those most in need. However, without significant investment in the provision of social services and community support (NHS and non-NHS) and investment in workforce recruitment and retention, we fear that the intention of the Bill will fail. Investment in preventative services is essential to reduce the rate of hospital admissions under the MHA.

3.4 We agree with the position stated by the CQC in their 2016/17 *Monitoring the Mental Health Act* report[v]: "Our findings support the view that changes to legislation alone may not have a major or immediate effect on the use of the MHA or rates of detention for specific groups."

4 How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act? Might there be unintended consequences and, if so, how should these risks be mitigated?

4.1 It is our opinion that the relationship between the MHA and the Mental Capacity Act 2005 (MCA) remains unclear and is likely to remain so as both Acts are undergoing amendments on different timetables.

4.2 The new Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS) whilst the MHA is being amended. Clear guidance will be required for all practitioners to ensure consistency in approach during this transitional period.

4.3 Currently, application and use of the MHA and MCA frameworks varies for a number of reasons. There remains uncertainty as to which legal framework applies and in what circumstances and depending on the decision to be made. High quality training is required for all health and social services staff involved to deliver consistency and enable practitioners to assess the most appropriate choice of framework.

4.4 Greater consistency in this respect can help to minimise any risk of either framework being used inappropriately, for example attempts to use the MHA framework to tackle the backlog of best interests assessments under the MCA. We must avoid a situation of perverse incentives are created at the expense of focusing on promoting the best interests and safeguarding the rights of an individual. This risk may be mitigated with the introduction of the LPS.

4.5 However, at the time of writing, no implementation date for LPS has been set. This needs to be done as a matter of urgency to minimise disruption and unintended consequences whilst both frameworks are changing.

4.6 See 10.8 and 10.9 about the risk of people with autism and/or a learning disability ending up in the criminal justice system.

5 To what extent is the approach of amending the existing Mental Health Act the right one? What are the advantages and disadvantages of approaches taken elsewhere in the UK?

5.1 The MHA is nearly 40 years old and in need of updating.

5.2 Much has changed in terms of how we view, define, and treat mental health, how we have improved the practice of individual human rights, how we view and support those with autism and/or learning disabilities, and how family and societal structures are constructed. It is appropriate that aspects of the MHA that do not reflect these circumstances, for example having a Nearest Relative chosen from a hierarchical list that does not take account of a person's individual circumstances and preferences (for example in the case of estrangement from relatives due to being in a same-sex relationship) are updated.

5.3 Northern Ireland has an integration of health and social services that is not reflected in England and Wales, the recent Health and Care Act 2022 for England notwithstanding. Adopting the same approach may therefore be difficult.

5.4 In Scotland, all Mental Health Officers (MHOs) are social workers. Whilst AMHPs are predominantly social workers, some have other professional backgrounds e.g. registered nurses. All MHOs being social workers may facilitate a more consistent approach to apply the legal framework. However, opening the role of AMHP to other professions was intended to address workforce issues and provide a larger pool for recruitment – although this has largely failed to emerge in practice.

5.5 The intention of the amendments – to reduce the number of detentions under the Act – and the new principles are appropriate. However, tightening the criteria for detention cannot reduce the number of detentions by itself. In order to be realised, there needs to be a significant injection in funding and resource, notably in preventative services (and see also Section 11.1). Better provision of support at an earlier point means fewer people being detained, although there will always need to be a basis for statutory intervention for those who represent a severe risk to themselves and/or others.

6 Does the draft Bill strike the right balance between increasing patient autonomy and ensuring the safety of patients and others? How is that balance likely to be applied in practice?

6.1 In applying the MHA, a balance often needs to be struck between the rights of the individual and the rights of those around them. Shifts in emphasis between the two over the last 40 years demonstrate the challenge of striking this balance in practice.

6.2 We support the view that detention should provide therapeutic benefit as set out in changes to the detention criteria (Clause 3). The justification for this exists through human rights law and existing case law. Promotion and protection of human rights is fundamental to ethical social work practice. In this respect, the definition of therapeutic benefit is key. We argue a broad view should be adopted that includes social and psychosocial benefits.

6.3 It is also important that services are culturally competent as some approaches may be counter-therapeutic for individuals from certain ethnic groups or cultural backgrounds (or with other protected characteristics), risking exacerbating rather than alleviating symptoms or distressed behaviour. The therapeutic benefits, and why they can only be achieved in a hospital setting, need to be clearly articulated.

6.4 A greater focus on alternatives to admission and therapeutic treatment in the community is required. Improvement in the range and accessibility of services is needed to reduce hospital admission. Yet many of the proposed amendments focus on what happens post-admission. Embracing the purpose of the principles means focusing on better non-hospital options.

6.5 This requires non-hospital options to be available. Decision-making is driven by the availability of services. Nothing will change if services aren't available due to lack of resource. Higher levels of acute mental illness in the community can only be managed effectively with greater investment in social services and NHS and non-NHS community provision.

6.6 Referrals and demand for services continue to increase. Pressure on the mental health social work workforce is growing, especially where credible alternatives to hospital admission are lacking, exacerbating existing workforce challenges (see 12.2 - 12.5). The UK Government response to their recent consultation on the draft 10-year Mental Health and Wellbeing plan needs to commit to providing community-based treatment and support in England.

6.7 Without comprehensive preventative and proactive services, people will continue to present at crisis point and trigger the new detention criteria.

6.8 Section 136 gives the police emergency powers under the MHA if they think you have a mental health disorder, are in a public place, and in need of immediate help. They can either keep someone at that place or take them to a place of safety until they can be assessed. We welcome Clause 41 removing the use of a police station as a place of safety. But again, without the availability of alternative health provision, the risk is that police cells will be the only option (see 11.3) but potentially even worse, this provision will exist outside of an appropriate legal framework.

6.9 However, section 136 is still used disproportionately against people from particular ethnic backgrounds and is an area where the issue of striking a balance between the rights of the individual and the rights of those around them needs to be addressed to ensure that everyone is treated fairly where the use of section 136 is being considered.

6.10 Screening out of those who do not genuinely require mental health assessment under section 136, but who may require some form of help, for example due to a high degree of inebriation or intoxication, and the means of doing this, should also be considered. Unless there is a credible plan in place for those in genuine need of section 136 and sufficient availability of places of safety, it is likely that people with mental disorders will continue to end up in police stations.

7 How far does the draft Bill deliver on the principles set out in the 2018 Independent Review? Does it reflect developments since? Is the Government right not to include the principles in the draft Bill?

7.1 Our understanding from the 2021 White Paper is that the Government originally intended to include the principles in the Draft Bill, as well as the Codes of Practice of both England and Wales.

7.2 This was a move we supported as it would place the principles on a statutory footing. We also supported repeating the principles through other relevant documents to increase familiarity and act as a reminder to encourage meaningful implementation.

7.3 We would be concerned that without statutory footing, there is a risk the principles are viewed as 'nice-to-haves' rather than as essential, especially in light of the ever-increasing demand for mental health services across the NHS, social services and in the community. For the individual to be empowered in the way the principles indicate, the principles have to underpin the approach to treatment and care.

8 To what extent will the draft Bill reduce inequalities in people's experiences of the Mental Health Act, especially those experienced by ethnic minority communities and in particular of black Africa and Caribbean heritage? What more could it do?

8.1 It cannot be assumed that attempts to improve the general operation of the MHA in practice will serve to address the particular needs for these population groups who are subject to structural and social-economic disadvantage. Just as poverty and disadvantage impact on physical health outcomes, they also impact on mental health outcomes[vi].

8.2 There is also the challenge of facing conscious and unconscious bias in decision-making throughout the mental health system.

8.3 People from these backgrounds may also be reluctant to seek help from formal services based on previous negative experiences[vii]. 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.

8.4 The largely medically focused approach of the reforms is not well placed to tackle issues such as the impact of experiencing racism, of growing up in a deprived neighbourhood and having fewer educational and job opportunities, or not feeling able to trust the very services that are supposed to be there to help and support. Social circumstances are fundamental to health and wellbeing and too overt a focus on a medical approach can fail to take these into account.

8.5 Consideration must be given to the need for culturally appropriate non-NHS services in local communities as well as how NHS services and the operation of the Act align with this wider need for more tailored community services. A culturally competent service is able to deliver services that "meet the social, cultural and linguistic needs of patients"[viii].

8.6 Appropriate community services can be supported by relationship-based social work which provides understanding of an individual's content and environment and is anti-discriminatory and anti-oppressive in its practice. Whilst some of the barriers faced are universal, others are more situation-specific and thus require more tailored service provision.

8.7 There are questions about how and where local authorities will be able to recruit appropriate individuals to the pivotal role of culturally appropriate advocacy to support those from disproportionately affected backgrounds, such as Black and Black British. The White Paper made clear the need to tackle issues of workforce diversity across health and social services. This is unlikely to happen quickly, and consideration must be given to the provision of such advocacy in

the interim. Recognition of peer advocacy as an appropriate and relevant option would be helpful.

8.8 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 the 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.

8.9 The package of CTO measures aims to reduce the use of CTOs. It is clear that 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.

9 What more could the draft Bill do to reduce the impact of financial inequalities in people's experiences of the Mental Health Act?

9.1 A narrow focus on medical approaches will do little to reduce the impact of financial inequalities on people's experiences of mental health and the MHA.

9.2 Not everyone can afford private help and support leaving those with limited or no resources dependent on the available public provision. With little preventative support available after years of public sector cuts, these people are more likely to face statutory intervention as they reach crisis point before receiving support. This creates inequities in the mental health system.

9.3 Poverty and deprivation can be aggravating factors in poor mental health, as they are with poor physical health. Experiences with, for example, the welfare system can trigger or aggravate episodes of poor mental health and people can become acutely unwell. Benefit sanctions can have severe impacts on mental health. Crisis prevention services often have benefits and housing advisors to facilitate 'every day' living.

9.4 It is conceivable that improving individual experiences with, for example, accessing Universal Credit or adequate suitable accommodation could help avoid hospital admission. This is a core reason why BASW places such emphasis on taking a broader view of the individual and their life circumstances, not just the medical diagnosis and indicated treatment.

9.5 People on lower incomes or more deprived backgrounds may also feel less able to challenge decisions about their care, feeling less confident in front of professionals or being less aware of their rights. Social workers and advocates can make a difference here, but the social work workforce is struggling to recruit and retain staff [see 12.5]

9.6 There are also disparities in services between local authorities so the area where someone lives can also have an impact. There may be fewer non-medical support services available in their locality.

9.7 Community services need to be funded to help maintain people in the community. They should not be competing for short-term funding or funded under programmes that are time limited and then discontinued in spite of their tangible positive impact.

9.8 Most localities don't have the resource to fund sufficient community services, even though this saves money in the long run compared with funding emergency interventions. Current economic circumstances are likely to reduce the available funding further.

9.9 Services need to be accessible to people at the time they feel they need it. The traditional model of commissioning and charging people for services needs to be approached with greater flexibility if it is to be effective.

10 What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?

10.1 Some people with learning disabilities and/or autism (LD/A) will have co-occurring mental health disorders. For these people the MHA needs to be used appropriately and proportionately to avoid unnecessary distress. This will require a significant investment in community-based services to provide appropriate, person-centred, even bespoke, alternatives to admission to an 'assessment and treatment unit' (ATU).

10.2 There also needs to be investment in ensuring that professionals have appropriate training to ensure the required level of understanding, expertise, skills, values and knowledge are available in the workforce.

10.3 For those with LD/A who do not have a co-occurring mental health disorder, the draft Bill proposes to remove them from the longer-term powers of detention for treatment as a 'solution' to the issue of their inappropriate long-detentions in ATUs. Since the scandal of Winterbourne View in 2010, there have been repeated initiatives to facilitate discharge for long-term detainees in this situation. Despite this, there are currently 3575 people with LD/A in mental health settings, where they often say longer than those with mental health disorders[ix].

10.4 This proposal causes us significant concern as to the potential use of the MCA framework for this group in the place of the MHA. Despite these concerns being raised during the White Paper consultation process, the draft Bill has not addressed concerns about the use of the MCA and the dilution of safeguards, whilst pressing ahead with the change to powers of detention. Removing the current legal safeguards provided in the MHA without addressing what is missing in other parts of the system, such as community-based support and appropriate housing, risks having devastating consequences for people with LD/A.

10.5 This is crucial because people with LD/A could be at **greater risk** of inappropriate long-term detention under the MCA as it contains fewer safeguards than the MHA. DoLS/LPS decisions receive less independent scrutiny and the rights to challenge them are weaker. It can actually be more difficult to get people released from inappropriate institutional care settings as a result. This could impact significantly on the Government's progress in achieving its own targets to reduce the number of autistic people and people with learning disabilities in inpatient facilities.

10.6 There is also a risk that people with LD/A could be subject to significant restrictions and restraint in 'community placements' without the statutory oversight, appeals and review processes contained in the MHA.

10.7 This weakness in the proposals for people with LD/A must be addressed as a matter of urgency. The rights of these individuals must be protected. A review of why so many of these individuals end up detained inappropriately, which involves people with LD/A is essential to understand and resolve this situation.

10.8 We also have concerns as to what happens if a person with LD/A, does not have a mental disorder, but is in crisis, presents in a way that poses a risk of harm to themselves or others. The danger is that these people could end up being detained by the police and dealt with under the criminal justice system. There should be no possibility that these individuals find themselves within the criminal justice system because of a lack of, or difficulty accessing, appropriate

community crisis resources. People who require this level of intervention require support in the correct environment, not to be placed in the criminal justice system.

10.9 It is conceivable that a lack of early help and support with issues such as diagnosis, communication and reasonable adjustments may also lead to a person with LD/A entering the criminal justice system as a result.

10.10 We acknowledge the move to ensure greater provision of support locally. However, the new duty on commissioners, whether local authority or NHS, is insufficient without adequate resourcing. This is particularly critical for local authorities whose budgets have been progressively cut. The duty to commission must result in support that is flexible, local, and tailored to the needs of the specific individual, with their involvement in establishing what that looks like for them (co-production). This is impossible at current funding levels. A detailed analysis and commitment from the government is required to the investment needed in community-based support to enable a focus on prevention.

10.11 BASW's Homes not Hospitals campaign group advocate ways of working to avoid admission and to support, advocate and challenge on behalf of those currently in ATUs or other restrictive settings. The campaign group calls for stronger legal levers to require public bodies to provide alternative care in the community and hold them accountable for delivery. Homes not Hospitals would support a dedicated review looking at how mental health and/or capacity legislation can strength discharge mechanisms for people with LD/A who are at risk of detention in ATUs, to address restrictive practices, and prohibit or prevent admission or longer-term detention in ATUs altogether. Such a review much include people with LD/A themselves and organisations that are led by people with LD/A.

10.12 The introduction of the register (under Clause 2) has the potential to support the commissioning of appropriate services by providing understanding of the level and nature of local needs. However, whilst the MHA groups people with LD/A together, their needs can be very distinct, and the purpose of the register should be clear to avoid raising expectations that cannot then be met.

11 To what extent will the draft Bill achieve its aims of reducing detention, avoiding detention in appropriate settings and reducing the number of Community Treatment Orders?

11.1 Detention in hospital should be the last resort – not the only resort. Without adequate funding and resource for community treatment and support, both medical and non-medical, there is little hope of achieving the intention of reducing the number of detentions as people will continue to present in crisis, meeting the threshold of the amended detention criteria.

11.2 Section 136 has long been controversial, particularly the use of police stations as a place of safety. We welcome Clause 41 to remove police stations and prisons as a place of safety.

11.3 However, there is a need to ensure that there is sufficient capacity for places of safety that can meet a variety of needs throughout the system to reduce the risk of out-of-area placement for people in crisis.

11.4 There also needs to be sufficient 24/7 crisis prevention to ensure that the police are not relied upon to deal with mental health emergencies. Many localities now have mental health support or triage working with or alongside the police, including in call handling. In the absence of better community prevention to stop people reaching crisis point, this can be a helpful approach.

11.5 In 8.8 we comment on the disproportionate use of CTOs on individuals from particular ethnic backgrounds. The measures to reduce the use of CTOs must be monitored as to their effectiveness in reducing this disproportionality, particularly affecting Black and Black British men, not just the reduction of overall CTO numbers.

12 What do you think the impact of the proposals will be on the workforce within community mental health services and multidisciplinary working practices both in inpatient and community services?

12.1 From the perspective of the social work workforce, there are already insufficient staff to deal with current challenges in the form of both increasing demand and the existing backlog of work which has been aggravated by the effects of the pandemic.

12.2 In the BASW 2021 Annual Survey, more than two-fifths of social workers who responded plan to either retire, take early retirement, change careers, or reduce their hours in the next three years[x]. This will further aggravate existing challenges in filling vacancies, with the vacancy rate in adult social work standing at 9.5% as of September 2021, an increase of 2% on the previous year[xi].

12.3 Existing data suggests up to one third of the current AMHP workforce are approaching retirement age[xii]. Approximately 95% of AMHPs are social workers. Whilst the option to qualify as an AMHP is open to other relevant professions, there has been little uptake. The reasons for this limited uptake require consideration.

12.4 Even before the Covid-19 pandemic, the training of social workers to become AMHPs was under pressure. Local authorities were unable to send groups of social workers for AMHP training because they were (and are) unable to backfill their roles within the service. This prevents the necessary number of social workers undertaking AMHP training because the broader issues of social worker recruitment and retention remain unaddressed, including years of cuts to local authority budgets and the highly demanding nature of the profession in increasingly difficult circumstances. It is thus impossible to see how the levels of AMHP workforce expansion predicted as required by the Government's own Impact Assessment can take place.

12.5 Broader issues facing the social work workforce need to be addressed to allow social workers to discharge their role as AMHPs and their broader role supporting those experiencing poor mental health effectively. Workforce pressures existed pre-pandemic and caseloads and referrals continue to increase. Growing vacancy rates impact workload and morale, with the latter also impacted by cuts to services which undermine the capacity of social workers to achieve positive outcomes for those they support.

12.6 The current tendency towards fragmentation in the system needs to be addressed. An example would be the breakdown of section 75 agreements between health and social services, resulting in people having two care coordinators rather than one. Another example is the separate delivery of substance use and mental health services even though many individuals may seek to self-medicate their mental health problems through substance use.

13 What changes and additional support do you think will be needed to help professionals and the third sector implement the proposals effectively? Will additional staffing and resources be required?

13.1 As highlighted throughout our submission, if the proposed Bill is to achieve its intention of reducing compulsory admissions, there needs to be a significant investment to improve the availability of services, both NHS and non-NHS, hospital and community, and to increase the number of staff available to provide both these services and to apply the Act in practice (see 12.3/12.4).

13.2 Reforms cannot focus upon what happens within the NHS without considering the implications for other parts of the support system. Unless the system as a whole is properly resourced and able to support people in the community, we may see greater levels of hospital admission if that is the only place where resource is available.

13.3 We underlined the existing problems of recruitment and retention in the social work workforce in addressing the previous question, especially the risk of a significant number of departures from the profession in the next three to five years unless there is considerable improvement in working conditions. This includes filling existing vacancies and reducing time spent on administrative tasks at the expense of relationship-based practice. This will impact the profession's ability to help support people in the community who are at risk of detention.

14 How far will the draft Bill allow patients to have a greater say in their care, with access to appropriate support and avenues for appeal?

14.1 In principle, the draft Bill will allow patients to have a greater say in their care. Some aspects of this are likely to depend upon the workload and availability of the professionals involved, for example, Independent Mental Health Advocates (IMHAs).

14.2 We recognise the importance of good advocacy and agree with the proposed extension of IMHA powers. The development of IMHA support is one of the changes with the most potential to change experiences of admission and protect people's ability to exercise their rights and express the wishes and views more effectively.

14.3 The current IMHA services are under-resourced and the proposals for IMHAs are highly resource-dependent, with further extension of advocacy provision being subject to the availability of funding. This leads to concern that funding may not materialise. Additional costs in supplying and training advocates need to be taken into account, especially in light of the importance of culturally appropriate advocacy highlighted in 8.5.

14.4 IMHA provision in Wales, under the Mental Health (Wales) Measure 2010, is currently more extensive than in England. Guidance is required on IMHA provision for patients who may find themselves detained in one nation but ordinarily resident in the other, for example because they require specialist treatment or due to a shortage of available acute beds. IMHA provision should aim for parity of support.

14.5 We agree with the proposed changes to the timetable for referrals to the Tribunal to allow more opportunities for both challenge and review. However, from a practical perspective, the pressures upon the Tribunal system require addressing. Colleagues in Wales note that the Welsh tribunal is already unable to cope with the demands placed upon it now, and nor can the Welsh AMHP cohort. In order for the new timetable to work effectively, the tribunal system and the AMHP workforce require a greater level of resource and supportt

14.6 With regard to the right to refuse treatment, we recognise the right of someone with capacity to be able to "choose to suffer" rather than having a particular treatment to which they object is consistent with the thrust of human rights law. It also brings treatment for mental health more closely in line with the ability to refuse treatment for physical conditions. People's rights should be upheld if they have capacity to make these decisions. Legally robust

assessments of capacity are essential – it is inappropriate to automatically conclude a lack of capacity because a professional disagrees with the choices made. We recognise that this proposal raises questions about the balance of different rights suggesting some future decisions may require legal review. This point relates to the changes to the fourth requirement for Category 3 treatment.

15 What do you think of the proposed replacement of "nearest relative" with "nominated persons"? Do the proposals provide appropriate support for patients, families and nominated people?

15.1 The hierarchy of the 'nearest relative' approach is outdated and requires revision. We support changes to introduce the Nominated Person (NP) as this empowers an individual's choice and better reflects the range of diverse living and family arrangements.

15.2 We query what would happen in the instance of an individual, with capacity to make the decision, attempting to change their selection of NP repeatedly until they find an NP who supports their personal view that they should not be sectioned.

15.3 Whilst the Bill instructs AMHPs on consulting with the apparent Nominated Person of a patient (Clauses 22-24), it does not cover the question of the appointment of an interim nominated person by the AMHP as happened with the Nearest Relative. It is important that there is clarity as to what happens in such circumstances. Will this be covered in the new Codes of Practice? AMHP leads should be involved in developing any criteria governing such appointments. As the choice would be more subjective than under the Nearest Relative approach, it is important that the Tribunal and/or Court would have to be working to the same criteria in the case of challenges to this choice.

15.4 Clauses 22-24 also do not cover the question of what happens when a Nominated Person may be inappropriate or unsuitable. This relates to the interface with the Care Act 2014 and the prospect of coercive control if the person nominating the NP is deemed to have capacity but is at risk of being coerced.

15.5 For the role of NP to operate effectively, training and support will be required to ensure those undertaking it have a clear understanding of what the role entails and what they may be expected to do.

16 To what extent is the Government right in the way it has approached people taking advance decisions about their care?

16.1 Clause 9 lays out the considerations the Responsible Clinician (RC) should take into account when making treatment decisions. These reflect the importance of considering the patient's past and present wishes, feelings, and beliefs insofar as they can be ascertained. It also lays out who the RC should consult as far as practicable.

16.2 Explicit references in the Bill to advance decisions refer to valid and applicable advance decisions made by the patient within the meaning of the MCA (Clause 17: Capacity to consent to treatment).

16.3 Neither of these clauses explicitly relate to the prospect of an Advance Choice Document (ACD) which was present in the White Paper consultation. Some concerns were raised by BASW at the time as to whether the scope of the proposed ACDs was sufficiently wide with regard to personal preferences. Concerns were also raised about practical issues such as storage and retrieval and being sure someone had capacity at the time of creating the document. Despite

these issues, these documents represent a way of capturing many of the dimensions an RC would be seeking to take into account under Clause 9.

17 What impact will the draft Bill have on children, young people and their families? Does it take sufficient account of the existing legal framework covering children and young people?

17.1 The MHA has always covered children and young people and has therefore interactive with the existing legislative framework for children and young people for some time.

17.2 It is difficult to predict in advance what impact legislative changes may have upon an existing balance of powers, duties, and responsibilities, of which there are many in relation to the safeguarding and wellbeing of children and young people.

17.3 From our perspective, it is vital that the proposed changes respect and protect Article 8 rights (Right to respect for private and family life) and that support and resource is available to avoid, for example, out of area placements where a young person can only receive the necessary specialist treatment at considerable distance from their family and community.

17.4 Given the well-documented problems with the backlog of CAMHS referrals and high thresholds for treatments, adequate resourcing of CAMHS is also a relevant issue.

18 To what extent are the proposals to allow for conditional discharge that amounts to a deprivation of liberty workable and lawful?

18.1 It is not our place to comment on whether these proposals are lawful. With regard to workability, we refer again to the need for both sufficient staffing levels and resources as these arrangements, although applying only to a small number of individuals, are likely to be resource-intensive to ensure the necessary conditions can be met.

18.2 We agree in principle with the idea of the conditional discharge. The proposed amendments in Clause 30 ensure there is a legal framework and safeguards to support such discharges. We agree with the proposed safeguard that any 'supervised discharge' orders are subject to annual tribunal review. Clear procedures need to be in place for those individuals placed on such discharges but for whom the arrangements are failing to work. This needs to be a robust and flexible procedure to ensure these people do not become a danger to themselves or others.

18.3 Any increase in the workload of social workers as a result of these arrangements must take into account the existing workforce pressures highlighted in 12.3 and 12.4.

19 What are your views on the proposed changes in the draft Bill concerning those who encounter the Mental Health Act through the criminal justice system? Will they see a change in the number of people being treated in those settings?

19.1 We appreciate the intention of Clause 31 to introduce a statutory 28-day time limit within which people in prison with severe mental health needs must be transferred to hospital for treatment. Given the shortage of available acute beds, we are concerned that meeting this time limit may prove challenging.

19.2 Reducing the automatic referral period for Part 3 restricted patients from three years to twelve months under Clause 29 aligns with changes to referral periods introduced elsewhere in the Bill.

19.3 We remain concerned that in the absence of sufficient community support, there is a risk of people being diverted into the criminal justice system if they don't meet the new detention criteria and are not receiving the care and support they require elsewhere.

19.4 We have particular concerns in this respect with regard to people with severe LD/A (see 10.8 and 10.9)

20 Are there any additions you would like to see to the draft Bill?

20.1 We would like to see responsible authorities required to publish a plan within twelve months of the Bill coming into force as a legislative Act that maps existing early intervention support and gaps in its provision.

20.2 Such plans would form the basis for building up the level of early intervention and community support required to make the intentions of the Bill achievable. The plans could also be used as the basis for scrutinising the level of allocation of resources to the service delivery required to prevent hospital admissions under the Act.

---

[i] Skills for Care/Workforce Intelligence: Approved Mental Health Professional (AMHP) Workforce (data correct as of 2021/22)

[ii] Skills for Care/Workforce Intelligence: Approved Mental Health Professional (AMHP) Workforce (data correct as of 2021/22)

[iii] NHS Digital: Mental Health Statistics, Annual Figures, England, 2020-2021. (Published 26 October 2021): p2

[iv] Stats Wales: Admissions to Mental Health facilities by local health board. Year 2019-20.

[v] Care Quality Commission: Monitoring the Mental Health Act in 2016/17 (CQC, 2019): p5

[vi] Davie, E: Poverty, economic inequality and mental health (Centre for Mental Health, Briefing 58, July 2022)

[vii] 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)

[viii] *Ibid*: p2

[ix] NHS Digital, Learning Disability Services Monthly Statistics, AT: May 2022, MHSDS: March 2022 Final (2022).

[x] BASW: The BASW Annual Survey of Social Workers and Social Work: 2021 – A summary report. (Birmingham: BASW, 2022): p17

[xi] Skills for Care/Workforce Intelligence: Headline Social Worker Information, (February 2022): p2

[xii] Skills for Care/Workforce Intelligence: The Approved Mental Health Professional workforce in the adult social care sector (2021): p8