Written evidence submitted by the Local Government Association (LGA) (MHB0017)

1. About the Local Government Association (LGA) & the Association of Directors of Adult Social Services (ADASS)

1.1. The LGA is the national voice of local government. We are a politically led, cross party membership organisation, representing councils from England. Our role is to support, promote and improve local government, and raise national awareness of the work of councils. Our ultimate ambition is to support councils to deliver local solutions to national problems.

1.2. ADASS is the voice of leaders in adult social care. ADASS are a membership charity, and a leading, independent voice of adult social care. We promote high standards of social care services, influence policies and decision makers so that anyone needing or providing care and support can live the lives they want regardless of age, disability, status or social background.

1.3. ADASS aim to ensure that high quality social work, care and support are available to all who need it. We aim to promote the need for adequate funding for social care and to ensure that the infrastructure needed to provide it is available. We aim to further the interests of people who require access to social care regardless of their background and status and to promote public understanding of social care.

1.4. Councils have statutory duties and powers related to mental health for children and young people and for adults under the Mental Health Act and Mental Capacity Act, they are they are also responsible for commissioning many local community based mental health support services.

2. Summary

2.1. The LGA and ADASS support the reform of the Mental Health Act to improve choice and autonomy, ensure least restriction, support therapeutic benefit, and promote the rights of the individual.

2.2. The Bill Impact Assessment does not identify any increase in demand of community mental health services, aside from advocacy. To achieve this reform successfully, it will require investment in local authority community mental health services and the workforce. This is particularly important as statutory local authority adult mental health services are funded from the social care budget.

2.3. Local authorities require sufficient funding to invest into early intervention and prevention services to reduce the increasing mental health needs among children and young people. Sometimes young people will require more specialist support.

Funding is required to ensure that they can be supported in their communities with specialist services and a trained workforce that can respond to their needs.

2.4. Such an investment in mental health must go beyond the traditional areas of 'treatment' provided by NHS colleagues, and recognise the role of councils in general, and adult social care in particular, in supporting a wide range of people whose mental health impacts on their ability to manage life effectively or compounds the other challenges they face.

2.5. The Bill will require a clear implementation programme with funding to ensure the workforce is prepared effectively, and availability of a range of community mental health services to ensure options for local person-centred care and support are available. This is currently not addressed in the Bill's impact assessment.

2.6. It is recommended that the Department of Health and Social Care (DHSC) Mental Health Act policy team and the Mental Capacity Act/Liberty Protection Safeguards (LPS) policy team work together to develop solutions to ensure there is no loss of safeguards for those individuals and to reassure the sector on these matters.

2.7. The LGA and ADASS will be keen to continue work with DHSC to shape the Act going forward. Particularly areas where the legislation and associated guidance reflect the role and responsibilities of councils in statutory mental health.

3. How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act 2005? Might there be unintended consequences and, if so, how should those risks be mitigated?

3.1. There have been questions raised within the local government sector about whether changes proposed to the Mental Health Act to exclude people with a learning disability or autism or both from long term use of that Act, would instead lead to people being deprived of their liberty in a mental health hospital under the Mental Capacity Act. And if this happened, whether they would be afforded the equivalent safeguards to those offered to them currently when detained under the Mental Health Act. It is recommended that the Mental Health Act policy team and the Mental Capacity Act/Liberty Protection Safeguards (LPS) policy team work together to develop solutions to ensure there is no loss of safeguards for those individuals and to reassure the sector on these matters.

3.2. It is likely that the Bill will lead to an increase in the use of Guardianship (s7). A Guardianship Order under the Mental Health Act is an order under either s7 of the Mental Health Act or by a judge under part 3 of the Act, which allows the Guardian (usually the local social services authority) to specify where someone should live and set expectations around the person allowing access to their home and attending somewhere for occupation or activity. Guardianship has been suggested as a

possible framework for some people with learning disabilities who are currently detained in hospital. It would be helpful for DHSC to publish information on the potential impact on Guardianship and to undertake an impact assessment, including the need to develop more guidance for local authorities who would need to manage any increase in its use.

4. 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?

4.1. The LGA and ADASS support the reform of the Mental Health Act to improve choice and autonomy, ensure least restriction, support therapeutic benefit, and promote the rights of the individual.

4.2. We prefer this to an approach that would amalgamate the Mental Health Act and Mental Capacity Act, as more time is needed to evaluate the impact of these different approaches on the care and support available to people experiencing mental health problems.

4.3. At present, the new Bill Impact Assessment does not identify any increase in community services, aside from advocacy. To achieve this reform successfully, it will require investment in local authority community mental health and learning disability services and the workforce, whilst also ensuring stability and continuity of commissioned services to keep people safe in the immediate future, with evidence that this has been progressed with meaningful coproduction between service users, commissioners, and providers. For more information, please see the submissions from ADASS and the LGA regarding the ten-year plan for mental health.

4.4. It is important to recognise that statutory local authority mental health services are funded from the social care budget. For adult social care, significant underfunding, coupled with rising demand and costs for care and support, have combined to push care services to breaking point. Over the past decade, adult social care costs increased by £8.5 billion while total funding (including the Better Care Fund) only increased by £2.4 billion. This left councils with a funding gap of £6.1 billion. Of this, £4.1 billion was managed through savings to the service, and £2 billion was managed through funding diverted from other services by cutting them faster than otherwise would have been the case.

4.5. Increased requests and referrals for mental health care, support and safeguards is also increasing. In the ADASS Spring Survey 2021/22 the majority of Directors reported increased requests and referrals because of mental health issues, as well as a rise domestic abuse and carer safeguarding concerns.

5. **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?**

5.1. The wording in the draft Bill appears to have the right balance between patient autonomy and safety of others. To be applied in practice, the Bill will require a clear funded implementation programme to ensure the workforce is prepared effectively, and availability of a range of community mental health services to ensure options for local person-centred care and support are available.

5.2. There are, however, some practical implications to the way in which the role of the 'Nominated Person' has been written that we are concerned are likely to result in many more people entering hospital without having someone to represent and support them. The draft as it stands has chosen not to take forward the recommendation from the Wesley review of the Approved Mental Health Professional (AMHP) being able to nominate an 'interim' nominated person, in circumstances where the person is unable to do this for themselves. What is currently being proposed is that the person the patient wishes to have as their nominated person, needs to be in the same room, and sign to say they accept the role, and have this witnessed in person. This is an impractical suggestion for many people.

5.3. Finally, careful thought needs to be given to the change in definition, and whether it's application may have unintended consequences, especially in relation to Section 2. For example, how easy will it be for professionals to make judgements about how soon harm might be likely to occur, particularly when considering someone new to mental health services? We know that early intervention in young people with first episode psychosis is essential to reducing harm, but how easy will it be to make judgements about how soon harm would occur? Equally, might this inadvertently lead to further discrimination against people from black and other ethnic minority communities, who are less likely to enter the mental health system early? It would be helpful to undertake further research on this point.

5.4. **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?**

5.5. The Bill appears to deliver on the principles set out in the Independent Review. The principles should be included in the Code of Practice for the Bill. For consistency, they could be included in the Bill introductory text as suggested by the Independent Review.

5.6. The Independent Review recommended that 'The person as an Individual: care and treatment must be provided and commissioned in a manner that: respects and acknowledges the person's qualities, strengths, abilities, knowledge and past experience; and respects and acknowledges person's individual diversity including any protected characteristics under the Equality Act'. Although these principles have been in the Mental Health Act's Code of Practice since 2007, the CQC found that the code was applied inconsistently. Embedding the guiding principles within the Act itself will promote better understanding and awareness but will also need to be supported by workforce training.

5.7. Achieving the principles is not solely about legislative change. It is also about culture and resource allocation change. There also needs to be a range of alternative treatments and services available commissioned by councils in the community as well as NHS services. The House of Commons Joint Committee on the treatment of autistic people and people with learning disabilities 2021–22 found that releasing or transferring funding from inpatient hospital beds would be challenging, particularly if a person with a learning disability or autistic person is in a general mental health bed. This further emphasises the importance of adequate investment in community support and wider resources.

6. 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 African and Caribbean heritage? What more could it do?

6.1. To achieve the aim to reduce detentions, particularly for those of Black African or Caribbean heritage, there will need to be sufficient specialist and culturally appropriate support and services in the community. Such services are often commissioned by the local authority and delivered by Voluntary, Community and Social Enterprise (VCSE) organisations. Aside from Independent Mental Health Advocacy (IMHA) services, the Bill's Impact Assessment does not identify any need for additional services or funding for such provision.

6.2. There also needs to be greater understanding of the ways in which people from different communities enter the mental health system. There have been concerns that people from migrant and Black communities are less likely to gain access via primary care (Coker, Eleanor 1995), and as recently as 2017 ADASS & NHS' Benchmarking study suggested that people who were not from white British communities were more likely to gain access via A&E, and of those assessed after arrest in police custody, there was some evidence that people were more likely to be young and black. This needs further investigation.

6.3. The Bill will need to be supported by funding for local authorities and partners, particularly VCSE organisations to develop and sustain services for people with black African and Caribbean heritage. It also needs to be understood that such services,

because they are specialist and bespoke, will be more expensive than more generic services. Many specialist services have, over the last 10 years, lost contracts to larger providers more able to provide a cheaper service.

6.4. It would be helpful to have more knowledge on what services are required locally in terms of community-based services for people from black African and Caribbean heritage. Such as what current services are effective in providing support, what service they provide, at what scale, training needs and the costs. It would be beneficial for DHSC to undertake research on costs and outcomes, and possibly some pilots on culturally appropriate community support. It may also be helpful for other general mental health services to have culturally specific training. There are existing resources that would help DHSC understand the mental health needs of BAME communities including a Research Toolkit.

6.5. DHSC are currently running three pilots on culturally appropriate advocacy, and these may provide some additional broad information on service need in communities and effective community-based interventions, but more intelligence on what works would be helpful.

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

7.1 People with a learning disability and autistic people need appropriate support to have their voice heard and if necessary, complain or take legal action (given there is a history of people being detained in assessment centres for many years). There is evidence from research that this group and their family carers are economically disadvantaged because of their disability. This could be a barrier to families paying for support to have their voice heard or taking legal action to appeal if this unfortunately becomes necessary and their rights are not being upheld within the system. Funding to facilitate such challenges needs to be available if needed. This may also need to apply to other vulnerable groups.

7.2 We welcome the Breathing Space mental health crisis legislation to support people in mental health crisis where financial debt is a major issue. We would suggest, however, that this initiative would be better supported by investing in the infrastructure needed to make it as effective as possible. This would include ensuring that the AMHP service is well supported and staffed to undertake assessments, and that debt support services are also available to people with mental health needs.

7.3 It is also our view that Breathing Space and debt repayment plans have the potential to be most effective and achieve better, more sustainable long-term outcomes if the approach is integrated with a Government wide approach to reducing problem debt and financial exclusion. Programmes and plans such as these also have the potential to be more effective if the wider role of councils and local partners in promoting financial inclusion is properly recognised and funded.

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

8.1. We agree with the proposal to change the Act to be clearer that autism or a learning disability are not considered to be mental disorders for the purposes of most powers under the act. However, it is important to recognise that some people with learning disabilities and autism will develop mental health conditions and may need inpatient assessment or treatment.

8.2. We support the commitment to reducing the reliance on specialist inpatient services for people with a learning disability and autistic people and towards developing community alternatives. CQC State of Care 2020/21 report found poor care in inpatient wards for people with a learning disability and/or autistic people. The overall proportion of services rated as inadequate rose from 4 per cent in 2018-19 to 13 per cent in 2019-20.

8.3. The Bill outlines (125E) duties relating to commissioning of services that an integrated care board (ICB) must seek to ensure that the needs of people with autism or a learning disability can be met without detaining them under Part 2 of the Act. Also, a local authority must, in exercising its market function seek to ensure that the needs of people with autism or a learning disability can be met without detaining them under Part 2 of this Act.

8.4. We agree that supporting people with learning disabilities and/or autism in the community is the best approach, but the Building the Right Support programme has shown that it has significant costs. It is essential that alternative specialist community-based care, provided or commissioned by councils, is developed and fully funded. No additional funding for this has been linked to the new Act or identified in the Impact Assessment. A better understanding of both learning disabilities and autism is promoted amongst all agencies is also needed. Specialist advocacy services for people with learning disabilities or autism will also need to be developed and funded, alongside all advocacy services being able to make reasonable adjustments for this group.

8.5. The removal of people with a learning disability or autism from the definition of a mental disorder for the purpose of treatment, unless they have a co-existing mental health condition, is likely to lead to an increase in hospitals seeking authorisation for a deprivation of liberty for people who may not wish to stay there or have care or treatment there. Mental health hospitals are often used as a place of last resort for people who exhibit “abnormally aggressive or seriously irresponsible conduct”, because there are not enough community resources in place that can meet their needs.

8.6. Sufficient community resources are key to reducing the number of people in long stay mental health hospitals. These would also be needed for young people, not just for those over 18s. The Transforming Care programme recognised the risk that as soon as young people ended up in either 52-week residential education or in

hospital, they were on a possible path to long-term institutionalisation. Both settings are used as a last resort when families are finding it difficult to cope, and when the young person becomes too old for residential school or college they often transition into hospital. This is one of the reasons why the Transforming Care programme struggled to get the numbers of inpatients down: because young people were still being admitted due to the lack of community alternatives.

8.7. It is often assumed that people who are discharged from long-stay hospital will go into services commissioned by local government, but there may be a case for jointly developed and commissioned services for some. What is important is that each service is designed around the person's needs.

8.8. If a person with a learning disability exhibits abnormally aggressive or seriously irresponsible conduct, but do not have a mental health condition, the important question is: what treatment is it that they need? Is it treatment that they need or is it care and support? And is it necessary to provide it in a hospital setting? Bespoke services have been proven to work very well for some individuals who have successfully moved from long-stay hospitals into the community, and remained there, but they need to be funded and require much joint work. Equivalent preventative services need to be developed to prevent young people from being admitted in the first place.

8.9. The Bill is retaining the learning disability qualification for Guardianship under section 7, which we support. This provides an opportunity for some people with a learning disability or autism, who need extra boundaries to move to successfully living in the community. Guardianship's focus is on social support, it has no powers around medication. It is managed by local authorities. However, Guardianship is not well enough understood or used by local authorities, and to become a realistic option, more guidance and support is needed.

8.10. It is recommended that the DHSC policy teams working on the Mental Health Act and the Mental Capacity Act work with the Building the Right Support policy team and with DfE, to explore how to fund and develop community services as alternatives to the admission of young people into mental health hospitals. It is noted that the definition changes do not prevent people with a learning disability or autism from being admitted for assessment. There needs to be a strong expectation that this assessment phase is time-limited and does not drift into staying long-term for treatment and care because there is nowhere else that can meet their needs.

8.11. A recent review of restraint, seclusion and segregation for people with a learning disability and autistic people who may also have a mental health condition by CQC found that people in adult social care services were experiencing better person-centred care than people in hospital. This meant that they were experiencing a better quality of life than the people CQC saw with comparable complex needs in hospitals. CQC found that in the community:

8.11.1 Services were more likely to be able to personalise people's living environments to their individual styles and personalities

8.11.2 There were more services with a positive social environment, with activities that were relevant to each person's needs and interests.

8.11.3 Some examples of people receiving good physical health care within community settings, where staff were aware of any medical conditions and continuously monitored people for any changes. This was particularly important for those who had communication needs and may have struggled to communicate when they were in pain or needed help.

8.12. Furthermore, hospital admission is particularly challenging for people who have a learning disability. Compared with the general population, this patient group is more likely to need and use health services and is also more likely to have a poorer experience of care and poorer health outcomes (including avoidable death).

8.13. In 2015 the LGA, ADASS and NHS England developed a service model for supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

8.14. The model vision statement was that 'Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life'

8.15. A positive example of this is the Small Support programme that is developed and commissioned by the LGA in partnership with National Development Team for Inclusion (NDTI) and NHS England. The programme is focussed on developing small, local, community focussed businesses to support people with behaviour that challenges. This programme of work requires councils and systems to think differently about the way they engage with the care and support market - working with people who know what good looks like in developing specialist provision. This means that the provider is small enough to know the people, families and the team supporting them.

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

9.1. To achieve these aims the Bill will need to be supported by investment in developing or expanding services that provide an alternative to in patient detention. Services will likely need to be resourced to provide specialist provision and require a well-

trained and supported workforce to deliver such support. There will need to be an expansion of such services in the community, and a recognition that specialised commissioned services are more expensive than regular community services. The Impact Assessment does not model such service provision or identify additional funding for such services.

9.2. There has been a long-term policy objective to reduce the numbers of people with a learning disability and autistic people who are long-stay patients in mental health hospitals. In 2015, the LGA, NHS England and NHS Improvement (NHSEI) and the ADASS published Building the Right Support, a national plan to develop community services and close inpatient facilities for people with a learning disability and autistic people.

9.3. The financial model for the Building the Right Support national plan is based on releasing savings from a reduction in inpatient care and using those savings to fund; accommodation with care and support for those discharged from inpatient beds, community support services which would better support people in their homes and therefore avoid the need for the volume of inpatient admissions. In addition to savings released from discharge from hospital, Building the Right Support also required contributions from a range of other funding streams, including council Adult Social Care budgets.

9.4. It is important to note the complexities and high costs of such placements – and the challenge of doing this without additional funding to councils to make such placements. 50 per cent of inpatients as of January 2022 do not qualify for released funding arrangements and must be funded from mainstream health and social care budgets.

9.5. The recent report by Red Quadrant, commissioned by DHSC, found that achieving successful discharges of many of the remaining inpatients, particularly those with longer lengths of stay, is likely to exceed the levels of funding released by reduced inpatient use. Additional funding will be required to ensure that the impact of the creation of significant deficits on local health and adult social care system budgets does not begin to act as a barrier to prompt and successful discharge those with higher levels of need.

9.6. Developing bespoke and personalised homes, alongside care and support solutions for people who may have been institutionalised over many years, needs funded lead-in time. This includes the need to prepare a home (as in, to build or adapt accommodation), recruit and train staff, and to settle the person into their new home. The Community Discharge Grant is designed to address such double running costs. However, the Community Discharge Grant only applies to a small number of people in specific circumstances, it is not widely available. The Grant is also due to end in 2023 and we are calling for it to be extended.

9.7. The availability and cost of suitable accommodation and access to the capital required to purchase and adapt properties can be a significant inhibitor to achieving discharges. Some capital funding rules limit the ability to develop a range and pipeline of accommodation. Recruitment and retention of an appropriately skilled workforce is an increasing difficulty for providers of community-based accommodation with care and support.

9.8. Complexities around funding responsibilities between health and council partners have, at times, caused difficulties. Strong partnerships, pooled budgets, and joint commissioning arrangements significantly improve performance on achieving discharges for people.

9.9. There is an increasing demand for greater access to flexible resources by autistic people and their families which can be used to support people to maintain healthy lives and to avert crises from developing which may progress to avoidable hospital admissions. Rigid approaches to commissioning can inhibit achieving discharges of people with high support needs. For example, local policies and practice around personal budgets – both health and social care – may impede the ability to achieve economies of scale around core support costs, for example where 3 of 4 people live in a cluster of flats or share some facilities within a scheme.

9.10. Active market development to increase the number and capacity of providers is an important element to achieving discharge of people with high support needs. This involves encouraging new providers into areas and developing partnership approaches with trusted providers.

9.11. Preventative approaches were outside the remit of the Independent Review and the reform of the Act and are not mentioned in the Bill. The LGA and ADASS have long supported a preventative approach to mental health support – investing in early intervention services in the community that will reduce the need for intensive care later. Investment in early support can provide an opportunity to naturally reduce budget spend as the person develops skills and resilience and as some of their risks reduce.

9.12. Bespoke support for people leaving an inpatient environment is often high cost because the people requiring it often have complex needs or have experienced trauma during their inpatient experience and therefore require high levels of skilled support. If we can work towards less people being admitted to inpatient facilities in the first place by supporting providers to offer good support in the community, this cost should reduce over time because less people will be experiencing trauma which results in first time hospital admission or re-admission.

9.13. The Bill supports the introduction of a register, to be maintained by the Integrated Care Board (ICB) to identify people with learning disabilities and autism who may be at risk of mental health crisis (Clause 125D). A local authority must refer to the register in exercising its market function to ensure that the needs of people with autism or a learning disability can be met without detaining them under Part 2 of the Act. We welcome the introduction of the register but need to be clear about how it will operate and its scope.

9.14. The register appears to be envisaged as a way of identifying people for whom early access to flexible support may reduce the risk of crises and potential inpatient admissions. However, not all people at risk of mental health illness will be known to services or identified before the onset of the crisis, also not all people will have a formal diagnosis of autism. A register does not currently exist to cover all potentially at risk, such as people with undiagnosed autism or people who develop mental health problems later in life who are not known to health or care services. Local authorities will likely be aware of people who have previously presented as having needs as well as those who they currently provide services.

9.15. Where there are gaps in provision, plans must be agreed to rapidly establish a safe alternative to NHS Accident and Emergency. This should include continued funding of VCSE crisis services and support, of which there is a range of recognised high-quality, accessible provision. The VCSE mental health sector has a unique perspective on individual and local needs and recognises the value of both their strategic and service provider roles. The Plan should confirm that local commissioners need to have flexible commissioning approaches which enable providers to adapt and blend services together locally and regionally, based on an alliance model.

10. 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?

10.1. This will require a commitment from government to grow and support the mental health workforce and a clear workforce strategy across partners.

10.2. The role of the Approved Mental Health Professional (AMHP) is critical to the success of the Bill. AMHPs across the country help identify alternatives to compulsory admissions under the MHA, working across local services to support patients and their families during assessment. In some areas, AMHPs also act as Best Interest Assessors locally for the Deprivation of Liberty Safeguards (DoLS). During 2016/17, there were 82,621 applications for DoLS – a 33 per cent increase from 62,237 in the previous year. The increase in the number of uses of the MHA and DoLS illustrates the importance and growing demands on AMHPs across the country over the last decade.

10.3. A current and future pressure on community mental health services is recruitment and retention of AMHPs. AMHPs are largely employed by councils, and there is a statutory requirement on local authorities to provide a 24hr service. However, what this service should look like, and the number of AMHPS is a matter for local decision making. It would be helpful to have a recommended minimum number of AMHPs, depending on the size of the local authority – this will need to be fully funded by the Government. The role is under a great deal of pressure because of difficulties with recruitment and retention of AHMPs. Many AHMPS are aged 55 and above, from a workforce planning perspective this group may retire within the next ten years. In some areas, it is increasingly hard to provide the statutory service prescribed by the MHA.

10.4. Other pressures on AHMPS include an inability to find a second doctor (there is no equivalent duty on ICSs to provide enough independent s12 doctors), and problems in locating suitable inpatient beds (for both specialist services, such as young people, and everyday services for an adult who is psychotic). This has led to additional stresses, with AMHPs carrying the emotional burden of having to 'walk away' and leave people at risk in the community who they believe need to be admitted to hospital, and for whom medical recommendations are available. All these factors lead to delays in assessment and admission, which amendments alone will not address.

10.5. In a recent CQC briefing on the rise in the use of the MHA, they found that between 2005/06 and 2015/16, uses of the Act have increased by 40 per cent to 63,622 sections per year. Most of these sections, plus the 58,920 short-term holding powers, will have needed the involvement of an AMHP at some stage in the process.

11. 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?

11.1. To make the proposals effective their needs to be investment in social care to grow the AHMP workforce and develop the skills of the wider social care workforce in community mental health.

11.2. There needs to be additional understanding of effective community-based services that can support people who are not suitable for inpatient assessment or treatment but need mental health support. Services such as floating support, supported housing, non-crisis social work support and mental and social health being a consideration in every contact etc are key to reducing detention.

11.3. There also needs to be funding for councils and the VCSE to develop and commission alternative community mental health services that may be quite

specialist or offer person centre individual support. Further research on services needed and costs is needed. Such community service provision is not addressed by the current Bill Impact Assessment.

12. 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?

12.1. The Bill gives more frequent access to the tribunal to review detention; bolsters support from family members and enables patients to make advance choices about their future mental health care and treatment. Expansion of the Independent Mental Health Advocacy service will also provide additional support for patients. There are also proposals designed to reduce the use of the Act for persons with a learning disability and/or on the autism spectrum, and a range of measures targeted at improving the experiences of persons from Black and ethnic minority groups.

12.2. Although we welcome patients having a greater say in their care, it is important to recognise the capacity of the sector which is already under great pressure. To meet the additional requirements will increase AMHP workload, and a consequence may be that demand will impact on timeliness of mental health support in the community.

13. 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?

13.1. We support the proposal, but there are, however, some practical implications to the way in which the role of the 'Nominated Person' has been written, that we are concerned are likely to result in many more people entering hospital without having someone to represent and support them. This is because the draft as it stands has chosen not to take forward the recommendation from the Wesley review of the Approved Mental Health Professional (AMHP) being able to nominate an 'interim' nominated person, in circumstances where the person is unable to do this for themselves. What is currently being proposed is that the person the patient wishes to have as their nominated person, needs to be in the same room, and sign to say they accept the role, and have this witnessed in person. This is clearly an impractical suggestion for many people.

13.2. Additionally, the nominated person will need to be clear of their role and responsibilities, and receive appropriate legal advice, information, and support. All terms, roles and responsibilities should also be clearly defined within the Bill and code of practice. For example, there is also reference to a relevant person and responsible commissioners. Clarification of each role and who might undertake these roles would be helpful.

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

14.1. The Government has undertaken extensive consultation, but it is always important to ensure that the people making advance decisions are aware of their choices and any potential consequences.

14.2. Good supporting information should be produced for patients or people who are considering making an advance choice and tailored information for their nominated people, carers and professionals.

15. 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?

15.1. The draft Bill applies to all children as there are no age limits within it (except for Guardianship under section 7, which is only available for those aged 16 years and over.) However, only a few specific sections focus on children and young people therefore this Bill still does not go far enough to state how the reforms will work in practice for children and young people.

15.2. In addition, there are no major legal changes targeted at this group and the focus instead is on changing and improving guidance. It is concerning that there are no statutory mechanisms in place for children under 16 years old that are Gillick competent (used to assess whether a child is mature enough to consent to treatment) and refuse admission and treatment. Whether parental decision making takes precedence needs to be clearer and should be made clear in legislative reform. Furthermore, under 18s still do not have the right to make advance decisions to refuse treatment which means they are unable to access the enhanced treatment safeguards in the same way as adults.

15.3. Still outstanding is the points raised in the LGA submission on the Reforming the Mental Health Act White Paper regarding the relationship between a nominated person and the local authority if a child happens to be in care. For children in care (on a care order, not under section 20), the local authority is their corporate parent. Greater clarity is required on how the role of the Nominated Person will interact with the role of the local authority as a corporate parent. However, it is positive that the use of Care, Education and Treatment Reviews (CETRS) is now on a statutory footing and will apply to all under 18-year-olds regardless of whether they are admitted informally.

15.4. However, to change the system to the extent that is required will not be achieved through this Act. Planning and good support needs to start from a young age to prevent unnecessary inpatient admissions in CAMHS tier 4 and Adult Mental Health inpatient services. If we invest in preventative and protective measures earlier on, we should see less spending in the long term, and we should be seeing less people admitted to inpatient facilities as a result. This is particularly important when

considering the need to reduce detention. Greater investment is required into appropriate accommodation for children particularly at a time when mental health needs are increasing following the pandemic and children are being held in inappropriate provision. Crisis care (including crisis houses) generally focus on the adult population. More thought is needed around how to ensure more appropriate crisis care for young people under the age of 18 years is available at a local level.

15.5. Consideration should be given to 'transitional' funding arrangements for young people who are being supported by providers prior to their 18th birthday, to ensure continuity of funding and support arrangements for young people between the ages of 18 and 25 years. This would encourage more providers to work with this age group. Greater investment into community support is required to provide children with the level of support that they need.

15.6. The child's voice needs to remain central to any care and treatment they receive and this needs to be clear in the accompanying guidance of the Act.

15.7. It is surprising that there does not appear to be reference to the Children Act 2004 given its focus on the wellbeing of the child. Interplay between other recent Government initiatives such as the Green Paper, the Care Review and the Police, Crime, Sentencing and Courts Act should be considered.

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

16.1. It is welcome to see this current gap in the law being addressed within the Bill in S30 (4). However, greater clarity is needed around the interplay between this, and the safeguards currently contained within the DoLS scheme (and proposed LPS scheme) to clarify when it would it be appropriate to use these new powers, as opposed to using powers contained within the Mental Capacity Act.

17. 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?

17.1. We support the aspiration embedded in this Bill, that those who enter the criminal justice system, but who need treatment and support for acute mental health conditions, should be swiftly moved out of prisons and into hospitals. Setting a deadline for such moves is an important first step, and we would welcome working with the Government to ensure the outcomes desired are met.

17.2 Supporting the diversion of people into alternative provision prior to their entry to prison is also essential, but will only be possible where appropriate resources and guidance is in place. For example, Guardianship under the Mental Health Act could provide a possible alternative for some of those on the Autistic Spectrum who might otherwise enter prison, but this would only be possible with appropriate

resources, and clear guidance and support for councils who are currently not used to working proactively with this framework.

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

18.1. The Bill needs to include a definition of 'Responsible Commissioner' in the definitions section in Part 3. This role is outlined in Part 2 Autism and Learning Disability as the lead officer – such a role may be undertaken by a range of officers.

18.2. The Bill uses the term 'disorder' about learning disabilities and autism. A better term would be 'condition'. We recommend that the Bill should refer to 'people with learning disabilities and/or autism' rather than 'patients'.

18.3. The Bill needs a clear implementation plan and funding to support:

18.3.1. **Workforce capacity**: including specific pressures on the voluntary and community sector workforce, and more generally across associated commissioned services including social care and public health.

18.3.2. **Community and crisis services:** There should be matched funding for mental health delivered by local authority social care services to mirror the expected improvements that are being funded within the NHS.

18.3.3. **Section 117**: The complexity of s117 legislation need to be addressed to improve the patients experience on discharge from hospital and to clarify funding responsibilities.

18.3.4. **Advocacy support:** Resources should be available to enable the commissioning and provision of comprehensive, culturally appropriate advocacy and support.

18.3.5. **Personal budgets and direct payments:** Resources need to be available to promote and deliver personal budgets and direct payments, to unlock their potential to improve outcomes for people with mental illness and mental health challenges.

18.3.6. **Supported accommodation:** Alongside the long-term need for expansion, local authorities need resources to innovate and develop safe, quality short term solutions in partnership with the NHS and VCSE. This along with a package of community support would help with preventing detention and admission.

14 September 2022