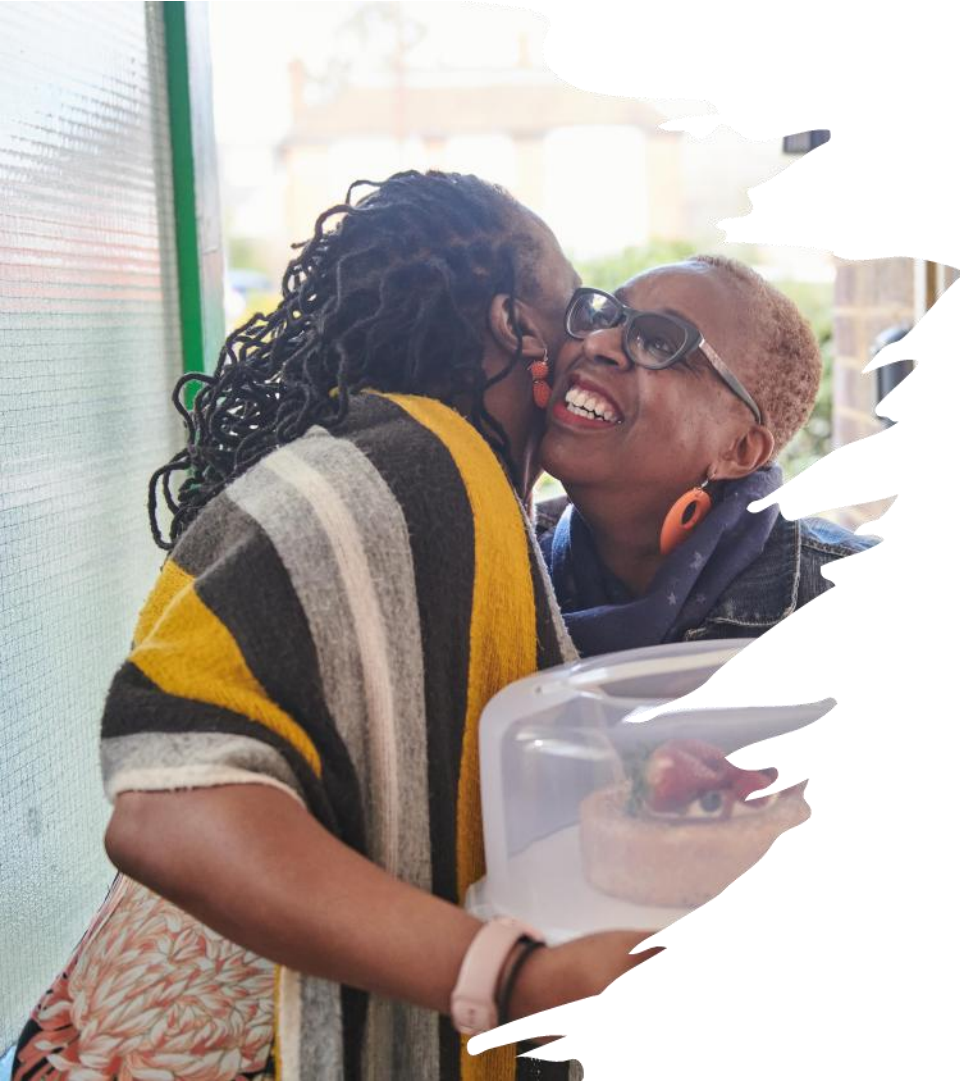


# Strategic & Practical Implications of Mental Health Act Reform

Claire Barcham,  
Senior Officer, Policy and Practice  
National ADASS Team

# Key themes:

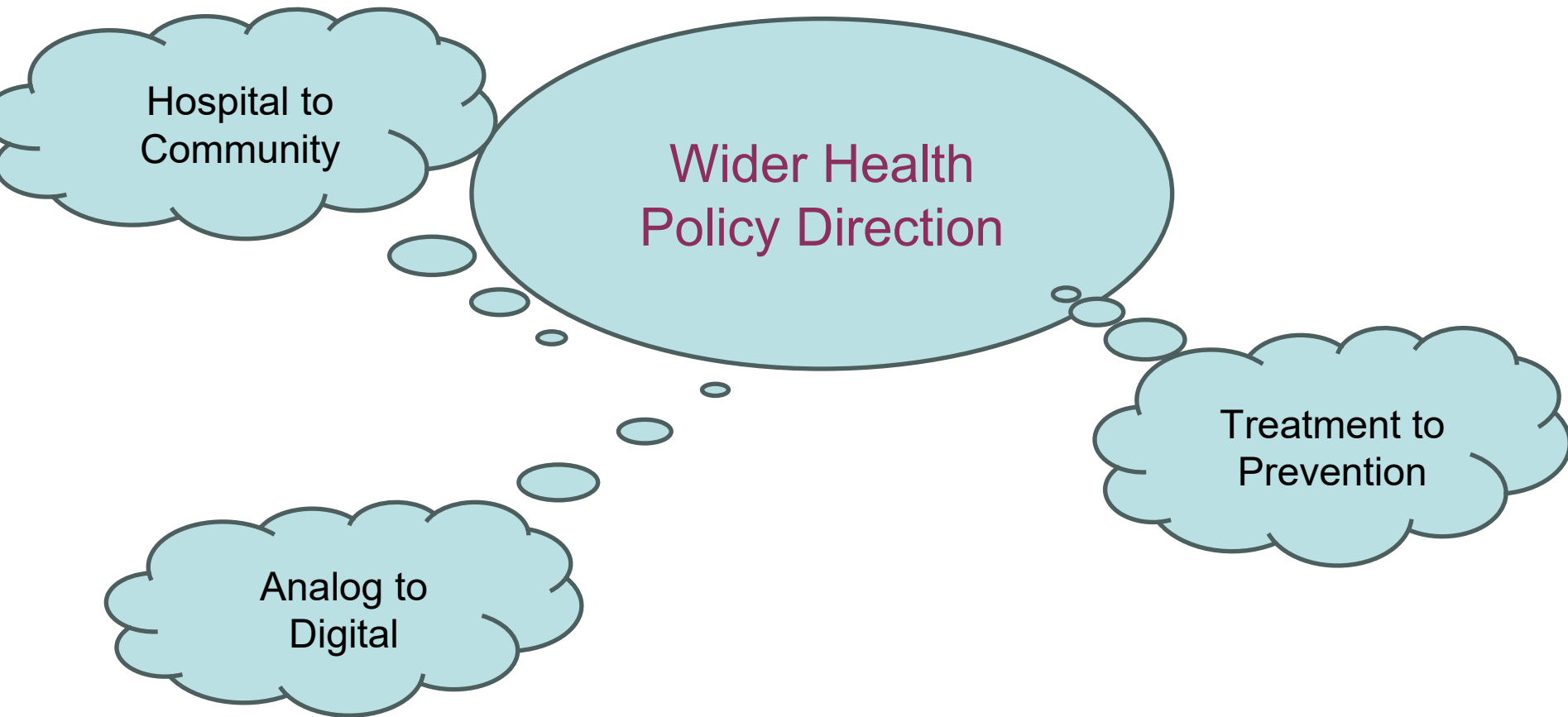
1. Policy Direction
2. The wider context
3. Legal Reforms



## Original intention of the reforms:

- rebalance the system to be more person centered
- address structural inequalities around race & ethnicity
- reducing admissions & use of the Mental Health Act

# Policy Drivers:



# Wider Policy Context:

Nottingham and Southport Public enquiries

Progression to Adulthood

NHS England abolition

Things to Consider....

How the money moves around the system...

The Supreme Court Judgement, DoLS & LPS - what happens next?

RCRP/ Powers of Entry/Public Protection

Neighborhood Health & Care

Local Government Reorganisation

# Legal Reforms

## Most Relevant Reforms

'Opt out' & culturally appropriate advocacy

Nearest Relative to Nominated Person

Limitations on use of CTOs

S117 brought into line with the Care Act

'increasing' threshold for detention

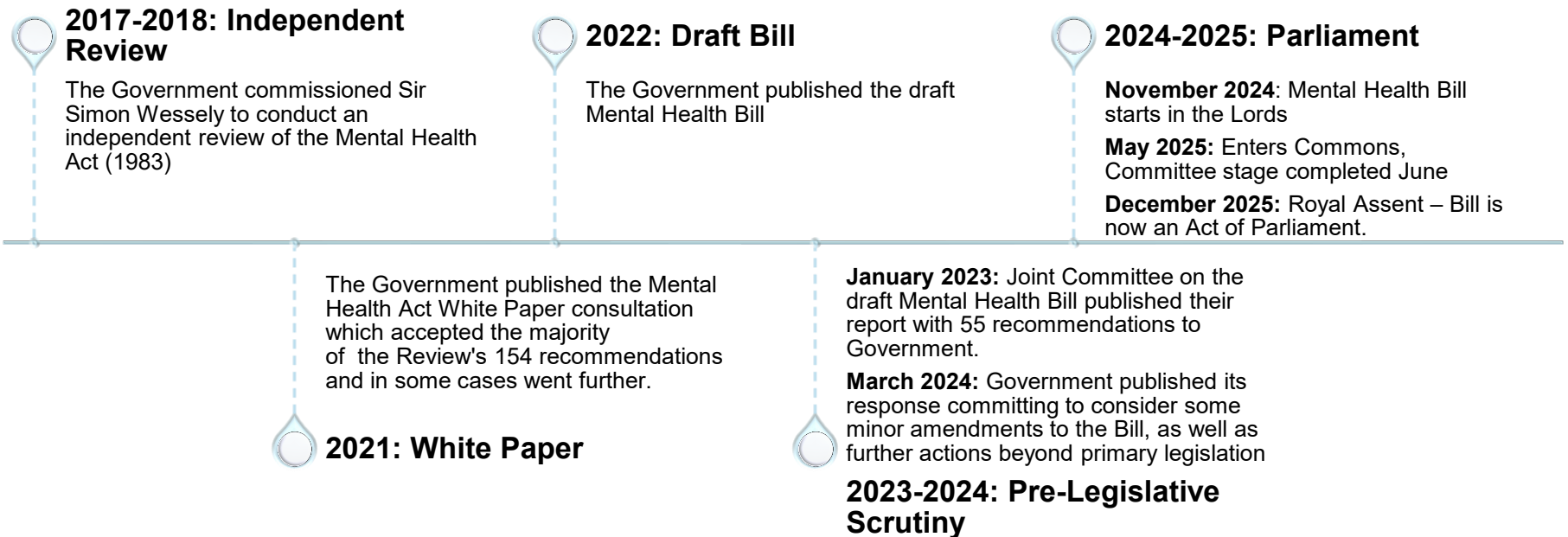
Removal of LD & A from definition Mental Disorder for longer term detention

Statutory Care and Treatment Plans

Legal time limits on transfers out of prison

Reinvention of Guardianship

# After many years of development, we have a new Mental Health Act



# The new Act aims to improve care across the pathway



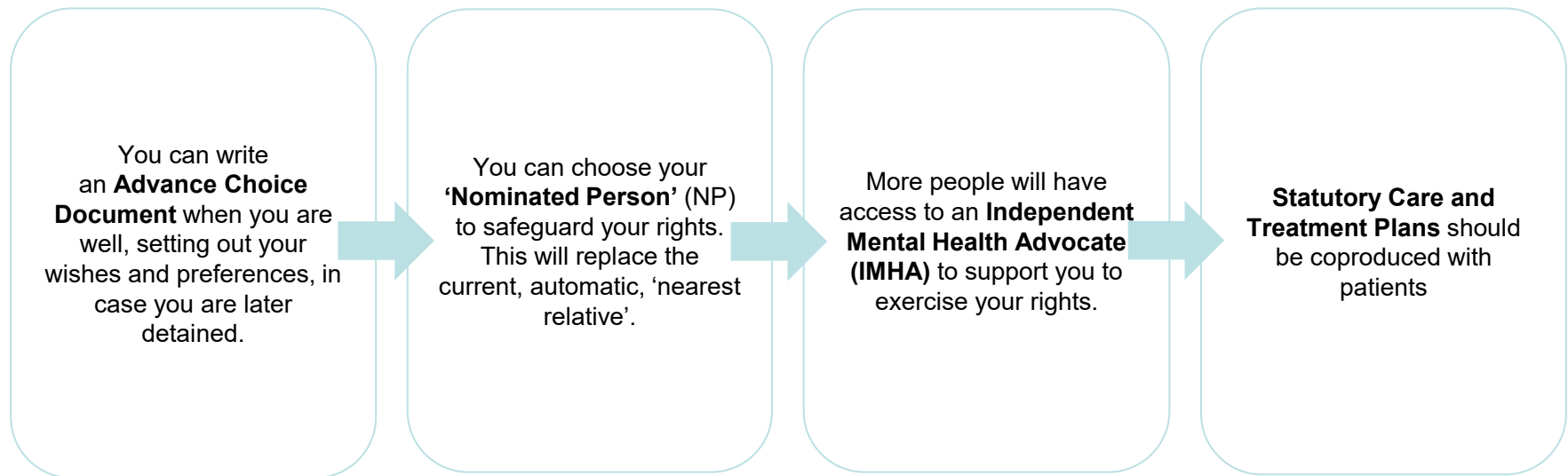
Reforms take forward **the vast majority of the 2018 Independent Review's recommendations** and include a wide range of changes to shift the balance of power from the system to the patient.

These changes have been **informed by the four principles** developed by the Independent Review and in partnership with people with lived experience. They are:

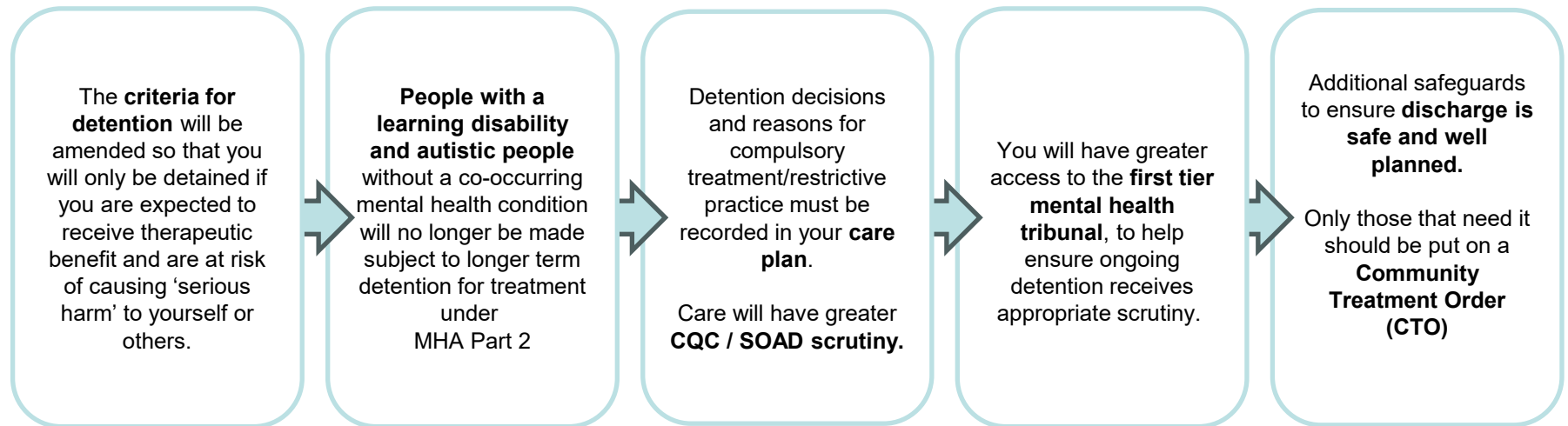
- Choice and autonomy – ensuring service users' views and choices are respected
- Least restriction – ensuring the MHA powers are used in the least restrictive way
- Therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the MHA
- The person as an individual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

The wording of the guiding principles are on the face of the Act, within the Act's requirements for the statutory Code of Practice.

## How will things change for people with mental health problems: Choice and autonomy



## How will things change for people with mental health problems: Least restriction and therapeutic benefit



## How will things change for people with mental health problems: Criminal Justice System



# Next Steps

## February 2026: First reforms commenced

- This includes supervised discharge.



## By December 2027 (2 years from Royal Assent)

- Commencement of reforms to timeline for prison transfers

## 2028/2029: First Major Reforms “Phase 1”

- Reforms that come at little to no additional cost or burden on the workforce. Such as:
  - Principles
  - Detention criteria changes (not including s3 for people with a learning disability and autistic people)
  - Nominated Person
  - Other reforms that change processes and decision making, but do not require significant workforce expansion, such as some of the treatment reforms that do not place additional burden on the SOAD system.



## Post 2029: Later Reforms

- Reforms that require additional funding; workforce expansion and/or development of infrastructure to commence safely. Such as:
  - Section 3 detention criteria changes for people with a learning disability and autistic people
  - Increased frequency of Mental Health Tribunals
  - ICB / NHSE Duties on Advanced Choice Document
  - Statutory care and treatment plans
  - Removal of police stations as place of safety

# Timeline to Phase 1

## Drafting the revised Code of Practice

We will consult extensively on the development of the Code.

Alongside we will develop the required secondary legislation.

2026

Early 2027

## Public Consultation on draft Code of Practice

We will launch a public consultation on the draft Code.

## Training workforce on draft Code of Practice

Following development of the revised Code of Practice we will then need time to train the existing workforce on the new Act, regulations and the Code – indicatively over 27/28.

2027-2028

2028/2029

## First major reforms commence

Initial implementation will follow training – indicatively in 2028/29.

In parallel we will publish the updated Code and required secondary legislation.

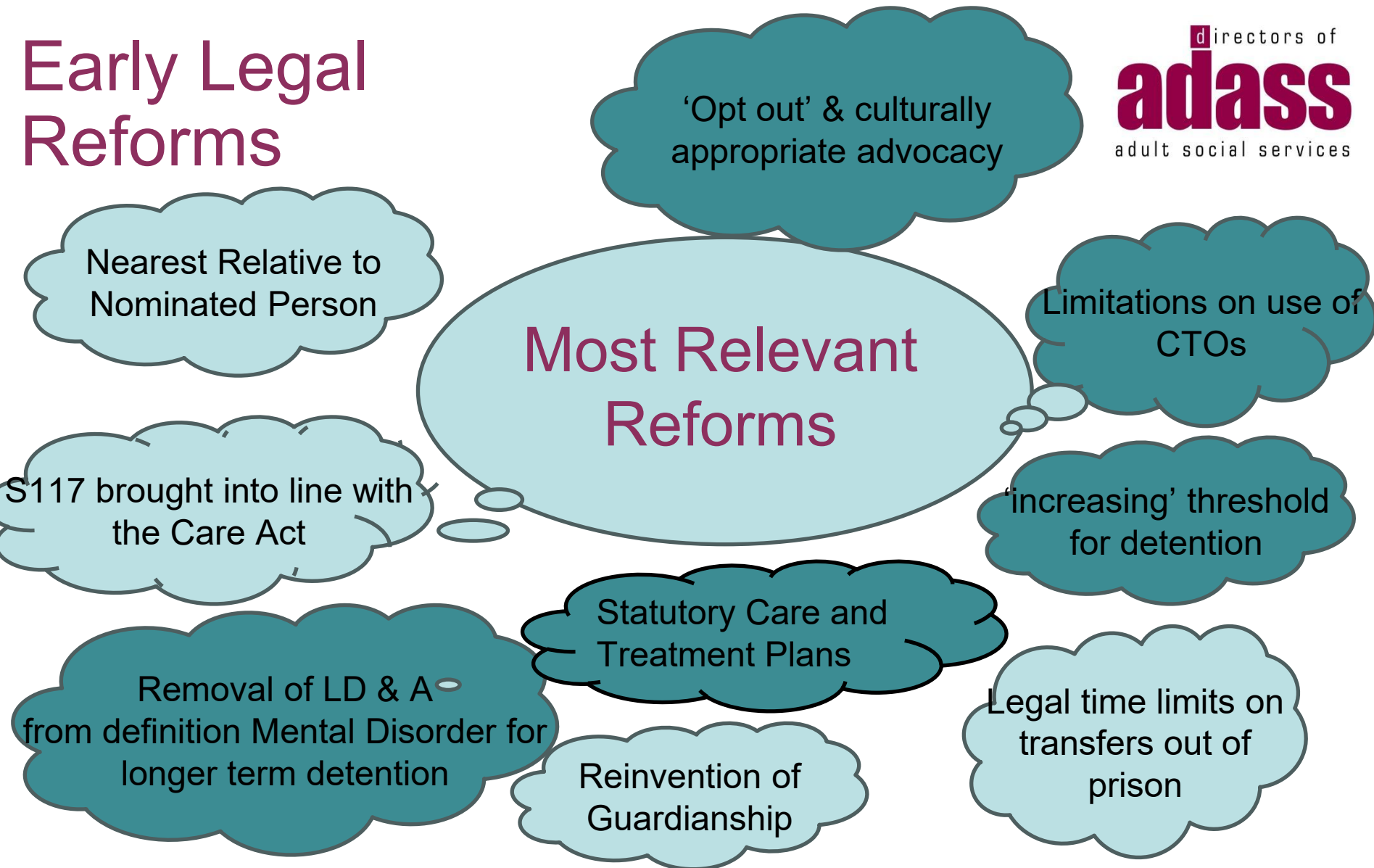


# S135/136 Consultation

- The DHSC have committed to **exploring the powers available to different professionals in different situations** and settings, in particular but not limited to consulting on the operation of **sections 135 and 136** emergency powers.
- The consultation will seek views on powers and joint working approaches to **ensure health and social care professionals and police have the appropriate powers** to act in order to protect people from harm to themselves and to others when in a mental health crisis.
- They have committed to work closely with the police, health and care representative groups and people with lived experience, to **define the scope for the consultation** and will set out further details in due course.

# Early Reforms

# Early Legal Reforms



## Nearest Relative to Nominated Person

- This change will allow people to choose the person they want to support and represent them if they are assessed or detained under the act, or made subject to Guardianship
- The AMHP will have an obligation to let the nominated person know if they are going or have admitted someone under s2 (for assessment). They will also have an obligation to consult the nominate person if they have been asked to consider admitting someone under s3 or using Guardianship.
- The nominated person can object to the use of s3 or guardianship, but **the AMHP will be able to overrule this objection** if they believe that without admission or the use of Guardianship the person would be likely to act in a manner that is dangerous to other persons or to the patient.

# 'Increasing' the threshold for admission

- **The criteria will only allow be able to be detained under s2, 3 or a CTO if**
- 'serious harm' may be caused to the health or safety of the patient or another person unless the person is detained
- Assessors must consider the 'nature, degree and likelihood' of the harm

# Changes for people with a learning disability and autistic people

- It will no longer be possible to detain people under s3 or a CTO (ie longer forms of detention) only on the basis that they have a learning disability or are autistic – however these **changes will only be introduced after 2029** once sufficient alternative community provision is available.
- ALSO a guardianship application may be made in respect of a person on the ground that the person has either a psychiatric disorder, or autism, or a learning disability with has serious behavioural consequences

# Changes in relation to people with a learning disability or autism

- However, there are also changes requiring ICB's to keep a register of those people within their area of responsibility who have a learning disability or autism, and who are at risk of admission. This is likely to start earlier 2027/8. (s125D)
- There are also duties on ICBs and Local Authorities to use the information in the register in relation to their commissioning and market shaping duties, to ensure community resources are available to prevent admissions to hospital.
- In addition, Care, Education and Treatment reviews for those with a learning disability or autism who are under 18yrs or over 18yrs but have an EHCP under s37 of the Children and Families Act 2014.

# Changes in relation to advocacy



- In the future (post 2029) advocacy will be available on an opt out basis to both informal patients and those detained or on Guardianship

## Community Treatment Orders – the changes

- One of the later changes (but worth knowing about now)
- The aim is to reduce the use of CTOs by:
  - Involving a 3<sup>rd</sup> person (the responsible community clinician) when the order is made, renewed or conditions are varied, if the original decision maker isn't the community clinician.
  - Providing a similar threshold to that used for s3
  - Providing that the nominated person can object to the use of the CTO (but this can be overruled in dangerous situations)
  - Providing additional review points (access the tribunals etc) at the 3 month point in the use of s3

# **AMHP Practice, Section 13 Considerations, data collection & the changing face of Mental Health Act Assessments**

With thanks to Robert Lewis,  
Mental Health Lead CSWO

## Approved Mental Health Practice – The Context



It is estimated that there are between 165k – 200k requests are made to AMHP services each year. Of those, approx. 55,000 (27-33%) result in the use of compulsion. This is a 15% increase in requests since ADASS was part of a ‘snapshot’ of AMHP data in 2017, when the estimated number of requests was 140k

Nationally, the outcomes for the rest is not known. Neither are the demographics of those referred, the identities of the referrers, the location or status of the individual, or the delays and challenges faced by AMHPs in securing the best outcome from their consideration. One of the commitments from the Government is to support the development of an AMHP data set – and work on this is currently underway.

## Considerations can start now



- Start to explore now with partners how to change the provision and deployment of AMHPs and other resources needed to make the revised systems work.
- Why? Financial and personal consequences of undertaking Mental Health Act assessments. Early pilots have resulted in reductions of upto 40% in the numbers of full assessments undertaken.

# Consequences of AGNI case on Mental Health Act assessments and admissions

# Implications for AMHPs of the AGNI Supreme Court Judgement



## INFORMAL ADMISSION & CONSENT: KEY FACTORS FOR PRACTITIONERS



A practical guide for understanding the new approach post-Supreme Court



### 1. STARTING POINT: ARTICLE 5 HIGH ALERT

**!** Informal admission to a mental health hospital is not a level playing field.

Default position: there may be a deprivation of liberty.

You must be able to show ALL of the following:

- ✓ Clear understanding of the nature and purpose of admission and treatment
- ✓ Meaningful acceptance (not just acquiescence)
- ✓ No objection and free from pressure
- ✓ Proportionate restrictions only
- ✓ Realistic ability to leave
- ✓ Access to challenge and review

If you cannot evidence these, consider ss.2, 3, 4 MHA / DoLS (England) / IMHA (Wales) or other Article 5 route.

### 2. RECENTLY DETAINED UNDER S.2 OR S.3?

**!** **HIGH CAUTION – NOT A NEUTRAL RESET**  
If compulsory powers were needed moments earlier, the bar for concluding there is now no deprivation of liberty is HIGH.

You must record:

- ✓ What has materially changed since detention was considered necessary?
- ✓ Why compulsory powers are no longer required
- ✓ Whether the person is genuinely accepting admission and treatment
- ✓ Whether restrictions remain, and why they are now proportionate
- ✓ Why Article 5 safeguards (ss. 2, 3, 4 MHA, DoLS/ IMHA or other) are not required

Avoiding ss. 2, 3, 4 MHA, DoLS or other safeguards must not be driven by convenience or s.117 aftercare implications.

### 3. INFORMAL ADMISSION VS OTHER ROUTES

**VOLUNTARY ADMISSION**



Clear, capacitated consent and decision-making

**INFORMAL ADMISSION**



Contextual assessment – but still requires understanding, acceptance and no objection

**FORMAL ROUTES**  
ss. 2, 3, 4 MHA



Where criteria met and compulsory treatment / safeguards required



**DoLS (England)**

Where there is a deprivation of liberty and no valid consent



**IMHA (Wales) – A RIGHT**

Available to informal and detained patients



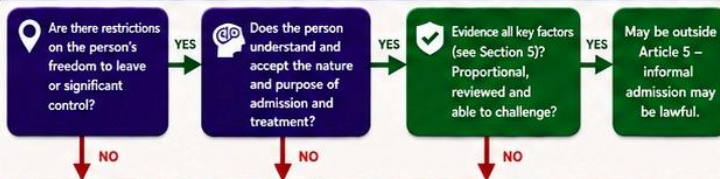
Informal admission is not a way to avoid safeguards – it is only lawful if Article 5 is not engaged.

### CORE MESSAGE

In mental health hospital settings, start from the practical possibility that there IS a deprivation of liberty, unless there are specific, evidenced reasons why not.

**!** LEAST RESTRICTIVE ≠ LEAST SAFEGUARDED

### 4. DECISION FLOW – IS THIS A DEPRIVATION OF LIBERTY?



**HIGH RISK OF DEPRIVATION OF LIBERTY – CONSIDER FORMAL ROUTE**  
ss. 2, 3, 4 MHA / DoLS (England) or other Article 5 route.

### 5. KEY FACTORS TO CONSIDER AND RECORD

**UNDERSTANDING**



Basic understanding of where they are, why, and what is proposed

**ACCEPTANCE**



Meaningful acceptance, not just compliance or acquiescence

**NO OBJECTION**



Freely agreeing or not objecting, not due to fear, pressure or lack of choice

**RESTRICTIONS**



Only what is necessary and proportionate to clinical needs and risk

**REVIEW & CHALLENGE**



Regular, active review and real access to challenge and advocacy

### 6. DO NOT ASSUME CONSENT

Be cautious if the person is:

### 7. ENGLAND / WALES PRACTICE NOTE

WALES – IMHA AVAILABLE TO

ENGLAND – SAFEGUARD GAP

# PCH Mental Act implementation project

# PCH project

- The aim of this project is to ensure councils are ready and able to meet due statutory responsibilities of the Mental Health Act for people with a learning disability and autistic people.
- Key focus will be the code of practice
- Council learning, experience and insights gathered through this work will inform ongoing input into developing the Mental Health Act 2025 Code of Practice and inform the production of additional PCH advice and guidance for councils
- Products will include: briefings, events, strategic and practical guides.....

## Products TBC

5 easy to use publications/resources to outline key changes in relation to the Mental Health Act 2025 which local council workforce will need to be aware of and integrate into daily practice covering: policy, practice, commissioning and workforce issues, including:

1. A basic briefing for all council staff groups including senior staff on the implications of the Act for councils.
2. Practice issues – to include role and responsibilities social worker/AMHP's in S117 assessments and new responsibilities for AMHPs
3. Commissioning – to help councils ensure that they expand their Care Act responsibilities to develop and manage the local care market to comply with section 117 responsibilities
4. Workforce: (a) social care provider workforce expectations and (b) practice reviews implications
5. To be agreed with the steering group

The PCH team will also produce a briefing regarding Positive Behaviour Support - appropriate commissioning and oversight - and will facilitate a face-to-face event to promote learning from the project.



## Questions & Discussion