Browne Jacobson

The new Mental Health Bill 2025: A closer look at its key provisions

03 December 2024 Katie Viggers

On 6 November 2024, a new Mental Health Bill (the Bill) was presented in Parliament by the government. The Bill has now been **published**, alongside **explanatory notes**, and it introduces several significant changes to the Mental Health Act (the Act). The Bill has already passed its second reading in the House of Lords.

The government has said that the primary aims of the Bill are to strengthen the voice of patients subject to the Act, to add statutory weight to patients' rights to be involved in planning for their care and to inform choices regarding their treatment. Further, the reforms are designed to ensure that detention under the Act it is only used when, and for as long, as necessary. Additionally, the reforms aim to limit the use of the Act to detain people with learning disabilities and autism.

The proposed reforms are in response to recommendations for legislative change made by an Independent Review of the Act, spearheaded by Professor Sir Simon Wessely in 2018. Whilst the Bill closely mirrors the version published by the preceding Conservative government in 2022, it has been revised to incorporate recommendations previously made by the Joint Committee of both Houses of Parliament.

This article delves into the critical elements of the Bill, shedding light on its key provisions.

Additional principles to be added to the Code of Practice:

The Bill amends the "statement of principles" that must be included in the Mental Health Act Code of Practice (which contains statutory guidance and sits alongside the Act). These principles should inform particular decisions taken under the Act, and must be included in both the Code of Practice for England and the Code of Practice for Wales. The principles are:

Principle	Matters to be addressed
Choice and autonomy	Involvement of patients in decision-making, and consideration of the views of carers and other interested parties.
Least restriction	Minimising restrictions on liberty so far as consistent with patient wellbeing and safety and public safety.
Therapeutic benefit	Effectiveness and appropriateness of treatment.
The person as an individual	Treating patients with dignity and respect and considering their attributes and past experiences.

Grounds for detention and community treatment orders (CTOs) – “risk of serious harm” criteria added

The criteria for detention under sections 2 and 3 of the Act will be amended to ensure that people can only be detained under these sections if they pose a risk of serious harm either to themselves or to others.

There are two new tests that must be met before a person can be detained under section 2 of the Act (admission for assessment):

1. serious harm may be caused to the health or safety of the patient or of another person, unless the patient is detained; and
2. given the nature, degree and likelihood of the harm, the patient ought to be detained.

For detentions under section 5(4) of the Act (nurses’ holding power), there will also be a requirement for risk of serious harm unless the patient is immediately restrained from leaving the hospital.

For detention under section 3 (admission for treatment), the Act will be amended to state that the following criteria must be met:

1. serious harm may be caused to the health or safety of the patient or of another person unless the patient receives medical treatment;
2. it is necessary, given the nature, degree and likelihood of the harm, for the patient to receive medical treatment;
3. the necessary treatment cannot be provided unless the patient is detained under this Act; and
4. appropriate medical treatment is available for the patient.

These same criteria will apply when renewing a patient’s detention under section 20 of the Act, and the first two “harm” criteria will apply when making or renewing a CTO.

The Bill does not define “serious harm” but further guidance will be provided in the Code of Practice. The Bill removes the obligation for clinicians to consider “how soon” harm might occur – a requirement which had been included in the previous 2022 draft Bill.

Autism and learning disability – requirement for a co-occuring mental disorder for detention for treatment under section 3

Due to numerous concerns about people with a learning disability and autistic people being subject to inappropriate lengthy detentions, which may provide little or no therapeutic benefit, amendments will be made to the Act to ensure that this cohort of patients can no longer be detained for treatment under section 3 of the Act unless they have a co-occuring psychiatric disorder that meets the detention criteria. It will also no longer be possible to place a person with a learning disability or an autistic person on a CTO unless they have a co-occurring mental health condition.

This exclusion does not apply to Part 3 patients (those in the criminal justice system).

New definitions of “autism”, “learning disability” and “psychiatric disorder” will also be included in the Act.

Appropriate medical treatment

There will be a new requirement in the Act, in line with the principle of therapeutic benefit, that when considering whether medical treatment is “appropriate” for a patient, consideration must be given to whether there is a reasonable prospect that the outcome of the treatment will have a therapeutic benefit for that patient.

Changes to section 58 – treatment certification

Section 58 of the Act applies to medication for mental disorder once three months have elapsed from the day on which treatment was first given to the patient. Under section 58, treatment can only be given to a patient after three months have passed if:

1. the patient consents to it and either the approved clinician or a second opinion appointed doctor (SOAD) certifies that the patient understands the nature, purpose and effects of the treatment,
2. a SOAD certifies that the patient is incapable of giving consent to the treatment but that the treatment is appropriate, or
3. a SOAD certifies that the patient has not consented to the treatment but that it is appropriate for them to receive it.

The Bill will amend the Act so that in scenarios 1 and 2 above, the three-month time period after which certification must be provided will be shortened to two months. The certification must confirm the treatment is appropriate, within the new meaning. The reason for this change is so that the use of compulsory medication where the patient lacks capacity/competence to consent receives independent scrutiny at an earlier point in the patient's treatment course.

Further, if a patient has capacity and is refusing treatment (as in scenario 3 above), or if the patient lacks capacity and treatment is in conflict with an advance decision or a decision made by a donee or deputy or by the Court of Protection, treatment can only be given if there is a "compelling reason" to do so and a SOAD has provided certification. In this context, a "compelling reason" includes there being no alternative medication available or no alternatives that the patient accepts. Certification must be given *before* treatment is given, which is a significant change from the current legislation.

Changes to section 62 – urgent treatment to alleviate serious suffering

Section 62 of the MHA allows for treatment in urgent circumstances. This section permits treatment without the usual consent and/or certification requirements if it is immediately necessary to (a) save the patient's life, (b) prevent a serious deterioration of their condition, (c) alleviate serious suffering, or (d) prevent the patient from behaving violently or being a danger to themselves or others. However, the new Bill removes the power to administer urgent treatment to patients with the relevant capacity or competence on the basis that it is considered immediately necessary to alleviate serious suffering by the patient. This change will allow patients who have capacity or competence at the time to decide on the degree of suffering they are willing to accept, strengthening the patient's right to self-determination and autonomy. This change does not apply to patients who lack the relevant capacity.

The ability to administer compulsory medication in the other urgent circumstances remains however, providing a backstop for exceptional situations.

Shortened detention periods

The Bill shortens the period that a patient admitted to hospital may be kept in detention for treatment. Under the Bill, the revised detention periods will be as follows:

Initial detention period: 3 months (reduced from 6 months)

First renewal period: 3 months (reduced from 6 months)

Second renewal period: 6 months (reduced from 1 year)

Successive renewal periods: 1 year

These changes will mean that a patient's initial detention period will expire sooner and if the patient's detention is to continue it must be reviewed and renewed more frequently.

Statutory care and treatment plans

The Bill will introduce statutory care and treatment plans for all patients formally detained under the Act. The main purpose of these new plans is to ensure that all patients have a clear and personalised strategy in place describing what is needed to progress them towards recovery and their timely discharge from the Act.

CTOs – requirement for consultation with the community clinician

The Bill will require the community clinician, responsible for overseeing the patient's care as a community patient, to be involved in decisions regarding the use and operation of CTOs. This covers the decision to make a person subject to a CTO, to vary or suspend conditions made under a CTO, to recall to hospital a patient subject to a CTO, and to revoke a CTO after a patient has been recalled. This is to introduce a further professional opinion and check on whether people really need the support of a CTO.

Change from nearest relative to nominated persons

In keeping with the previous draft Bill, the 2024 Bill includes the new statutory role of “nominated person”. The nominated person will replace the role of “nearest relative”, as the Independent Review found the current model of nearest relative to be outdated and insufficient.

The new Bill allows a patient to personally select a nominated person to represent them and exercise the relevant statutory functions included within the Bill, at any time when they have capacity or competence to do so – although it is envisaged that nominations will be made either in advance of detention under the MHA or at the time of assessment for detention. This supports the principle of choice and autonomy. If someone lacks the relevant capacity / competence to make a nomination at the point of detention or at any other time, and has not previously nominated anyone, a nominated person can be appointed by an Approved Mental Health Professional (AMHP).

The nominated person will have the same rights and powers as the nearest relative has now, but will also be given new ones, such as the right to be consulted about statutory care and treatment plans, renewals and extensions of the patient’s detention and transfers between hospitals, and the power to object to the use of a CTO.

More regular Tribunal reviews

The Bill enhances patient accessibility to the First-tier Tribunal (Mental Health). In particular, patients detained under section 2 will be able to apply to the Tribunal within 21 days following their detention (an extension from the current 14-day period). Further, should a patient not utilise their right to apply to the Tribunal, automatic referrals must be made earlier and at more frequent intervals – three months from the date of detention and every 12 months thereafter.

Requirement to consult before discharge

Currently, the patient’s responsible clinician (RC) has the power to unilaterally decide to discharge an individual from detention under section 2 or section 3. The Bill will introduce a new requirement for the RC to consult with a person who has been professionally concerned with the patient’s treatment, and who belongs to a different profession to them, before they can discharge the patient. The same will apply in the case of an RC discharging a patient from guardianship. Where someone is under a CTO, the RC must consult with the community clinician (if they are not themselves the community clinician) before they discharge from the CTO. This amendment seeks to formalise best practice and ensure safer discharge from a hospital bed.

Removal of police stations and prisons as places of safety

Prisons and police cells will be removed as “places of safety” under the Act. This is in response to evidence that suggests these settings are not suitable environments for individuals with a severe mental health, in crisis, awaiting assessment and treatment. Alternatives, such as hospitals and other healthcare-based settings, are more appropriate.

Increased access to Independent Mental Health Advocates (IMHAs)

The Bill will extend the right of access to IMHAs to voluntary patients in England (i.e. those not detained under the Act), and detained patients will be automatically referred to an IMHA provider.

Advance Choice Documents

The new Bill takes a different approach in relation to Advance Choice Documents, which are written records of a person’s wishes, feelings and decisions about their care and treatment, made when the person has the relevant capacity or competence. Clinicians must have regard to these documents, but not necessarily follow them, when providing treatment under the Act. The new Bill seeks to introduce duties on Integrated Care Boards (ICBs), NHS England and Local Health Boards (Wales) to make arrangements so that people at risk of detention are informed of their ability to make an Advance Choice Document, and (if they accept) are supported to make one.

Time limits on transfers from prison to hospital

Under the Act, the Secretary of State is permitted to transfer mentally disordered persons from prisons and other places of detention to hospital for treatment. The new Bill introduces a statutory 28-day time limit within which agencies must seek to ensure individuals who

meet the criteria for detention under the Act are transferred to hospital for treatment. This mirrors an approach consistent with good practice guidance on this issue previously published by NHS England.

Comment

All political parties are in agreement on the need to reform the MHA, and since the proposed Bill closely resembles an earlier draft published by the Conservatives, it's expected to face little opposition. The Bill is likely to become law by summer 2025, with the new MHA provisions being gradually introduced over ten years. While these reforms are generally seen as positive, especially for increasing patient choice and autonomy, our previously expressed reservations about the feasibility and cost of some changes remain.

The Bill's explanatory notes detail significant financial requirements for implementing the reforms. The estimated ongoing costs for resourcing the reforms and upfront training costs of existing staff are substantial: £1.9 billion for the NHS, £396 million for local authorities, £287 million for HM Courts and Tribunal Service and the Legal Aid agency (due to more frequent Tribunal referrals), and an additional £2.5 billion for housing and care related to reforms for individuals with learning disabilities and autism.

The NHS Confederation has indicated that restrictions on detaining people with autism or learning disabilities will only be implemented once the government is confident that sufficient community services are in place. We consider this must include having proper safeguards for these individuals, who are likely to require detention in the community under the Deprivation of Liberty Safeguards (DoLS) or a Deprivation of Liberty Order from the Court of Protection. However, a recent report by the Care Quality Commission (CQC) on the state of health and social care in England pointed out significant issues with the DoLS system, mainly due to local authorities lacking the resources to handle the growing number of applications, resulting in delays and leaving vulnerable individuals unprotected. The Liberty Protection Safeguards (LPS) were meant to address these problems but were indefinitely postponed by the previous Conservative government in 2023. With the new government not yet discussing the LPS, it raises questions about when the necessary community systems and safeguards will be in place, which in turn affects the timeline for implementing MHA reforms for individuals with autism or learning disabilities.

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