Title: Mental Health Bill **IA No:** DHSCIA9587 (1) **RPC Reference No:** RPC-DHSC-5184(2) **Lead department or agency:** Department of Health & Social Care **Other departments or agencies:** Ministry of Justice	Impact Assessment (IA) **Date:** November 2024 **Stage:** Final Stage **Source of intervention:** Domestic **Type of measure:** Primary legislation **Contact for enquiries:** MHBill@dhsc.gov.uk
Summary: Intervention and Options	**RPC Opinion:** Awaiting Scrutiny

Cost of Preferred (or more likely) Option (2019/20 prices)			
Total Net Present Social Value	**Business Net Present Value**	**Net cost to business per year**	**Business Impact Target Status**
-£119.3m	-£10.9m	£0.7m	Non qualifying provision

What is the problem under consideration? Why is government action or intervention necessary?

The Mental Health Act 1983 (MHA) provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others. A 2018 Independent Review of the MHA found that it was out of step with a modern-day mental health service: the patient's voice lost within processes that are out-of-date; an unacceptable overrepresentation of people from ethnic minorities amongst people detained, especially black people; and people with a learning disability and autistic people also facing particular disadvantage in their care and treatment. This Impact Assessment (IA) accompanies the Mental Health Bill which intends to update legislation. This legislation is part of a suite of reforms informed by a public consultation and recommendations of the Independent Review.

What are the policy objectives of the action or intervention and the intended effects?

The main policy objectives of the proposals are to:

- maintain the power to intervene and detain people under the Act when appropriate, to prevent harm to self or others;
- modernise mental health legislation to give patients greater choice and autonomy over their care and treatment, and access to enhanced rights and support under the MHA;
- ensure that the patient, their family and/or carer, and their Nominated Person are proactively supported to take part in decision making around care, treatment, and planning.
- introduce new patient safeguards, such as granting informal patients access to an Independent Mental Health Advocate (IMHA);
- improve existing patient safeguards, such as giving patients earlier access to the Mental Health Tribunal (MHT) and to a Second Opinion Appointed Doctor (SOAD);
- reduce racial disparities under the MHA and promote equality;
- ensure that patients receive therapeutic benefit from detention and that they are treated with dignity and respect, with a view to improving patient experience and limiting the length of their detention; and
- prevent longer term detentions for people with a learning disability and autistic people under the civil parts of the Act where they do not have a co-occurring mental disorder that would warrant hospital treatment

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Business as Usual (BAU) with no changes to the MHA.
Option 2: Implement the proposals outlined in the Government's response to its consultation on the MHA reforms. The IA's main focus is on the reforms requiring legislation to improve safeguards, both in the health and social care system and in the justice system. It does not include wider costs and benefits of investment and quality improvement that are required to deliver the wider ambitions of the Bill in terms of patient experience and treatment outcomes, which fall beyond the scope of the legislation and therefore the IA. It is recognised that realising the ambitions of the Independent Review and other commitments are also dependent on this wider activity.
Option 2 is the preferred option.

Is this measure likely to impact on international trade and investment?	No

Are any of these organisations in scope?	**Micro** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:** N/A	**Non-traded:** N/A	
Will the policy be reviewed? It will not be reviewed. **If applicable, set review date: N/A**				

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Wes Streeting Date: 05/11/2024

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 24/25	PV Base Year 24/25	Time Period Years 20	Net Benefit (Present Value (PV)) (£m)		
			Low:	**High:**	**Best Estimate:**

COSTS (£m)	**Total Transition** (Constant Price) Years		**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low				
High				
Best Estimate				

Description and scale of key monetised costs by 'main affected groups'

This option pertains to the counterfactual, that is, the status-quo with no new national policies implemented. Therefore, we assume that there are no additional costs to the baseline associated with the Business as Usual option and impacts are assessed as marginal changes against the Business as Usual baseline.

Other key non-monetised costs by 'main affected groups'

N/A

BENEFITS (£m)	**Total Transition** (Constant Price) Years		**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low				
High				
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

This option pertains to the counterfactual, that is, the status-quo with no new national policies implemented. Therefore, there are no additional benefits to the baseline associated with the Business as Usual option and impacts are assessed as marginal changes against the Business as Usual baseline.

Other key non-monetised benefits by 'main affected groups'

N/A

Key assumptions/sensitivities/risks	**Discount rate (%)**
N/A	

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs:	**Benefits:**	**Net:** 0	

Summary: Analysis & Evidence

Policy Option 2

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 24/25	PV Base Year 24/25	Time Period Years 20	Net Benefit (Present Value (PV)) (£m)		
			Low: -4,835	**High: 3,876**	**Best Estimate: -169**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	19	2	141	**2,016**
High	19		468	**6,623**
Best Estimate	19		282	**4,006**

Description and scale of key monetised costs by 'main affected groups'

The overall costs of the reforms are estimated at around £5.3 billion for housing, health and social care costs and £313 million for costs to the justice system in England and Wales (in 2024/25 prices and constant value terms).

The below breakdowns have been provided for England. These will not sum to the total NPV above as these have been uplifted to account for the cost of the reforms on Wales whilst the costs below are provided in constant value terms.

In England, the net monetised costs relate to:

- £1.9 billion of costs for the NHS (excluding housing costs for reforms relating to people with a learning disability or autistic people)
- £396 million of costs for Local Authorities (excluding reforms relating to people with a learning disability or autistic people)
- £2.5 billion of housing-and care-related costs for reforms for people with a learning disability or autistic people
- £78 million of costs for the Care Quality Commission (CQC)
- £287 million of costs for the Courts and Tribunals Service

In the latest annual data for 2023/24, there were 52,458 new detentions under the Mental Health Act and 5,618 uses of Community Treatment Orders (CTOs)[1]. The monetised costs associated with these reforms include:

- Transitional costs of around £19m for familiarisation of existing staff with MHA reforms – modelled to occur over two years in 2025/26 and 2026/27.
- Around £1.3 billion of net process costs to health and social care. This includes:
    - Additional process costs resulting from increased workload for the Mental Health Act workforce as they are expected to support additional activities due to the reforms. For instance, these include the costs associated with expanding eligibility of advocacy support to informal patients (expected to add an additional 27,000 to the IMHA caseload per year once implemented) and the costs associated with greater take-up of Advance Choice Documents (expected to be around 40,000 new ACDs drafted per year once fully implemented). Full breakdowns of cost by policy or process can be found in the monetised cost section.
    - Process cost savings, representing a reduction in the additional process costs above resulting from fewer detentions and CTOs expected due to the reforms (estimated to be a reduction of around 1,300 CTOs per year once fully implemented).
- Training costs of around £132 million for expanding the health and social care workforce to accommodate additional demands of the reforms.
- Costs of around £99m for alternative community mental health care for people who are no longer admitted to hospital, associated with an increase in the use of Advanced Choice Documents (expected volumes listed against monetised benefits).
- Costs of around £3.4 billion for community services, care and housing for people with a learning disability and autistic people who are no longer detained in hospital following reform (expected volumes listed against monetised benefits).
- Costs of around £287 million for the proposals relating to the Mental Health Tribunal (MHT), including legal aid. This mainly reflects the judicial costs of the additional sitting days needed and includes £219m for automatic referrals, £56m for proposals relating to treatment choice, £14m for expanded powers of the MHT, and cost savings of around £1m for reforms to detention criteria.

[1] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

Other key non-monetised costs by 'main affected groups'

Key non-monetised costs for the health and social care system pertain to ensuring cultural change and familiarisation for the reforms for workforce groups not modelled, monitoring duties for CQC, additional workload for MHA managers, making ACDs available at the point of need, and other reforms such as prison transfers, section 117 aftercare, supervised discharge, crown dependencies and improving discharge. For the justice system, the non-monetised costs pertain to expanded tribunal powers and impacts on the court of protection.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	0	-	127	**1,788**
High	0		421	**5,892**
Best Estimate	0		274	**3,836**

Description and scale of key monetised benefits by 'main affected groups'

We present quantified monetised benefits for reforms relating to Advanced Choice Documents (ACDs) and new detention criteria for people with a learning disability and autistic people. These are based on estimates of the reduction in admissions or patient numbers caused by the policies, combined with estimates of the total hospital costs per bed day for mental health patients.

The monetised benefits for England and Wales (2024/25, constant prices) are estimated at:

- £400m of benefits from fewer overall admissions (either as an informal patient or detention) due to ACDs (estimated to equate to a reduction in admissions in England by around 1,500 per year on average once reforms are fully implemented).
- £5.1 billion of benefits from fewer detentions due to reforms for people with a learning disability and autistic people (estimated to equate to a reduction in admissions in England by around 400 per year on average once reforms are fully implemented)

These benefits should not be understood as cashable savings but will in practice lead to health benefits for other patients.

Other key non-monetised benefits by 'main affected groups'

The key non-monetised benefits pertain to improved patient experience of the MHA due to improved safeguards and increased patient empowerment, avoiding unnecessary or inappropriate detention and admission, a potential reduction in length of detentions, benefits associated with timeliness of prison transfers and stopping prison being used as a place of safety on the grounds of mental health, and health benefits to patients and associated wider economic benefits of improved mental health.

The Independent Review of the MHA heard concerns around the disparity of access to, and experience of, mental health services for different disadvantaged groups, including LGBTQ+, ethnic minority communities, people with a learning disability or autistic people, and asylum seekers and refugees. This can influence the likelihood of detention in the first place, given varying access to and success of alternatives, as well as experiences when subject to the Act. Broadly, it is anticipated that improved involvement of patients in treatment decisions (before or after the potential need for detention arises) could improve patient satisfaction and adherence with treatment, and lead to improved health outcomes in the face of the specific needs for such disadvantaged groups. We have further explored the differential impacts of the reforms in the distributional and wider impacts section.

In the absence of quantitative evidence, we use a breakeven analysis to illustrate the benefits per patient detained required to offset the cost of Option 2. For the total discounted costs of the policy to be offset by these benefits from 2025/26 we estimate that in the central scenario, it would require a 0.33 day reduction in length of stay per detention, a patient health gain of 0.003 QALYs per detention (equivalent to helping someone live an extra 0.9 day in perfect health), or a 0.01 point improvement in patient wellbeing on the self-reported life satisfaction scale.

Key assumptions/sensitivities/risk	**Discount rate**	3.5%

Many impacts were not able to be monetised due to lack of data or research evidence, and furthermore given the 20-year appraisal period, there is a likelihood that input assumptions/estimates may change over the period in ways it is not possible to accurately predict now. Therefore, there is significant uncertainty around monetised estimates of costs and benefits. This is reflected in sensitivity analysis which varies key assumptions, such as the impact of reforms on workforce time requirements, community costs and baseline detention scenarios, to approximate low and high estimates of the additional costs and benefits of Option 2. The estimated benefit presented here should not be understood as cashable savings. Other risks have been considered including wider capacity and workforce constraints, risks around provision of housing, duration of community care costs and possible unintended consequences.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs: 1.1	**Benefits:** 0.0	**Net:** 1.1	

Table of Contents

Policy Rationale

Policy background

1. The Mental Health Act 1983 (MHA)[1, 2] is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. It provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others. Powers for compulsory admission under the MHA are set out in Part II and Part III.

2. Part II of the MHA deals with patients who are detained in hospital and have no criminal proceedings against them, or have criminal proceedings against them not related to their mental health. These are generally referred to as civil patients.

3. Part III of the MHA is concerned with the care and treatment of offenders with severe mental health needs who are involved in criminal proceedings or under sentence. There are two categories of Part III patients – unrestricted or restricted:

   - **Unrestricted patients** - are defendants or offenders without a restriction order who receive a hospital order or transfer direction. This includes patients who were originally subject to restrictions, but whose restrictions have since ended or been lifted. The Secretary of State for Justice does not have involvement in these cases, unless the patient falls into their ambit in another way, for example multi agency public protection cases.
   - **Restricted patients** - are offenders with severe mental health needs who are detained under Part III of the Act in hospital for treatment and who are subject to special controls by the Secretary of State for Justice. Restrictions are imposed either by a Court or the Secretary of State, for offenders who present a risk to the public. They can take the form of a restriction order, limitation direction or a restriction direction, depending on the type and status of patient within the criminal justice system. The aim of the restricted patient regime is to protect the public from serious harm while at the same time recognising patients' right to access treatment in an appropriate setting.

4. The Independent Review[3] conducted by Professor Sir Simon Wessely in 2018 identified that the current MHA is out of step with a modern-day mental health service and is in significant need of reform to make it work better for everyone. The reforms the Review recommended were driven by the following problems: rising rates of detention; racial disparities in detentions and Community Treatment Orders; poor patient experience; and the particular disadvantages felt by people with a learning disability and autistic people. These are explained below.

[1] A list of the acronyms used in this IA can be found in Annex A

[2] Mental Health Act 1983 (legislation.gov.uk)

[3] Department of Health and Social Care. (December 2018). Modernising the Mental Health Act - Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Accessed at: Modernising the Mental Health Act – final report from the independent review - GOV.UK (www.gov.uk)

5. Between 2006[4] and 2016[5], in the lead up to the Independent Review, the number of detentions rose by over a third. According to the Care Quality Commission investigation monitoring the MHA published in January 2018[6], this increase may have been due to a range of factors such as:

   - the 2007 reform of the MHA, which widened the definition of mental disorder and of treatment;
   - greater police awareness of mental health and more diversion from the Criminal Justice System;
   - changes in legal requirement for patients without capacity to consent to admission made it more likely that these patients would be assessed for detention under the MHA than in the past;
   - reduced availability of alternative community care;
   - population growth, including among groups that are more at relatively high risk of detention (for instance those experiencing social exclusion and untreated drug and alcohol misuse); and
   - improvements in data quality, which also prevented double counting of detentions when hospital transfers took place[7].

6. Recent data from NHS England showed that the number of detentions continued to increase from 2016/17 up to 2020/21. However, there were decreases in the number of detentions for the next two years up until 2022/23, before increasing again in 2023/24[8]. (More detail is given in Annex B.I.) The Review considered that improvements in community mental health services and crisis care services could make a substantial contribution in tackling this increase.

Problem under consideration and rationale for intervention

7. The Independent Review recognised the continuing need for the Mental Health Act. As Sir Simon Wessely notes in the Independent Review "*I often heard from those who told me, looking back, that they realise that compulsory treatment was necessary, even life-saving, but then went on to say "why did it need to be given in the way it was?". And it was that last comment which has given rise to the majority of our recommendations.*" The aim of these reforms is to improve patient outcomes and experiences under the Act, whilst maintaining the appropriate powers to intervene when appropriate to protect vulnerable people and the wider public.

8. In considering the need to improve patients' experiences of detention under the MHA, evidence shows that patients' involvement in care and treatment planning is patchy, and they are not always aware of their rights under the MHA. The CQC's 'Monitoring the MHA in 2022/23[9] report suggests that there are still examples of patients not being told their rights or not understanding them. In 2020/21, during the COVID-19 pandemic, patient involvement in care and access to advocacy services was variable, with some good examples of good practice but with some services continuing to fail to explain patients' legal rights effectively[10]. In the 2022/23 report, the CQC reported that they are seeing many positive examples of good practice where patients have been involved in decisions around their care and treatment plans but there is also evidence of patients not being involved in their care amongst many providers. The Independent Review identified that

[4] NHS Digital (14 October 2009). Inpatients Formally Detained in Hospitals Under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment - 1998-1999 to 2008-2009. Accessed at: Inpatients Formally Detained in Hospitals Under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment - 1998-1999 to 2008-2009 - NHS England Digital

[5] NHS Digital (30 November 2016). Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment 2015/16, Annual Figures. Accessed at: [ARCHIVED CONTENT] Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures - NHS Digital (nationalarchives.gov.uk)

[6] Care Quality Commission (January 2018). Mental Health Act – The rise in the use of the MHA to detain people in England. Accessed at: Mental Health Act – The rise in the use of the MHA to detain people in England - Care Quality Commission (cqc.org.uk)

[7] Data published prior to 2016/17 were collected using an aggregate data collection (KP90), which did not allow for identifying transfers to another hospital and therefore, double counted some detentions; this is now recorded in the Mental Health Services Data Set (MHSDS), and so can be identified and excluded from the total number of detentions in the year – estimated at 15% in 2016/17 (see Annexes B.I and H).

[8] Mental Health Act Statistics, Annual Figures - NHS England Digital

[9] Monitoring the Mental Health Act in 2022/23 - Care Quality Commission (cqc.org.uk)

[10] Monitoring the Mental Health Act in 2022/23 - Care Quality Commission (cqc.org.uk)

more needed to be done to proactively support patients to take part in care and treatment decisions and ensure their views were taken on board as far as possible.

9. Regarding ethnic disparities, Black or Black British people are disproportionately likely to be detained under the MHA (three and a half times higher than that of the White ethnic group) or be subject to community treatment orders (over seven times the rate for the White ethnic group); have longer periods of detention and more repeated admissions, and are also more likely to be subject to police holding powers under the MHA[11]. The Independent Review was clear that the use of coercion is far greater for the Black or Black British population, and that this at least in part stems from "unconscious bias, structural and institutional racism" in the mental health system. It recommended that the legal framework be reformed to increase patient agency and give more opportunity to challenge inappropriate restriction, to protect against the disproportionate use of coercion amongst racialised communities and other inequalities.

10. Regarding people with a learning disability and autistic people, we know there are cases of poor care where a common theme was that detained inpatients were not receiving sufficiently therapeutic or reasonably adjusted care. The use of the MHA to detain someone for treatment can lead to perpetuated detention even when detention criteria are no longer satisfied and, while this could be true of other people detained under the MHA, the sensory needs of autistic people and people with a learning disability and reduced ability to self-advocate may exacerbate these risks[12].

Policy objective and options

11. The main policy objectives of the proposals are to:
    - maintain the power to intervene and detain people under the Act when appropriate, to prevent harm to self or others;
    - modernise mental health legislation to give patients greater choice and autonomy over their care and treatment, and access to enhanced rights and support under the MHA;
    - ensure that the patient, their family and/or carer, and their Nominated Person are proactively supported to take part in decision making around care, treatment, and planning.
    - introduce new patient safeguards, such as granting informal patients access to an Independent Mental Health Advocate (IMHA);
    - improve existing patient safeguards, such as giving patients earlier access to the Mental Health Tribunal (MHT) and to a Second Opinion Appointed Doctor (SOAD);
    - reduce racial disparities under the MHA and promote equality;
    - ensure that patients receive therapeutic benefit from detention and that they are treated with dignity and respect, with a view to improving patient experience, improving recovery and therefore reducing the length of their detention; and
    - prevent longer term detentions for people with a learning disability and autistic people under the civil parts of the Act where they do not have a co-occurring mental disorder that would warrant hospital treatment.

12. As has been highlighted through the Independent Review, regular reports from the CQC as part of their monitoring of the MHA and stakeholder feedback (including from people with lived experience), there is significant variation in the experiences of people detained under the MHA compared to the expectations for care and treatment outlined in national guidance, including the statutory Code of Practice. Given the severity of the decision to remove someone's liberty, and

[11] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

[12] Independent review of the Mental Health Act: interim report - GOV.UK (www.gov.uk)

treat them at times against their will, it is vital there are clear standards and expectations for all patients, for their safety and protection and the protection of others, and also to ensure that detention provides a therapeutic benefit, supports recovery and doesn't only manage risk. The current guidance, while in line with many of the changes being introduced in the Bill, clearly is not sufficient to ensure that expected practice is followed. By placing requirements directly into primary legislation, they *must* be followed, whereas the statutory guidance *should* be followed, with clinicians deviating from the guidance if they think there is a rationale for doing so. While some elements will appropriately remain in guidance to allow flexibility to respond to the very different needs of particular groups of and individual patients, the provisions being taken forward in the Bill are critical areas of the detention process where we wish to tighten requirements so that all patients can expect the same processes to be followed and safeguards provided. As such, other options for improving practice within the current legislative framework or reducing variability have not been assessed in this Impact Assessment.

Non legislative reforms

13. A range of non-legislative actions will play a role in addressing the disparity in outcomes and detentions, enhancing patient voice, increasing transparency and scrutiny of decisions, improving patient's right to challenge and keeping people safe. Further reforms and guidance to tackle racial inequalities will be included in the Mental Health Act Code of Practice, the statutory guidance that will be drafted after Royal Assent to support the implementation and application of the new Act. These actions are expected to happen in both the BAU and Option 2. Whilst not within the scope of this IA's analysis which focuses primarily on the legislative changes, further actions include:

- Filling evidence gaps, particularly on tackling racial disparities – the National Institute for Health Research Policy Research Programme (NIHR PRP), on behalf of the Department of Health & Social Care (DHSC), has now funded four new research projects on how to tackle the rising rates of detention and understanding the experiences of people from minority ethnic backgrounds and family and friends of people who have been detained[13].
- Improvements in data collection – DHSC are working with NHSE to improve the validity and completeness of existing data collections, such as the Mental Health Services Data Set (MHSDS), which will support with measuring the use of mental health services and the Mental Health Act, and monitoring patient outcomes against the policy objectives. NHS Executive in Wales are also improving data to include patient level information and outcome/experience measures.
- Culturally Appropriate Advocacy (CAA) – DHSC have commissioned pilots to develop models for delivering CAA for people from ethnic minority backgrounds who access mental health services. The first phase of piloting ran from November 2021 to June 2022 and tested various models of CAA in three areas of England. An independent evaluation took place and recommended further testing to develop understanding. Phase 2 of the pilots went live in October 2023 and will run until March 2025. The final evaluation will inform the development of a framework for commissioning and delivering CAA.
- Cultural change – legislation alone will not drive changes in the day-to-day experiences of patients and staff. To achieve this, we need to bring about an overall culture change. This will require a whole system response and strong leadership from clinicians and experts informed by experience. To contribute to this, NHSE are delivering a Mental Health, Learning Disability and Autism (MHLDA) Quality Transformation programme. All mental health, learning disability and autism inpatient services for children and young people, adults and older adults are in scope of this programme, including specialised inpatient services. The programme, which has

[13] New research to improve experiences of people with serious mental health problems | NIHR

been co-produced with key stakeholders from across systems and especially people, families and staff. The programme includes specific consideration of the cultural change required to create and sustain an inpatient environment in which patients and staff can flourish, such as reducing restrictive practice and embedding therapeutic relationships. This programme complements wider ongoing transformation of all-age mental health services – to ensure that people can access the care they need when they need it, helping people to live well in their communities and reducing the need for use of the MHA.

- Another way we are achieving cultural change is via NHS England's anti-racism framework, the Patient and Carer Race Equality Framework (PCREF)[14] published in October 2023. The framework was developed with a number of stakeholders including the support and ongoing commitment from CQC. The PCREF is a mandatory framework to ensure mental health trusts and mental health providers are responsible for co-producing and implementing concrete actions to reduce racial inequality within their services and will become part of CQC's and EHRC's inspection processes.
- The national roll out will support mental health providers to improve access, experience and outcomes and reduce disparities for people from ethnic minority groups which includes data submission on the mental health act broken down by ethnicity. All mental health providers will be required to report on the PCREF metrics set out in the framework by March 2025 as aligned to the NHS Standards Contract 2024/25.
- DHSC and MoJ will continue to work with NHSE, and other partners, to look at further national support requirements to drive change in the system including but not limited to: ensuring that training is centred around supporting meaningful co-production with the patient; that we drive up expert-by-experience leadership roles within providers and local systems.

Option 1: Business as Usual

14. The Business as Usual option (BAU) assumes that there are no changes to the MHA and that none of the Government proposals are implemented. This is the counterfactual used in this IA, which reflects the status quo considering only current national policies in England and Wales. Therefore, there are no additional costs and benefits to the baseline associated with the BAU option.
15. To provide a counterfactual this 'BAU' option assumes no other legislative changes to mental health (MH) services and performance over the 20-year appraisal period. In reality, even without the proposed MHA reforms we might expect to see alternative changes to services which might impact detentions and costs, but it is not possible to anticipate these with confidence. There is currently a large amount of unmet need, therefore we expect to require ongoing reform and investment in MH services to better meet existing demand.

Option 2: (Preferred option) Implementation of the Bill

Summary of preferred option

16. The Bill includes the following measures:

- **Detention criteria** – Detention criteria are set out in the MHA to provide a threshold against which decisions are made about whether to detain a person, and whether to keep that person detained. It is important that this threshold balances the interests of public protection and risk,

[14] NHS England » Advancing mental health equalities

with personal freedoms and autonomy. This Bill includes amendments to the MHA which aim to ensure that, in order for a person to be detained, there must be a risk of serious harm and that this harm is likely to occur. The Bill will also ensure that people are only detained if there is a reasonable prospect of the patient receiving therapeutic benefit from detention. This is achieved as the detention criteria require that there is appropriate medical treatment available in order to detain. The Bill changes adds to this definition: 'has a reasonable prospect of alleviating or preventing. The intention is that treatment outcomes such as a short-term reduction in aggression or dangerousness will still be capable of satisfying the detention criteria when someone is first detained. However, 'appropriate medical treatment' with a more enduring therapeutic benefit should be considered when decisions are being made about renewing a patient's detention. the worsening of, the disorder or one or more of its symptoms or manifestations'.

- **Discharge protocol and managing patient safety** – Although it is already established good practice for clinicians to consult with the wider multi-disciplinary team, technically a clinician can act independently to discharge patients under Part II or unrestricted Part III patients at any time under the Act. Similarly, for Part II patients under guardianship, the local authority, responsible clinician or nearest relative have the power to independently decide to discharge a person from guardianship. This is the same for guardianship patients under Part III of the Act, the only modification being that these patients cannot be discharged by their nearest relative. The Bill includes amendments to the discharge protocol to put good practice into law - requiring that the decision maker must consult with one or more professionals concerned with the patient's care who, where relevant, must be of a different profession to the Responsible Clinician before making an order for discharge. For patients subject to a restriction under Part III of the Act, the decision to discharge (either absolutely or conditionally) remains for the Secretary of State for Justice and/or the Tribunal, though the Responsible Clinician will be required to consult before making recommendations. In addition, as part of the patient's Statutory Care and Treatment Plan (see below), our intention is that the Responsible Clinician should create a safety management plan for the patient (this is to be set out in secondary legislation).

- **Detention periods** – The Bill will shorten the initial period that patients under certain sections can be kept in detention for treatment. This change 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 sooner. Currently the responsible clinician must renew the detention of a patient subject to section 3 every six months in the first year of detention and every 12 months thereafter; the Bill will shorten the initial period so a patient's detention will be reviewed at three months, then at six and 12 months from date of admission.

- **Learning disability and autism** – The Bill will further limit the extent to which Part II of the MHA can be applied to people with a learning disability and autistic people, most notably by removing the power to detain for treatment under Part II section 3 where the patient does not have a co-occurring mental health condition that warrants hospital treatment. We do not propose an equivalent change to the detention criteria for people with these conditions who are sentenced to hospital stays by the court or those transferred from prison to hospital for treatment under the MHA i.e., because they have been detained after a criminal offence.

- The Bill introduces a duty on the patient's responsible commissioner to make arrangements to ensure that care, (education) and treatment review meetings happen within a certain timeframe for people with a learning disability and autistic people who are liable to be detained under the Act. The patient's responsible clinician, responsible commissioner, ICB and local authority must have regard to the recommendations of the review meeting.

- The Bill also places a duty on ICBs to create a register of people with a learning disability and autistic people who may be at risk of admission. ICBs and local authorities would be required to have regard to the information on the register when exercising their commissioning and market functions respectively. The Bill requires that both ICBs and local authorities seek to ensure that the needs of people with a learning disability and autistic people can be met without detaining them under Part II of the Act.
- **Strengthening the rights of patients to express a treatment preference** – Under the Bill patients will have greater opportunity to inform clinical decision making through measures such as a personal Advance Choice Document (ACD). Mental health service users can record their wishes, feelings, beliefs and values, including advance decisions to refuse specific medication in their ACD, such that these can inform clinical decision making when they are too unwell to express these things at the time. Commissioning bodies will be under a duty to make arrangements so that people who are at risk of detention are informed of their ability to make an ACD and that those who wish to receive professional support to write an ACD, receive it.
- The Bill places a duty on clinicians to follow a 'checklist' to ensure that care and treatment decisions are personalised to the patient's individual needs. For example, the clinician must support the patient to take part in decision making about their care, they must consider their wishes and feelings (whether in an ACD or expressed at the time) and not make unjustified assumptions about the patient that may unfairly bias their decision.
- While the Bill does not remove the power to give compulsory treatment, it introduces new safeguards that aim to strengthen patient autonomy and ensure that it is only used when strictly necessary. For example, if a patient is refusing non-urgent medical treatment (through an advance decision or at the time), the treatment can only be provided if there is a 'compelling reason' i.e. the clinician can't identify a clinically viable alternative medication or one that is acceptable to the patient. This is to prevent compulsory treatment being administered without any attempt by the clinician to find a more agreeable alternative medication. Where it is deemed appropriate to treat a patient with medication for their mental health disorder without their consent, the patient will benefit from much earlier access to a second opinion appointed doctor (SOAD), appointed by the Care Quality Commission. Furthermore, patients who lack capacity to consent to treatment (where treatment is not in conflict with an advance decision) will also receive earlier access to a SOAD. Lastly, the Bill also introduces stronger safeguards around when urgent compulsory treatment can be used (including in relation to electro-convulsive therapy).
- **Statutory Care and Treatment Plans** – The Bill includes provisions to ensure that patients under detention receive a Care and Treatment Plan as soon as possible, which will provide details of how the patient will be supported towards recovery and discharge (where relevant). The plan should be developed by the person in charge of the patient's care in direct collaboration with the patient and those close to them, so that it is tailored to the patient's individual needs and preferences. Staff will be required to review and revise plans on a regular basis and plans will be subject to internal scrutiny, to ensure that they meet all statutory requirements. It is our intention that they will also be shared with the Mental Health Tribunal (MHT) to help inform decisions regarding the patient's ongoing detention.
- **Community Treatment Orders (CTOs)** – CTOs were introduced in the 2007 revision of the MHA and have been subject to high levels of criticism since. They mean that a person can still be subject to conditions after they are discharged from hospital and be recalled if concerns about their need for treatment develop. Stakeholders believe that in the last eight years they are have been overused.[15] with around 5,000 to 6,000 orders per year. The Government proposes reforms to introduce greater scrutiny to CTOs and amend the CTO criteria in line

[15] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital Table 3a.

with the new detention criteria are expected to have the effect of reducing CTOs by ensuring they are used in a more targeted way. They should only be used where there is a risk of serious harm self or others and where the community clinician agrees that it is necessary and appropriate for the patient. Earlier automatic referrals to the tribunal should also see people discharge from CTOs sooner. However, it is possible that clinicians may be more risk averse in the public protection context and therefore more inclined to issue a CTO, which may negate the degree to which use of CTO decreases overtime with our changes.

- **Improving patient representation and support** – The Bill will modernise the existing arrangement under the MHA in which a family member is automatically appointed 'nearest relative' and has powers to make decisions about a person's care. Instead, the Bill will give patients the freedom to choose their own 'nominated person' (NP), when they are well enough and have the mental capacity to do so. The role of a NP will also include increased powers within the legislation, for example, a NP will have a new right to be consulted on the patient's statutory care and treatment plan and the power to object to the use of a CTO (where the Responsible Clinician doesn't deem this a danger to the patient or others).
- **Independent Mental Health Advocates** - The Bill will make informal patients, those who have agreed to come into hospital voluntarily, eligible to access an independent mental health advocate (IMHA), to support patients to understand their rights and to participate in decisions about their care and treatment. The Bill will also make changes to improve advocacy uptake among formal patients.
- **Places of safety** –The Bill also includes legislative changes that will end the use of prison and police cells as a place of safety under the MHA. For people in contact with the criminal justice system this will end the practice of courts diverting defendants requiring assessment and treatment in an inpatient setting to prison when there is no hospital bed available.
- **Removal of remand for own protection solely on mental health grounds** - The Bill will amend the Bail Act to end the use of remand for own protection where the court's sole concern is the defendant's mental health. Instead, courts will be directed to bail the defendant and work with local health services to put in place appropriate support and care to address risks to their safety.
- **The Mental Health Tribunal** – The role of the MHT is to act as the ultimate safeguard for a patient in detention. It forms part of HM Courts and Tribunals Service (HMCTS) and provides judicial oversight of detentions made under the MHA. The MHT has the power to consider whether the conditions for continuing treatment under compulsory powers are met and it may authorise treatment orders that specify the detention of a patient in a specific hospital or to reside at a specified place (when not able to reside at home). The Bill proposes increasing the frequency with which patients can appeal their detention and will ensure that those who do not appeal themselves will nevertheless have their case referred to the Tribunal for it to determine whether they continue to meet the criteria for detention[16]. The Tribunal will have a power to recommend that community services are provided, where this could facilitate a fast/smoother discharge, and they will also be able to inform the conditions that apply to a patient's Community Treatment Order. The Bill will also reduce the burden of hearings cancelled at the last minute due to Section 3 patients no longer meeting the criteria.
- **Supervised Discharge** – The Bill includes a new power to allow for patients detained through the courts, who are subject to special controls by the Secretary of State for Justice to protect the public from serious harm, to be discharged into the community with conditions which amount to a deprivation of liberty. This power will only be applicable when a patient is no longer

[16] **Hearing** - The hearing is a meeting at which the tribunal panel considers evidence (either orally or paper based) and reaches a decision (where the decision may be to adjourn or to agree a final outcome). Source: Guide to Tribunal Statistics Quarterly - GOV.UK (www.gov.uk)

therapeutically benefiting from hospital detention but continues to pose a level of risk which needs supervision to be managed in the community.

- **Transfers to hospital from prisons and other places of detention** - The Bill introduces a statutory time limit of 28 days for the transfer of patients who meet the threshold for detention under the Mental Health Act from prisons, Immigration Removal Centres (IRCs) and other places of detention to mental health hospitals for treatment. It aims to further embed the good practice set out in NHS England's guidance on transfers and remissions published in June 2021 and increase accountability among the agencies involved in the transfer process to meet the deadline.
- **Crown dependencies** - The Bill will remove the exclusions that exist in sections 83 and 85 of the MHA that prevent offenders remanded to hospital or made subject to interim hospital orders from transferring between the Crown Dependencies and England and Wales. The exclusions have had an effect of limiting the powers of courts in the Crown Dependencies from appropriately dealing with offenders suffering from complex mental health needs. The Bill will resolve this by providing that remand and interim patients can be transferred into England and Wales from the Crown Dependencies for reports or treatment, whilst being appropriately detained under domestic provision, and then returned for the continuation of their criminal proceedings.
- **Section 117 aftercare ("ordinary residence")** – The Bill applies the 'deeming rules' under social care legislation to the determination of ordinary residence to identify which local authority is responsible for arranging section 117 aftercare to an individual patient. Namely, in relation to those aged under 18, section 105(6) of the Children Act 1989 (as modified) applies, and in relation to adults, the deeming rules under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014 apply for the purposes of determining ordinary residence.
- **Principles -** The Independent Review, working closely with service users, developed four guiding principles to be considered when carrying out the functions and powers under the Mental Health Act. These principles are Choice and Autonomy, Least Restriction, Therapeutic Benefit and The Person as an Individual. The principles have had strong support since the review, and stakeholders and PLS have sought their inclusion in the Bill. In response, we are amending Section 118, which imposes statutory requirements in relation to the content of the Code of Practice, the statutory guidance which sits alongside the Act, to include the wording of the Review's principles. Secretary of State will be required to include the four principles in the statement of principles in the Code of Practice, and those subject to the Code should have regard for these principles when performing functions under the Act.

Description of implementation plan

17. The Bill will extend and apply to England and Wales. The proposed reforms concern health, which is primarily a devolved matter in Wales, and the criminal justice system, which is reserved for England and Wales. Where legislating for devolved areas, we will seek a Legislative Consent Motion (LCM) from the Welsh Government. The Welsh Government has expressed support for the reforms as they apply to Wales and will confirm this following the Bill's Introduction. In this document, we have modelled the impacts on Wales for the majority of the reforms, excluding advocacy and Statutory CTPs, C(E)TRs and DSRs, as these policies either apply to England only or are already in place in Wales[17].
18. **The commencement dates referenced in this impact assessment are provided for illustrative purposes only and cost and benefit estimates and should not be interpreted as fixed timelines or commitments. Actual commencement dates may vary depending on the progression of relevant processes, legislative actions, or unforeseen circumstances.**

[17] Annex A page 53 Draft Mental Health Bill: explanatory notes (publishing.service.gov.uk)

Table 1, for illustrative purposes, sets out start dates for various reforms, for the purpose of modelling costs and savings.

19. Expected timelines for implementation of the reforms are set out in Table 1. Departments are developing a cross-agency workplan to ensure that clear pathways are in place to safely enact our proposed reforms which will take into consideration both judicial and clinical resourcing.

Table 1. Estimated commencement dates for specific MHA reforms

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
New detention criteria, including for people with a learning disability and autistic people *			Implementation starts					
C(E)TRs made statutory		Implementation starts						
All ICBs required to establish & monitor DSRs		Implementation starts						
Nominated Person				Implementation starts				
Auto referral of formal patients to IMHA services				Implementation starts				
Expansion of IMHAs to informal patients					Implementation starts			
Advance Choice Documents						Implementation starts		
Changes to SOAD role**							Implementation starts	
Changes to SOAD visits - Urgent ECTs								Implementation starts
Changes to CTOs								Implementation starts
Compulsory CTPs								Implementation starts
Increased S3 Renewals							Implementation starts	
Changed frequency of tribunals							Implementation starts	
Supervised Discharge		Implementation starts						
Transfers to hospital from prisons and other places of detention			Implementation starts					
Remand for Own Protection	Departments are working together to ensure there are clear pathways and provision in place to safely enact these reforms and the timeline for implementation will depend on the conclusion of this work.							
Prison as a place of safety								
Crown Dependencies								

**This timeline is highly indicative as an illustration for modelling purposes. This reform will commence once systems are able to demonstrate sufficient levels of community support for people with a learning disability and autistic people as an alternative to hospital-based care.*

***Includes costs for other professional groups such as clinical staff, who have a role in the interaction with the SOAD.*

20. As the policy implementation is staggered over time, with the latest powers (for increased frequency of tribunals) potentially turned on in 2031/32, the economic appraisal period will cover 20 years of impacts of Option 2 (implementation of the Mental Health Bill).

21. Estimates developed for this Impact Assessment are economic estimates developed for the purpose of economic options appraisal, where the options being considered are either (1) maintaining the status quo and current legislation, or (2) proceeding to make the legislative changes set out in the Bill. They are not financial projections and shouldn't be viewed as such, nor should they represent a full implementation and workforce plan which will be developed

alongside the Code of Practice. Cost estimates are partial in nature and don't reflect, for instance, cost pressures or efficiencies that would occur in both Option 1 and Option 2 scenarios. More information on the approach economic appraisal used in Impact Assessments can be found in the HMT Green Book[18].

Cost Benefit Analysis

Summary and changes since the previous IA

22. This Impact Assessment (IA) focusses on analysing the costs and benefits associated with proposed legislative changes in the Mental Health Bill, particularly on improving safeguards in both the Health and Social Care system and in the Justice system. It accompanies the Bill and updates the previous IA (published alongside the draft MHA Bill in 2022 for Pre-legislative scrutiny (PLS)[19]).[20]

23. This Final Stage IA updates the estimates for costs and benefits in response to further updates of methodologies and development of policies, including: detentions and patient number projections; the scope, expectations and impacts of Advanced Choice Documents (ACDs); the delivery of Care and Treatment Plans (CTPs); changes to the rules of around urgent use of electroconvulsive therapy (ECT); the implementation of Nominated Persons; changes to Community Treatment Order (CTO) processes and use; the benefits and costs from reduced hospital admissions and detentions, and the incorporation of impacts for reforms applying in Wales. It also covers, in quantitative or qualitative terms, the impacts of the following policies which were not included in the previous IA:

    - Discharge protocol and managing patient safety
    - ACD duty to signpost and support
    - Dynamic Support Registers (DSRs)
    - Care, Education, Treatment Reviews (C(E)TRs)

24. It is important that Government proposals relating to access to the MHT are not seen in isolation from clinical care. The MHA operates in a complex and dynamic system, where changes to the balance of safeguards can have profound impacts on patient care. We have tried to account for this interaction when feasible e.g., MHT hearing volumes generated from a model estimating the impact of the Justice System proposals inform another which estimates the impacts on clinical staff and estimates of potential reductions in the number of detentions caused by policy changes effect estimates of the costs of changing patients' experience of detention.

25. In this Impact Assessment, we have modelled the impacts for the majority of the reforms on Wales, excluding advocacy, Statutory CTPs, C(E)TRs and DSRs. These reforms have been excluded when modelling the impacts on Wales as the policies either apply to England only or are already in place in Wales. To account for the impact of the reforms on Wales, we have used a scaling approach where costs and benefits have initially been estimated for England only. Impacts have then been weighted by scaling up impacts depending on the processes that the reforms are linked to. See further detail in Annex G.

[18] The Green Book (2022) - GOV.UK (www.gov.uk)

[19] PLS allows for the detailed examination of a draft Bill by either the relevant Commons Departmental select committee, or an ad hoc joint committee of both Houses (House of Commons and House of Lords). It seeks to improve legislation by allowing thorough consultation and scrutiny of legislation while it is in a more easily amendable form and makes it easier to ensure that potential parliamentary objections and stakeholder view are elicited. This ultimately helps to smooth the Bill's passage in Parliament by reducing the need for amendments.

[20] Mental Health Act Draft Bill: impact assessment (publishing.service.gov.uk)

Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)

26. This impact assessment presents our best estimates of costs and benefits of the options considered based on available data and evidence.

27. We present the modelling assumptions and estimated costs throughout the following section and annexes, highlighting uncertainties and associated risks. The assumptions for the models were discussed with NHSE, CQC and also other stakeholders (e.g., MHT judiciary and HMCTs operational colleagues, providers of services, professional associations) and drawn from data or research whenever possible.

28. For some policies, their timing of introduction and impact depend on wider policy changes, funding, and secondary legislation. This means it is currently less clear what the potential costs and benefits will be, or how far they should be attributed to this legislative change, and this is also discussed. We have included sensitivity analysis to capture this uncertainty and demonstrate changes to the costs and benefits when key assumptions are varied.

29. In some cases, further changes to practice and/or investment will be needed to achieve the aims of the reforms. Costs and benefits associated with these are not captured in the IA as they are not directly implied by the legislative changes in the Bill but will be important to consider for future policy.

Option 1: Business as Usual

Detentions and admissions baseline scenarios

30. The number of Business as Usual (BAU) detentions and admissions under Option 1 informs estimates for the Health and Social Care workforce requirements for the additional recommended safeguards and for the volume of MHT activity.

31. The BAU approach for detentions under the MHA assumes that:

    - In the central scenario, detention rates for different age groups remain constant in the future, at the same level as the rates observed in the 2023/24 published data. These rates are applied to ONS population forecasts to produce projections for the number of detentions in each group.

32. The BAU approach for admissions assumes that:

    - In the central scenario, admission rates for different age groups remain constant in the future, at the same level as the rates observed in the 2023/24 published data. These rates are applied to ONS population forecasts to produce projections for the number of detentions in each group. The number of informal admissions is then calculated by subtracting the projected number of detentions from the projected number of admissions.

33. The BAU approach for people with a learning disability and autistic people is nearly identical, but instead of holding figures constant at the same level as the rates observed in the 2023/24 published data, we ignore the latest 8 months of data, and calculate an average from the 12 months of timeseries data preceding this point (December 2022 – November 2023). This is due to known late reporting, partly due to diagnosis of patients as having a learning disability or as autistic after admission to hospital.

34. There are known limitations in the data quality for the number of detentions recorded under the Mental Health Act, with not all providers submitting data, and some submitting incomplete data. Therefore, we consider low and high scenarios in the sensitivity analysis section.

Community Treatment Order (CTO) baseline scenarios

35. The number of BAU CTOs under Option 1 informs estimates for the Health and Social Care workforce requirements for the additional recommended safeguards and for the volume of MHT activity.

36. The BAU approach for CTOs assumes that:

    - The number of CTOs as a proportion of the average total detentions (estimated over eight years from 2016/17 to 2023/24) stays stable in BAU and hence will grow in line with weighted demographic changes from annual detention forecasts.
    - There have previously been some concerns about data quality issues with the CTO data as well as wider factors. Therefore, we consider low and high scenarios in the sensitivity analysis section.

37. As with detentions, we also consider a high and low scenario in the sensitivity analysis section.

Mental Health Tribunal (MHT) receipts

38. We assume that the volume of MHT receipts[21] will follow the same trend as the projected number of detentions. From the latest 2023/24 figure, the trajectory is applied to future years. Further information is provided in Annex E.

Option 2: (Preferred option) Implementation of proposed reforms

Costs

39. The monetised costs of the reforms include:
    - Costs to the Health and Social Care (H&SC) system. We present additional costs in two ways:
        - Impacts disaggregated by the specific policies that cause them; and
        - Impacts disaggregated, where possible, by the relevant professional groups in the NHS and Local Authorities in England.
    - Costs to the justice system. We present additional costs for the proposed changes to the MHT, disaggregated by the specific policy areas of automatic referrals, expanded powers and treatment choice, changes to the detention criteria, and legal aid impacts.

40. The monetised cost estimates include the 'process costs' introduced by the reforms, which mostly relate to additional workload for the MHA workforce. Some reforms are anticipated to reduce the number of patients voluntarily admitted to hospital, detained or put onto CTOs. This will have the effect of reducing some of the additional process costs described above. The reduction in process costs have been presented in the costs section, to better represent the overall impact on these processes and workload. Additional costs also arise from the transfer of activity from hospital into community care associated with these reductions in admissions and detentions.

41. The cost tables are set out in 2024/25 prices using the GDP deflator as set out in the June 2024 Quarterly National Accounts from ONS[22]. Figures in tables are rounded to the nearest million and may not sum exactly due to this rounding. Due to rounding, some figures may appear as zero but

[21] **Receipt** - Volumetric term covering the acceptance of a case by a HMCTS Tribunal. Source: Guide to Tribunal Statistics Quarterly - GOV.UK (www.gov.uk)

[22] Office for National Statistics (ONS), released 30 September 2024, ONS website, statistical bulletin, https://www.ons.gov.uk/economy/grossdomesticproductgdp/bulletins/quarterlynationalaccounts/apriltojune2024

still have a net impact e.g., C(E)TRs. All monetary values exclude VAT. All costs are undiscounted unless otherwise specified.

42. Costs for Wales have been estimated by applying an uplift to costs for England. Further detail is provided in Annex G.

43. There are expected to be a range of costs which have not been able to be monetised. These are additionally discussed in the non-monetised section and split into costs to the Health and Social Care system and Justice system.

Summary of monetised costs

44. Overall costs of the reforms are estimated at £5.7 billion over the 20-year appraisal period for England and Wales. Due to the phased implementation nature of the proposals, these costs are not evenly split over the 20 years starting from when the necessary legislation is assumed to be in place. Costs are estimated to average around £294 million per year over the implementation period from 2031/32 (undiscounted real 2024/25 prices).

Table 2. Summary of health, housing and social care costs and costs to the justice system, England and Wales (£millions, 2024/25 prices, undiscounted) – Central Estimate

	2024/25 *	***2025/26 ****	***2026/27 ****	**2027/28 ***	**2028/29 ***	**2029/30 ***	**2030/31 ***	**2031/32 ***	**2032/33 ***	**2033/34 ***
Additional costs	0	4	466	360	203	232	291	307	317	317
Of which health, housing, and social care	0	4	466	360	203	232	260	283	290	291
Of which justice	0	0	0	0	0	0	30	24	27	26
Process cost savings	0	0	1	1	1	2	5	6	7	9
Of which health, housing, and social care	0	0	0	1	1	2	1	2	3	4
Of which justice	0	0	0	0	0	0	4	4	5	5
Total costs	**0**	**4**	**465**	**359**	**203**	**230**	**285**	**300**	**310**	**308**
Of which health, housing, and social care	**0**	**4**	**465**	**359**	**203**	**230**	**259**	**281**	**288**	**287**
Of which justice	**0**	**0**	**0**	**0**	**0**	**0**	**26**	**19**	**22**	**21**

	2034/35 *	**2035/36 ***	**2036/37 ***	**2037/38 ***	**2038/39 ***	**2039/40 ***	**2040/41 ***	**2041/42 ***	**2042/43 ***	**2043/44 ***	**Total**
Additional costs	326	320	327	327	330	332	335	337	340	342	**5,811**
Of which health, housing, and social care	296	294	298	299	301	304	306	308	310	313	**5,417**
Of which justice	30	26	29	28	28	29	29	29	29	30	**394**
Process cost savings	10	12	12	12	12	13	13	13	13	13	**156**

Of which health, housing, and social care	5	6	6	6	6	6	6	6	7	7	**75**
Of which justice	6	6	6	6	6	6	6	6	7	7	**81**
Total costs	**316**	**308**	**315**	**315**	**318**	**320**	**322**	**324**	**327**	**329**	**5,656**
Of which health, housing, and social care	**291**	**288**	**292**	**293**	**295**	**297**	**299**	**302**	**304**	**306**	**5,342**
Of which justice	**25**	**20**	**23**	**22**	**22**	**22**	**22**	**23**	**23**	**23**	**313**

*****Timeline and cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Summary of costs by public service sector

45. The estimated monetised costs of the policy interventions under Option 2 in England have been disaggregated into costs relating to the NHS (excluding housing costs for people with a learning disability and autistic people), Local Authorities (excluding reforms relating to people with a learning disability and autistic people), Housing and Care costs (reforms relating to people with a learning disability and autistic people), Care Quality Commission (CQC), and the Justice System.

46. Over the 20-year appraisal period, in England, there are an estimated £1.9 billion of costs for the NHS (excluding housing costs for people with a learning disability and autistic people), £396 million of costs for Local Authorities (excluding reforms related to people with a learning disability and autistic people), £2.5 billion for housing and care costs (reforms relating to people with a learning disability and autistic people, NHS/LA/DWP), £78 million of costs for the CQC, and £287 million of costs for the Justice system.

47. These costs include process cost savings, which represent reductions in the additional process costs due to the reforms, such as those relating to a reduction in the use of CTOs. It has not been possible to disaggregate the costs by public service sector in Wales.

Table 3. Additional costs by public body, England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
NHS (excl. housing costs for people with a learning disability and autistic people)	0	4	215	110	38	62	84	100	107	106
Local Authority (excl. additional community care costs for reforms relating to people with a learning disability and autistic people)	0	0	2	15	18	21	20	26	26	26
Housing and care costs (reforms relating to people with a learning disability and autistic people), (NHS, LA, DWP)	0	0	202	201	129	129	130	130	131	132
CQC	0	0	0	0	0	0	5	5	5	5
Justice System	0	0	0	0	0	0	28	22	24	24

Total	**0**	**4**	**419**	**326**	**185**	**213**	**267**	**283**	**293**	**293**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
NHS (excl. housing costs for people with a learning disability and autistic people)	109	107	109	110	111	112	113	114	115	116	1,941
Local Authority (excl. additional community care costs for reforms relating to people with a learning disability and autistic people)	27	27	27	28	28	29	30	30	31	31	441
Housing and care costs (reforms relating to people with a learning disability and autistic people) (NHS, LA, DWP)	132	133	133	134	134	135	135	136	137	137	2530
CQC	5	6	6	6	6	6	6	6	6	6	78
Justice System	28	24	27	26	26	26	26	27	27	27	362
Total	**302**	**296**	**302**	**303**	**305**	**308**	**310**	**312**	**315**	**317**	**5,352**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Table 4. Process cost savings by public body, England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
NHS (excl. housing costs for people with a learning disability and autistic people)	0	0	0	1	1	2	1	1	1	1
Local Authority (excl. additional community care costs for reforms relating to people with a learning disability and autistic people)	0	0	0	0	0	0	0	1	2	2
Housing and care costs (reforms relating to people with a learning disability and autistic people) (NHS, LA, DWP)	0	0	0	0	0	0	0	0	0	0
CQC	0	0	0	0	0	0	0	0	0	0
Justice System	0	0	0	0	0	0	4	4	4	5
Total	**0**	**0**	**0**	**1**	**1**	**2**	**5**	**6**	**7**	**8**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total

NHS (excluding housing costs for people with a learning disability and autistic people)	2	2	2	2	2	2	2	2	2	2	28
Local Authority (excl. additional community care costs for reforms relating to people with a learning disability and autistic people)	3	4	4	4	4	4	4	4	4	4	44
Housing and care costs (reforms relating to people with a learning disability and autistic people) (NHS, LA, DWP)	0	0	0	0	0	0	0	0	0	0	0
CQC	0	0	0	0	0	0	0	0	0	0	0
Justice System	5	6	6	6	6	6	6	6	6	6	74
Total	**10**	**11**	**11**	**11**	**12**	**12**	**12**	**12**	**12**	**13**	**147**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Table 5. Total costs by public body, England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
NHS (excluding housing costs for people with a learning disability and autistic people)	0	4	215	109	38	61	83	99	106	105
Local Authority (excl. additional community care costs for reforms relating to people with a learning disability and autistic people)	0	0	2	14	18	21	20	24	24	24
Housing and care costs (reforms relating to people with a learning disability and autistic people) (NHS, LA, DWP)	0	0	202	201	129	129	130	130	131	132
CQC	0	0	0	0	0	0	5	5	5	5
Justice System	0	0	0	0	0	0	24	18	20	19
Total	**0**	**4**	**419**	**325**	**184**	**210**	**262**	**277**	**286**	**285**

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
NHS (excluding housing costs for people with a learning disability and autistic people)	108	105	107	108	109	110	110	111	113	114	**1,913**
Local Authority (excl. reforms relating to people	24	23	24	24	25	25	26	26	26	27	**396**

with a learning disability and autistic people)											
Housing and care costs (reforms relating to people with a learning disability and autistic people) (NHS, LA, DWP)	132	133	133	134	134	135	135	136	137	137	**2,530**
CQC	5	6	6	6	6	6	6	6	6	6	**78**
Justice System	23	18	21	20	20	21	21	21	21	21	**287**
Total	**292**	**285**	**291**	**292**	**294**	**296**	**298**	**300**	**302**	**304**	**5,205**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Monetised Costs - Health and Social Care System

Costs by process/policy

48. The estimated additional costs for the main health and social care policies for each policy change or process have been monetised and are presented in Table 7 for England only. The majority of these costs relate to additional process costs due extra workload. Some of the reforms are expected to reduce the volume of detentions, admissions, and CTOs, which will reduce these process costs. We refer to these as process cost savings in Table 8. The total estimated costs of these reforms are shown in Table 9. Some associated costs have not been monetised, which are discussed in the non-monetised section. Detail of the analytical assumptions used to monetise these costs can be found in Annex C.

49. Costs for Wales have been estimated based on applying an uplift factor to costs for England. Further detail and costs for Wales are presented in Annex G.

50. The details of the health and social care policies are presented below:

- **Nominated person (NP)** - This includes administrative costs for activities such as recording the NP, and any associated changes, in the patient's record, providing information to the NP (e.g. on the CTP) and consulting with them where necessary. This also covers costs associated with additional meetings required between AMHPs and Nominated Person before a CTO can be finalised, and costs to nurses relating to CTP liaison.
- **Opt-Out Advocacy** - This covers costs to IMHAs for providing advocacy support for formal patients which equates to between 46,000 and 48,000 detentions each year post implementation.
- **Informal advocacy** - This covers costs to IMHAs for providing advocacy support for informal patients which equates to around an additional 27,000 admissions each year post implementation.
- **Advance Choice Documents (ACDs)** – This covers the costs associated with the additional workload for staff who may be involved with signposting and supporting people identified as being at high risk of admission under the MHA to draft an ACD. The modelling assumed to include costs for the NHS staff (key worker/care coordinators and ACD facilitators, psychiatrists, administrative staff) and local authority staff (social workers). In practice, a wider range of workforce groups may be involved, and the extent of support is dependent on what is best for individuals. For example, this may include VCSE staff, may not always require clinical involvement, or may any form of professional support at all, where the person wishes to write the ACD alone or with their family or carer. This also includes process cost savings resulting from a reduction in overall admissions (driven by a reduction in detentions). Full assumptions used to monetise these impacts can be found in Annex C.III.

- **Changes to SOAD visits** – This covers costs to SOADs relating to additional visits from around 15,000 per year to 28,000 per year post implementation. It also covers costs for Section 61 reviews, and their new role in deciding urgent ECTs. This also includes process costs to Approved Clinicians and Nurses relating to additional contact with SOADs.
- **Changes to CTOs** – The reforms introduce greater scrutiny to CTOs and amend the CTO criteria in line with the new detention criteria are expected to have the effect of reducing CTOs by ensuring they are used in a more targeted way. They should only be used where there is a risk of serious harm self or others and where the community clinician agrees that it is necessary and appropriate for the patient. Earlier automatic referrals to the tribunal should also see people discharge from CTOs sooner. However, it is possible that clinicians may be more risk averse in the public protection context and therefore more inclined to issue a CTO, which may negate the degree to which use of CTO decreases overtime with our changes.
- This costs for this policy therefore includes additional process costs for community supervising clinicians relating to additional involvement in CTO assessments and renewals. This also includes process costs savings due to a reduction in the use of CTOs, which is expected following changes in the CTO criteria and greater scrutiny applied to CTOs.
    - In the central scenario, we assume that CTOs will decrease gradually over a five-year period from 2031/31, reaching a total 20% reduction relative to the baseline. Table 6 shows this reduction in CTOs, which is inclusive of reductions due to the impact of reforms for people with a learning disability and autistic people and ACDs. Further information can be found in Annex C.I.

Table 6. Estimated Reduction in CTOs (based on central detention scenario)

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
Central Scenario - (gradual reduction in CTOs reaching 20% reduction in 2031/32)										
Reduction in CTOs	0	0	20	40	40	130	170	400	630	850
	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
Reduction in CTOs	1,070	1,290	1,290	1,300	1,300	1,310	1,310	1,320	1,320	1,330	15,100

*Profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: These numbers have been modelled using data from England only. Numbers are rounded to nearest 10.

- **Statutory Care and Treatment Plans (CTPs)** – This includes costs to Approved Clinicians for setting up CTPs, costs to nurses for CTP updates, costs to administrative staff for setting up an automated system and for CTP audits, and costs to IMHAs for preparation, meeting and travel.
- **Additional tribunals** – This covers support for more frequent tribunal for patients detained under the MHA and CTOs, which corresponds to additional costs for clinicians, nurses and key workers/care coordinators (relating to certification, travel and report writing), and costs to administrative staff for setting up tribunals.
- **Increased S3 renewals** – This includes costs related to additional workload for Approved Clinicians.
- **C(E)TRs -** This includes workforce costs for staff conducting the C(E)TR, including a chairperson, a clinical expert, an expert by experience, clinical staff involved in delivering an individual's everyday care, education representatives if the CETR is for a CYP, and an administrator.
- **DSRs** - This includes workforce costs for staff conducting the DSR care plan review, including a commissioning manager, a learning disability and autism senior officer, a social care services

manager, an administrator, and the following additional staff if the review is for a CYP: a senior EHCP coordinator and keyworker support.

- **Change in detention criteria for people with a learning disability and autistic people -** This includes costs of community care e.g. housing capital and revenue costs, care and support packages. This also includes estimates for community infrastructure costs which cover a range of support services including intensive support teams, community forensic teams, and keyworker services. See Annex D for more details on associated cost modelling.
- **Familiarisation and backfill costs** – This includes costs for one-off familiarisation training and backfill pay for Approved Clinicians, Section 12 doctors, MHA managers, SOADs, AMHPs and IMHAs, and costs to establish an NHS online learning hub.
- **Training costs –** This includes training costs for all modelled staff groups, assuming an expansion in workforce to accommodate additional workload of the reforms.

Table 7. Additional costs for the Health and Social Care system by policy or process, England only (£millions, 2024/25 prices, undiscounted) – Central Estimate

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Nominated Persons	0	0	0	2	2	2	2	3	3	3
Opt-Out Advocacy	0	0	0	10	10	10	10	10	10	10
Informal Advocacy	0	0	0	0	5	5	6	6	6	6
ACDs	0	0	0	0	0	22	16	16	16	16
Changes to SOAD visits	0	0	0	0	0	0	9	10	10	10
Changes to CTOs	0	0	0	0	0	0	0	0	3	3
Statutory CTPs	0	0	0	2	2	2	2	22	23	23
Additional Tribunals	0	0	0	0	0	0	10	6	7	6
Increased S3 Renewals	0	0	0	0	0	0	6	7	7	7
C(E)TRs – see Annex DXI for costs	0	0	0	0	0	0	0	0	0	0
DSRs	0	3	3	3	3	3	3	3	3	3
Familiarisation & Backfill Costs	0	0	9	9	0	0	0	0	0	0
Training Costs	0	0	0	1	0	3	7	10	11	10
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	0	0	0	0	0	3	5	5	6	6
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	0	0	343	130	0	0	0	0	0	0
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	0	0	0	44	44	44	44	44	44	45

Housing capital cost	0	0	12	58	58	58	58	59	59	59
Housing revenue cost	0	0	19	35	27	27	27	28	28	28
Community Infrastructure cost	0	0	33	33	33	33	33	33	33	33
Total	**0**	**4**	**419**	**326**	**185**	**213**	**239**	**262**	**269**	**269**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Nominated Persons	3	3	3	3	4	4	4	4	4	4	55
Opt-Out Advocacy	10	11	11	11	11	11	12	12	12	12	181
Informal Advocacy	6	6	6	6	6	7	7	7	7	7	99
ACDs	16	17	17	17	18	18	18	18	19	19	263
Changes to SOAD visits	10	10	11	11	11	11	11	11	11	12	149
Changes to CTOs	3	2	2	2	2	2	3	3	3	3	31
Statutory CTPs	23	24	24	25	25	26	26	26	27	27	329
Additional Tribunals	9	6	8	7	7	8	8	8	8	8	105
Increased S3 Renewals	7	7	7	7	7	8	8	8	8	8	102
C(E)TRs – see Annex DXI for costs	0	0	0	0	0	0	0	0	0	0	4
DSRs	3	3	3	3	3	3	3	3	3	3	53
Familiarisation & Backfill Costs	0	0	0	0	0	0	0	0	0	0	18
Training Costs	10	9	10	9	9	9	9	9	8	8	133
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	7	7	7	7	7	8	8	8	8	8	99
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	0	0	0	0	0	0	0	0	0	0	472
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	45	45	45	45	46	46	46	46	46	47	766
Housing capital cost	59	60	60	60	60	60	61	61	61	61	1,023
Housing revenue cost	28	28	28	28	29	29	29	29	29	29	505
Community Infrastructure cost	33	33	33	33	33	33	33	33	33	33	603
Total	**274**	**272**	**276**	**277**	**279**	**281**	**283**	**285**	**288**	**290**	**4,990**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding. This may make some non-zero figures appear as “0”, for example, C(E)TRs. Due to the interaction between different policies and processes related to detention volumes, the impacts listed for each policy include not only the impacts of the policy change, but also impacts affecting the process cost item most relevant to the policy. This means that some impacts may occur before a specific policy change has been implemented.

Table 8. Process cost savings for the Health and Social Care System by policy or process, England only (£millions, 2024/25 prices, undiscounted) – Central Estimate

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Nominated Persons	0	0	0	0	0	0	0	0	0	0
Opt-Out Advocacy	0	0	0	0	0	0	0	0	0	0
Informal Advocacy	0	0	0	0	0	0	0	0	0	0
ACDs	0	0	0	0	0	0	0	0	0	0
Changes to SOAD visits	0	0	0	0	0	0	0	0	0	0
Changes to CTOs	0	0	0	0	0	1	1	2	3	4
Statutory CTPs	0	0	0	0	0	0	0	0	0	0
Additional Tribunals	0	0	0	0	0	1	0	0	0	0
Increased S3 Renewals	0	0	0	0	0	0	0	0	0	0
C(E)TRs	0	0	0	0	0	0	0	0	0	0
DSRs	0	0	0	0	0	0	0	0	0	0
Familiarisation & Backfill Costs	0	0	0	0	0	0	0	0	0	0
Training Costs	0	0	0	0	0	0	0	0	0	0
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	0	0	0	0	0	0	0	0	0	0
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	0	0	0	0	0	0	0	0	0	0
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	0	0	0	0	0	0	0	0	0	0
Housing capital cost	0	0	0	0	0	0	0	0	0	0
Housing revenue cost	0	0	0	0	0	0	0	0	0	0
Community Infrastructure cost	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**1**	**1**	**2**	**1**	**2**	**3**	**4**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Nominated Persons	0	0	0	0	0	0	0	0	0	0	**0**
Opt-Out Advocacy	0	0	0	0	0	0	0	0	0	0	**0**
Informal Advocacy	0	0	0	0	0	0	0	0	0	0	**0**
ACDs	0	0	0	0	0	0	0	0	0	0	**0**
Changes to SOAD visits	0	0	0	0	0	0	0	0	0	0	**0**
Changes to CTOs	5	6	6	6	6	6	6	6	6	7	**69**
Statutory CTPs	0	0	0	0	0	0	0	0	0	0	**1**
Additional Tribunals	0	0	0	0	0	0	0	0	0	0	**2**
Increased S3 Renewals	0	0	0	0	0	0	0	0	0	0	**0**
C(E)TRs	0	0	0	0	0	0	0	0	0	0	**0**
DSRs	0	0	0	0	0	0	0	0	0	0	**0**
Familiarisation & Backfill Costs	0	0	0	0	0	0	0	0	0	0	**0**
Training Costs	0	0	0	0	0	0	0	0	0	0	**1**
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	0	0	0	0	0	0	0	0	0	0	**0**
NHS Community Care Services (transfer of activity) (people with a learning disability	0	0	0	0	0	0	0	0	0	0	**0**

and autistic people) - excl. Housing Costs											
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	0	0	0	0	0	0	0	0	0	0	**0**
Housing capital cost	0	0	0	0	0	0	0	0	0	0	**0**
Housing revenue cost	0	0	0	0	0	0	0	0	0	0	**0**
Community Infrastructure cost	0	0	0	0	0	0	0	0	0	0	**0**
Total	**5**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**7**	**73**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding. Due to the interaction between different policies and processes related to detention volumes, the impacts listed for each policy include not only the impacts of the policy change, but also impacts affecting the process cost item most relevant to the policy. This means that some impacts may occur before a specific policy change has been implemented.

Table 9. Total costs for the Health and Social Care System by policy or process, England only (£millions, 2024/25 prices, undiscounted) – Central Estimate

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Nominated Persons	0	0	0	2	2	2	2	3	3	3
Opt-Out Advocacy	0	0	0	10	10	10	10	10	10	10
Informal Advocacy	0	0	0	0	5	5	6	6	6	6
ACDs	0	0	0	0	0	22	16	16	16	16
Changes to SOAD visits	0	0	0	0	0	0	9	10	10	10
Changes to CTOs	0	0	0	0	0	-1	-1	-2	1	-1
Statutory CTPs	0	0	0	2	2	2	1	22	23	23
Additional Tribunals	0	0	0	0	0	-1	10	6	7	6
Increased S3 Renewals	0	0	0	0	0	0	6	7	7	7
C(E)TRs – see Annex DXI for costs	0	0	0	0	0	0	0	0	0	0
DSRs	0	3	3	3	3	3	3	3	3	3
Familiarisation & Backfill Costs	0	0	9	9	0	0	0	0	0	0
Training Costs	0	0	0	1	0	3	7	10	11	10
NHS Community Care Services (transfer of activity) (excl. people a with learning disability and autistic people)	0	0	0	0	0	3	5	5	6	6
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	0	0	343	130	0	0	0	0	0	0
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	0	0	0	44	44	44	44	44	44	45
Housing capital cost	0	0	12	58	58	58	58	59	59	59
Housing revenue cost	0	0	19	35	27	27	27	28	28	28
Community Infrastructure cost	0	0	33	33	33	33	33	33	33	33
Total	**0**	**4**	**419**	**325**	**184**	**211**	**238**	**260**	**266**	**266**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Nominated Persons	3	3	3	3	4	4	4	4	4	4	**55**
Opt-Out Advocacy	10	11	11	11	11	11	12	12	12	12	**180**
Informal Advocacy	6	6	6	6	6	7	7	7	7	7	**99**
ACDs	16	17	17	17	18	18	18	18	19	19	**263**
Changes to SOAD visits	10	10	11	11	11	11	11	11	11	12	**149**
Changes to CTOs	-2	-3	-3	-3	-4	-4	-4	-4	-4	-4	**-38**

Statutory CTPs	23	24	24	25	25	26	26	26	27	27	**328**
Additional Tribunals	9	6	8	7	7	8	8	8	8	8	**103**
Increased S3 Renewals	7	7	7	7	7	8	8	8	8	8	**102**
C(E)TRs – see Annex DXI for costs	0	0	0	0	0	0	0	0	0	0	**4**
DSRs	3	3	3	3	3	3	3	3	3	3	**53**
Familiarisation & Backfill Costs	0	0	0	0	0	0	0	0	0	0	**18**
Training Costs	10	9	10	9	9	9	9	9	8	8	**132**
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	7	7	7	7	7	8	8	8	8	8	**99**
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	0	0	0	0	0	0	0	0	0	0	**472**
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	45	45	45	45	46	46	46	46	46	47	**766**
Housing capital cost	59	60	60	60	60	60	61	61	61	61	**1,023**
Housing revenue cost	28	28	28	28	29	29	29	29	29	29	**505**
Community Infrastructure cost	33	33	33	33	33	33	33	33	33	33	**603**
Total	**269**	**266**	**270**	**271**	**273**	**275**	**277**	**279**	**281**	**283**	**4,917**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding. This may make some non-zero figures appear as "0", for example, C(E)TRs. Due to the interaction between different policies and processes related to detention volumes, the impacts listed for each policy include not only the impacts of the policy change, but also impacts affecting the process cost item most relevant to the policy. This means that some impacts may occur before a specific policy change has been implemented.

Costs by professional group

51. Below presents a summary of the approach for monetising process costs due to changes in MHA activities, disaggregated by workforce group where this has been possible in England. This has not been the case for all impacts considered, so the following results should not be taken as comprehensive of all the impacts on affected workforces, with some additional effects detailed under 'Non-monetised costs'.

52. Presented below are our best estimate of the process cost impacts, mostly valued using information on salaries and on-costs applied to staff time estimates, with more methodological detail provided in annexes for different policy changes. In some cases, these estimates represent a simplification, with some costs estimated using assumptions that all relevant tasks are conducted by certain types of staff when in practice some other professionals may undertake these duties instead in some cases.

53. These cost estimates disaggregated by staff group do not sum to the total costs of the policies, because they exclude the impact of changes to detention criteria for people with a learning disability and autistic people, presented separately, or the wider cost impacts (which go beyond MHA process costs) of diverting other patients away from hospital care. They also only consider the costs in England, as it has not been possible to disaggregate by workforce group in Wales.

54. The assumptions around additional FTE needed (which underpin the cost estimates) can also be found below, disaggregated by workforce group. This only shows a partial picture of workforce impacts for the same reasons above. We also do not include the benefits (time saved) for

workforce resulting from diverting people away from admission in these FTE estimates, as these were modelled using a 'top down' approach using total bed day costs rather than by costs for each workforce group. These estimates represent the additional workforce time in equivalent FTE to indicate the scale of additional pressure on the system. They do not represent headcount estimates or imply a workforce implementation plan.

Costs by professional group – Independent Mental Health Advocates (IMHAs)

55. An IMHA is an independent advocate who is trained to work within the framework of the MHA to support people understanding their rights under the Act and participating in decisions about their care and treatment. IMHAs are not employed by the NHS or any private healthcare provider; they are commissioned via local authorities in England[23].

56. Under Option 1 (BAU), IMHAs are assumed to be involved in the following activities:

- Providing independent mental health advocacy to formal patients
- Providing advocacy for Care and Treatment Plans (CTPs)
- Providing support for Mental Health Tribunals (MHT)
- Providing support at CTO assessments

57. Under Option 2, the IMHA is expected to have additional workload resulting from the following policy changes:

- The Government proposes that all formal patients (excluding those under short term sections, like Section 4) receive a timely plan on their care and treatment and how they will be progressed towards discharge. This is expected to increase the uptake of CTPs which will require more support from IMHAs.
- The Government proposes to increase access to and frequency of MHTs. proposals relating to MHTs. This is expected to increase the support required from IMHAs.
- The Government proposes to increase the uptake of independent advocates among formal patients. The statutory right to an IMHA will also extend to all mental health patients, including informal/voluntary patients. This will result in additional people requiring IMHA advocacy and support.

58. Under Option 2, the IMHA is expected to have a reduced workload resulting from the following policy change:

- The Government proposes to introduce greater scrutiny and ensure that a CTO is only used when appropriate. This is expected to reduce the use of CTOs.

59. In both Options 1 and 2, annual costs associated with IMHAs cover estimated salary, oncosts, overheads, and capital costs. Costs were calculated by multiplying the estimated FTEs in each year by the estimated annual cost per AMHP in Option 1 (BAU) and Option 2. The total additional cost is the difference between Option 1 and Option 2. Further detail of the assumptions used to estimate the impact of policy changes on this workforce group can be found in Annex C.

60. Table 10 illustrates the additional process costs and savings over the twenty-year appraisal period from 2024/25 to 2043/44, giving a total cost for IMHAs of £382 million.

Table 10. Process costs and additional FTE for Independent Mental Health Advocates, England only (£millions, 2024/25 prices, undiscounted) - Central Estimate

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*

[23] POhWER. Independent Mental Health Advocacy (IMHA). Accessed at: Independent Mental Health Advocacy (IMHA) | POhWER

Additional process costs	0	0	0	12	17	17	17	22	23	23
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total process costs	**0**	**0**	**0**	**12**	**17**	**17**	**17**	**22**	**22**	**23**
Total additional FTE (in year)	0	0	-1	227	333	326	323	415	416	417

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
Additional process costs	23	24	24	25	25	26	26	27	27	28	**386**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**4**
Total process costs	**23**	**24**	**24**	**25**	**25**	**25**	**26**	**26**	**27**	**27**	**382**
Total additional FTE (in year)	419	420	421	423	424	426	427	428	430	431	

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Costs by professional group – Approved Mental Health Professionals (AMHPs)

61. Approved Mental Health Professionals (AMHPs), who are mostly commissioned by local authorities, are responsible for organising and undertaking assessments under the MHA and, where statutory criteria are met, authorising detention under the Act. Their work covers a wide range of activities, including, but not limited to, ensuring service users are interviewed in an appropriate manner, that they know what their rights are if they are detained, and that detainees are treated in a human and dignified way[24].

62. Under Option 1 (BAU), AMHPs are assumed to be present at assessment and at renewals of Community Treatment Orders (CTOs).

63. Under Option 2, the AMHP is expected to have additional workload resulting from the following policy change:

    - The Government proposal to introduce greater scrutiny and ensure that a CTO is only used when appropriate will require an AMHP to attend an additional meeting with the Nominated Person for a CTO assessment.

64. Under Option 2, the AMHP is expected to have a reduced workload resulting from the following policy change:

    - The Government proposal to introduce greater scrutiny and ensure that a CTO is only used when appropriate is expected to reduce the use of CTOs.

65. In both Options 1 and 2, annual costs associated with AMHPs cover estimated salary, oncosts, overheads, and capital costs. Costs were calculated by multiplying the estimated FTEs in each year by the estimated annual cost per AMHP in Option 1 (BAU) and Option 2. The total additional cost is the difference between Option 1 and Option 2. Further detail of the assumptions used to estimate the impact of policy changes on this workforce group can be found in Annex C.

66. Table 11 illustrates the additional process costs and process cost savings over the twenty-year appraisal period. As AMHPs are involved with CTO activity, which is forecast to reduce due to the reforms, there is estimated to be an overall saving for AMHPs of £31 million.

[24] Lancashire Care NHS Foundation Trust (2018). What is an Approved Mental Health Professional. Accessed at (12/09/19): https://www.lancashirecare.nhs.uk/Approved-Mental-Health-Professional

Table 11. Process costs and additional FTE for Approved Mental Health Professionals, England only (£millions, 2024/25 prices, undiscounted) - Central Estimate

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Additional process costs	0	0	0	1	1	1	1	1	1	1
Process cost savings	0	0	0	0	0	0	0	1	2	2
Total process costs	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**-1**	**-2**
Total additional FTE (in year)	0	0	-1	6	6	4	2	-4	-10	-16

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Additional process costs	1	1	1	1	1	1	1	1	1	1	10
Process cost savings	3	3	3	3	4	4	4	4	4	4	41
Total process costs	**-2**	**-3**	**-3**	**-3**	**-3**	**-3**	**-3**	**-3**	**-3**	**-3**	**-31**
Total additional FTE (in year)	-22	-29	-29	-29	-29	-29	-29	-29	-29	-29	

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Costs by professional group – Social Workers

67. Under Option 2, we expect that local authority staff will have additional workload resulting from the following policy change:
    - Commissioning bodies will be under a duty to make arrangements so that people who are at risk of detention are informed of their ability to make an ACD and that those who wish to receive professional support to write an ACD, receive it.

68. Local authority staff may be involved with supporting people to draft an ACD. We have proxied local authority costs using mental health social worker salaries. We have used evidence from the Personal Social Services Research Unit (PSSRU) at the University of Kent[25] to estimate annual costs to employ social workers. Costs include salaries, oncosts (such as National Insurance) and overheads as well as accommodating for annual leave and sick leave.

69. It is assumed that local authority staff may be involved with supporting drafting of ACDs in 50% of cases. Assumptions around staff time for ACDs can be found in Annex C.III. This is estimated to cost £35 million over the 20-year appraisal period as seen in Table 12.

Table 12. Process costs and additional FTE for Social Workers, England only (£millions, 2024/25 prices, undiscounted) - Central Estimate

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Additional process costs	0	0	0	0	0	3	2	2	2	2
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total process costs	0	0	0	0	0	3	2	2	2	2
Total additional FTE	0	0	0	0	0	35	26	25	25	25

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total

[25] Personal Social Services Research Unit: p75, The unit costs of health and social care_Final3.pdf (kent.ac.uk)

Additional process costs	2	2	2	2	2	2	2	2	3	3	**35**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**0**
Total process costs	2	2	2	2	2	2	2	2	3	3	**35**
Total additional FTE (in year)	25	25	25	25	25	25	25	25	25	25	

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Costs by professional group – Second Opinion Appointed Doctors (SOADs)

70. The Second Opinion Appointed Doctor (SOAD) service is managed by the Care Quality Commission (CQC) and safeguards the rights of patients detained under the MHA who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment, determined by the patient's clinical team, is appropriate. As part of this assessment, the SOAD should assess if due consideration has been given to the views and rights of the patient.

71. Under Option 1 (BAU), certain cohorts of patients are eligible for the SOAD service. Under this option, the SOAD service is also responsible to review Section 61 reports, which are reports made by the Clinician and sent to CQC when patients are not consenting to treatment.

72. Under Option 2, the SOAD is expected to have additional workload resulting from the following policy changes:

- The cohort eligible to be in scope for a SOAD visit is widened.
- The SOAD will also be able to request Section 61 reports for consenting patients and will also be required to certify urgent Electro-Convulsive Therapy (ECTs) for patients who are not consenting (either refusing via an advance choice document (ACD) or lacking capacity to consent at the time).

73. This will result in additional demand for SOADs, with more requirements placed on individual SOADs and more SOADs being needed than are currently in place. Further information is provided in Annex C.VI. In both options, annual costs associated with SOADs cover unit costs per SOAD visit as well as other oncosts like travel and subsistence.

74. Table 13 illustrates the additional process costs and process cost savings over the twenty-year period from 2024/25 to 2043/44, showing an overall net cost of £77 million.

Table 13. Process costs and additional headcount for Second Opinion Appointed Doctors (SOADs), England only (£millions, 2024/25 prices, undiscounted) - Central Estimate

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
Additional process costs	0	0	0	0	0	0	5	5	5	5
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total process costs	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**5**	**5**	**5**
Total additional headcount (in year)**	0	0	0	0	0	-1	274	385	396	404

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
Additional process costs	5	6	6	6	6	6	6	6	6	6	**77**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**0**

Total process costs	**5**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**77**
Total additional headcount (in year)**	410	414	419	421	422	423	425	426	428	429	

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

** The additional headcount was modelled by using number of visits and so FTE was not appropriate

Note: Totals may not equal the sum of the annual figures due to rounding. Costs in the table above exclude training costs.

Costs by professional group – Clinical teams

75. Clinical teams in inpatient and community settings are formed of multiple disciplines, including psychiatrists, nurses, occupational therapists, social workers, psychologists, support workers and healthcare assistants.

76. Under Option 1 (BAU), members of multi-disciplinary teams may be involved in the following activities:

- Set up of Care and Treatment Plans (CTPs)
- Attending and follow up of Mental Health Tribunals (MHTs), including providing certification.
- Assessment and renewals of Community Treatment Orders (CTOs)
- Contact with SOAD visits.
- Section 3 detention renewals

77. Under Option 2, clinical teams will have additional workload resulting from:
    - increased number and reviews of CTPs
    - increased number and frequency of MHTs
    - increased frequency of Section 3 renewals
    - increased SOAD visits

78. In addition, given a new duty placed on ICBs to provide make people aware of ACDs and provide support to people to develop ACDs, these professionals (particularly those working in the community) will likely play a new role in supporting patients to prepare their Advanced Choice Documents (ACDs). More details can be founded in Annex C.III.

79. However, there will be process cost savings resulting from fewer CTOs under Option 2 on this professional group.

80. For both options, we calculated the additional costs to the healthcare system by multiplying the number of extra staff required for each profession by estimated staff costs. ACD annual costs were assessed separately for each healthcare profession for Option 2 with assumptions about additional workload discussed and agreed with NHS England.

81. NHS staff costs have been estimated using data from the PSSRU where total annual costs are provided per staff group. Annual costs include Salary costs, oncosts and overheads and account for annual/sick leave.

82. Over the twenty-year period from 2024/25 to 2043/44, additional process costs were estimated at £761 million and process cost savings of £28 million, showing an overall process cost of £734 million as shown in Table 14.

Table 14. Process costs and additional FTE for clinical teams, England only (£millions, 2024/25 prices, undiscounted) - Central Estimate

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
Additional process costs	0	0	0	1	1	19	34	46	51	51
Process cost savings	0	0	0	0	0	1	1	1	1	1

Total process costs	**0**	**0**	**0**	**0**	**0**	**17**	**34**	**45**	**50**	**50**
Total additional FTE (in year)	0	0	-1	6	6	175	263	308	327	320

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
Additional process costs	54	51	54	54	55	56	57	58	59	60	**761**
Process cost savings	2	2	2	2	2	2	2	2	2	2	**28**
Total process costs	**52**	**49**	**52**	**52**	**53**	**54**	**55**	**56**	**57**	**58**	**734**
Total additional FTE (in year)	333	313	323	321	321	322	323	324	325	326	

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Costs by professional group – Administrative staff in healthcare providers

83. Policies that are expected to bring additional costs for administrative staff under Option 2 are:
    - The development of ACDs
    - Increased number of tribunals
    - Extra workload from the reform of Nearest Relative to Nominated Person as a patient may be able to update this multiple times per detention.
    - Additional responsibilities for the Mental Health Act Managers
84. To estimate these additional tasks for administrative staff costs, we used assumptions on extra time required for the additional tasks and multiplied the number of these by the average staff costs associated with each[26]. More information can be found in Annex C under each policy description.
85. The estimated additional process costs are estimated at £43 million over the twenty-year appraisal period from 2024/25 to 2043/44, as shown in Table 15.

Table 15. Process costs and additional FTE for administrative staff in healthcare providers, England only (£millions, 2024/25 prices, undiscounted) - Central Estimate

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
Additional process costs	0	0	0	1	1	2	2	3	3	3
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total process costs	**0**	**0**	**0**	**1**	**1**	**2**	**2**	**3**	**3**	**3**
Total additional FTE (in year)	0	0	0	17	17	26	28	43	43	42

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
Additional process costs	3	3	3	3	3	3	3	3	3	3	**43**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**0**
Total process costs	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**43**
Total additional FTE (in year)	43	42	43	43	43	43	43	43	43	44	

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

[26] It is quite uncertain how the NP changes will be in practice and how much more additional administrative they would require. Due to this uncertainty, agreement on illustrative scenarios was more difficult and they would need to be refined.

Familiarisation training & associated backfill costs

86. It is expected that there will be transitional costs to services associated with reforming the MHA, as several organisations, such as local authorities, commissioners, and providers will have to update policies, procedures, and documentation. It is likely that extra training would be needed to prepare those organisations whose roles will directly change because of the reforms. Since it is not clear at this stage to what extent some of Government's proposals already represent best practice in some organisations, and what will be taken forward as part of routine updates to clinical practice, it is not possible to obtain a clear estimate of costs.

87. To help facilitate the planned changes, we have considered that existing staff may need familiarisation training to bring them up to a working knowledge of the reforms. We have modelled familiarisation costs based on data available to us on the size of the existing MHA workforce and additional training that may be required for the reforms. In this IA, we have monetised familiarisation costs for existing staff for the following workforce groups: NHS staff (Approved Clinicians[27], Section 12 doctors, MHA managers), Local Authority Staff (AMHPs and IMHAs), and SOADs. We expect that these are the groups that will require the most significant amount of training because of the reforms. See Annex C.X where further detail on familiarisation and backfill cost assumptions has been provided.

88. Familiarisation training is likely to occur in a staggered way in line with the implementation plan as reforms are 'switched on'. However, given the uncertainty around actual commencement dates and difficulty in estimating the size of the affected workforce in each stage of the familiarisation programme, we have modelled this familiarisation training as occurring for half of the total existing workforce in 2026/27 and half in 2027/28, as a simplification. We would expect that ongoing training beyond this initial familiarisation would become part of their normal refresher training and absorbed into baselines.

89. Familiarisation costs for other existing staff groups could not be monetised due to a lack of available data on the number of existing staff working on the MHA; we expect many mental health staff will need to understand what these reforms mean for patients and their work, though these groups are expected to require less intensive training. We have additionally included a cost of £350k (2024/25 prices) to establish an online MHA training hub which will capture some of the cost of delivering familiarisation training to other existing NHS staff, which has been estimated using stakeholder advice. This cost is expected to occur in 2026/27.

90. A full scoping is required before training can be properly costed. However this is currently estimated at £18 million over the appraisal period, as shown in Table 16.

Table 16. Familiarisation & backfill costs by staff group, England (£million, 2024/25 prices, undiscounted) - Central Estimate

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
AMHPs	0.0	0.0	1.5	1.5	0.0	0.0	0.0	0.0	0.0	0.0
IMHAs	0.0	0.0	0.3	0.3	0.0	0.0	0.0	0.0	0.0	0.0
Approved Clinicians	0.0	0.0	4.8	4.8	0.0	0.0	0.0	0.0	0.0	0.0
S12 doctors	0.0	0.0	1.9	1.9	0.0	0.0	0.0	0.0	0.0	0.0
MHA managers	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0
SOADs	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0
NHS online learning hub	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	**0.0**	**0.0**	**9.2**	**8.8**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

[27] The British Psychological Society. Approved Clinician frequently asked questions. (2017). Accessed at: Mental Health Act Advisory Group | BPS

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
AMHPs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0
IMHAs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6
Approved Clinicians	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	9.6
S12 doctors	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.7
MHA managers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4
SOADs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
NHS online learning hub	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**18.0**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Training costs of expanding the workforce

91. There will be a range of training requirements for clinical staff that will need consideration, including operational training on implementing the changes to the MHA and training aimed at embedding the cultural change the Government wants to achieve as part of the reform agenda – for example, ensuring that the patient has a greater say and control over their care and treatment. It is still not defined how this training will be designed, so these costs have not been monetised yet.

92. DHSC is working with system partners to understand the workforce requirements of the Mental Health Act Reforms, which will provide the foundation for planning the phased approach to implementation of the reforms. Monetised staff costs in this IA are based on providing greater capacity due to additional workload requirements which will likely be satisfied by existing and newly recruited staff. As ongoing staff training costs are not directly impacted by the reforms and would be incurred under Option 1, they have not been monetised in the IA.

93. In this IA, the training costs for staff groups have been modelled where we have quantified estimates of additional resource requirements, were the workforce to be expanded to accommodate the additional demands modelled for each staff group.

- **NHS Workforce (Clinicians, Nurses, Other Clinical Staff, Key Workers, Community Supervising Clinicians):** To estimate the costs of training new NHS staff due to additional workforce being required, we have used evidence from the Personal Social Services Research Unit (PSSRU) at the University of Kent[28] to inform staff unit qualification costs. These represent the total training cost for a member of staff apportioned across their whole health service career. The number of additional FTEs estimated to be required to deal with additional MHA process costs annually is converted to headcount equivalents using data on average workforce contract hours and multiplied by these unit costs. Reflecting that many staff will spend the majority of their time on other tasks beyond those assessed in this IA and may work well beyond the time horizon assessed here (generating patient benefits not captured), this approach ensures that only the marginal impact on training costs of the additional workforce demands of the reforms are included, for a fair comparison with benefits, but means that the estimates are smaller and not as front-loaded as might be necessary to deliver the necessary capacity in the shorter term. They do not correspond precisely with the financial costs of a workforce recruitment plan that considered these reforms along with other staffing requirements.

- Training costs incurred have been estimated using proxies where appropriate, i.e. using Nurses training costs as a proxy for key workers whilst 'Other Clinical Staff' could include psychologists,

[28] Personal Social Services Research Unit: p106, The unit costs of health and social care_Final3.pdf (kent.ac.uk)

occupational health therapist or healthcare assistants and have been costed using Band 5 nurses as a proxy, so may overstate those for some named workforces whilst omitting others that will in practice work for the similar organisations and play relevant roles. For the purposes of this IA, we only include training costs that occur over the appraisal period and are adjusted for inflation over time. PSSRU estimates of training costs include tuition costs, living expenses and clinical placements. For doctors, placement fees and salaries are also included.

- **AMHPs and IMHAs**: the year-on-year difference in additional staff required across the period has been used to estimate training costs in a simpler way, given training courses for AMHPs/IMHAs are relatively short compared to clinicians who will incur larger training costs over a longer period of time. Note, the modelling does not factor in the training pipelines and the supply routes that will need to be used to increase the supply of staff to support the expansion of the MHA workforce.

94. Ongoing training costs for existing staff have not been modelled on top of familiarisation costs, as it is expected that the reforms will form part of refresher training as BAU. See Annex C.X where further detail on training costs has been provided.

95. The estimates do not include the potential impact of offsetting savings arising from reduced hospitalisation of patients, which were modelled using sector-level unit costs rather than a bottom-up assessment for specific staff groups. Therefore, they may overstate additional demands and are not a definitive forecast of the exact workforce numbers that are required or when it would be optimal to bring additional staff in.

96. Training costs are estimated at £133 million over the appraisal period, as shown in Table 17.

Table 17. Additional training costs by staff group, England only (£million, 2024/25 prices, undiscounted) - Central Estimate

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
AMHPs	0	0	0	0	0	0	0	0	0	0
IMHAs	0	0	0	1	0	0	0	0	0	0
Social Workers	0	0	0	0	0	0	0	0	0	0
Approved Clinicians	0	0	0	0	0	1	5	8	8	7
Nurses	0	0	0	0	0	0	0	1	1	1
Key Worker/ Care coordinators	0	0	0	0	0	2	1	1	1	1
Other Clinical Staff	0	0	0	0	0	0	0	0	0	0
Community Supervising Clinician	0	0	0	0	0	0	0	0	1	1
SOADs	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**1**	**0**	**3**	**7**	**10**	**11**	**10**

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
AMHPs	0	0	0	0	0	0	0	0	0	0	0
IMHAs	0	0	0	0	0	0	0	0	0	0	1
Social Workers	0	0	0	0	0	0	0	0	0	0	5
Approved Clinicians	7	7	7	7	6	6	6	6	6	6	92
Nurses	1	1	1	1	1	1	1	1	1	0	8
Key Workers / Care coordinators	1	1	1	1	1	1	1	1	1	1	18
Other Clinical Staff	0	0	0	0	0	0	0	0	0	0	2
Community Supervising Clinician	1	1	1	1	1	1	1	1	0	0	7
SOADs	0	0	0	0	0	0	0	0	0	0	0
Total	**10**	**9**	**10**	**9**	**9**	**9**	**9**	**9**	**8**	**8**	**133**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Opportunity costs

97. The measurement and valuation of direct health benefits/costs from a policy intervention is typically performed by estimating the number of Quality adjusted life years (QALYs) generated. QALYs account for impacts on length of life (longevity) and health-related quality of life (QoL). It assumes that a year of life lived in perfect health is worth 1 QALY (1 year of life x 1 utility = 1 QALY) and that a year of life lived in a state of less than perfect health is worth less than 1. For example, half a year lived in perfect health is equivalent to 0.5 QALYs (0.5 years x 1 utility), the same as 1 year of life lived in a situation with a utility 0.5 (e.g. bedridden) (1 year x 0.5 utility).

98. We estimate the opportunity costs that would arise if health and social care spending was funding from existing budgets, in terms of the QALY gains forfeited.

NHS resources opportunity cost

99. In DHSC, it is considered that an additional QALY (valued by society at £70,000) can be purchased for £15,000. Where proposed health spending redirects resources from alternative use in the NHS, the opportunity cost of spending is around 4.7 times the financial cost (£70,000 divided by £15,000 ≈ 4.7).

100. If funding for these policies were met from within existing NHS resources rather than provided for separately, this would create an opportunity cost of around £4.7 for every £1 of diverted resources. To estimate the impact were this to be the case, in the table below we have uplifted estimated total net costs for NHS to account for the lost social value. These healthcare opportunity costs were not applied in cost estimates presented above and are not included in the NPV reported on the summary sheets of this IA.

101. The total cost to the NHS is estimated to be £1.9m (excluding housing costs relating to reforms on people with a learning disability and autistic people). This equates to a potential opportunity cost of £8.9m as shown in Table 18.

Table 18. Summary of total NHS costs with and without opportunity costs – England only (£millions, 2024/25 prices, undiscounted)

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
NHS (without opportunity costs)	0	4	215	109	38	61	83	99	106	105
NHS (with opportunity costs)	0	18	1003	511	176	284	387	464	493	490

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
NHS (without opportunity costs)	108	105	107	108	109	110	110	111	113	114	**1,913**
NHS (with opportunity costs)	503	488	500	502	507	511	516	520	525	530	**8,928**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Social care resources opportunity cost

102. Forder et al. (2018)[29] analysed the impact of social care services on the quality of life of service users. The estimates they produced indicate that the marginal cost of generating one additional QALY in social care was approximately £20,000. This implies an opportunity cost of £3.5 for every £1 of diverted resources. To estimate the impact were this to be the case, we have uplifted

[29] Forder (2018) 'The impact and cost of adult social care: marginal effects of changes in funding' QORU Discussion Paper, https://www.pssru.ac.uk/pub/5425.pdf

the total Local Authority and Housing care costs by a factor of 3.5 to account for the lost social value.

103. The total net Housing and Care cost is £2.9m (including reforms for people with a learning disability and autistic people). This equates to a potential opportunity cost of £10.2m as shown in Table 19. These opportunity costs were similarly not included in the NPV reported on the summary sheets of this IA.

Table 19. Summary of total housing and care costs with and without opportunity costs – England only (£millions, 2024/25 prices, undiscounted)

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Housing and care costs (without opportunity costs)	0	0	204	215	147	150	150	155	155	155
Housing and care costs (with opportunity costs)	0	0	713	753	513	525	524	542	543	544

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Housing and care costs (without opportunity costs)	156	156	157	158	159	160	161	162	163	164	**2,926**
Housing and care costs (with opportunity costs)	545	546	550	553	557	560	563	567	570	574	**10,242**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding

Monetised Costs – Justice System

104. The Government aims to enhance the rights and freedoms of people using mental health services. As a result, there will be an increased role for the Mental Health Tribunal (MHT), which handles legal matters related to mental health care. The costs associated with this expansion of the MHT's role will impact the justice system.

105. These costs have been divided into two main areas: the MHT itself and legal aid expenses. More details on how these estimates were made can be found in Annex E.

106. Since this kind of analysis involves many uncertainties, a sensitivity analysis was done to test various assumptions. Below is the central estimate, with additional details in the sensitivity analysis section.

Table 20. Costs for the Mental Health Tribunal, including legal aid, England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Additional costs	0	0	0	0	0	0	28	22	24	24
Process cost savings	0	0	0	0	0	0	4	4	4	5
Total costs	**0**	**0**	**0**	**0**	**0**	**0**	**24**	**18**	**20**	**19**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Additional costs	28	24	26	26	26	26	26	27	27	27	361
Process cost savings	5	6	6	6	6	6	6	6	6	6	74
Total costs	**23**	**18**	**21**	**20**	**20**	**20**	**21**	**21**	**21**	**21**	**287**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

107. Note that the above table presents costs for England only. Applying a scaling approach based on the number of tribunal hearings in England and Wales (see Annex G for details), we estimate the total costs for England and Wales to be £313m, compared with £287m for England only.

108. The main additional costs for the justice system, including legal aid, relate to the following proposals:

- **Automatic referrals to the MHT:** Patients detained or receiving treatment under the MHA who haven't applied to the MHT will be automatically referred at specific intervals.
- **Treatment choices:** This proposal involves considering a patient's statutory Care and Treatment Plan (CTP) during an MHT hearing.
- **Expanded powers of the MHT**: The MHT would gain new powers to discharge patients and review Community Treatment Orders (CTOs).
- **Detention criteria:** Before a Tribunal hearing for a section 3 detention, the Responsible Clinician and Approved Mental Health Professional (AMHP) must confirm 10 days in advance that the patient still meets the criteria for detention.

109. The estimated monetised costs of the policy interventions under Option 2 in England have been disaggregated into costs relating to these 4 areas as shown in Table 21.

Table 21. Total costs for the Mental Health Tribunal, including legal aid, by proposal type, England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Automatic Referrals	0	0	0	0	0	0	20	14	16	14
Treatment choice	0	0	0	0	0	0	4	3	4	4
Expanded Powers	0	0	0	0	0	0	1	1	1	1
Detention criteria	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**24**	**18**	**20**	**19**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Automatic Referrals	18	14	16	15	15	15	15	15	16	16	**219**
Treatment choice	4	4	4	4	4	4	4	4	4	4	**56**
Expanded Powers	1	1	1	1	1	1	1	1	1	1	**14**
Detention criteria	0	0	0	0	0	0	0	0	0	0	**-1**
Total	**23**	**18**	**21**	**20**	**20**	**20**	**21**	**21**	**21**	**21**	**287**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes
Note: Totals may not equal the sum of the annual figures due to rounding.

Automatic referrals

110. Under Option 1, patients must wait longer for reviews of their detention due to the current automatic referral system. Some patients, such as those conditionally discharged in the community, may not be automatically referred even if they could qualify for an absolute discharge, leaving them under unnecessary restrictions.

111. Under Option 2, patients detained or receiving treatment under the Mental Health Act (MHA) who haven't applied to the Mental Health Tribunal (MHT) will be automatically referred at specific

intervals. The automatic referral proposals impact different patient groups (e.g., some proposals only affect Part III patients).

112. The Government plans to implement the following under Option 2:
    - For patients detained under Section 3: Automatic referral to the MHT at 3 months, 12 months, and then annually after detention begins. This works alongside a proposal to shorten the initial detention periods for Part II patients (three periods: two of 3 months, then one of 6 months).
    - For Part III patients: Automatic referral to the MHT every 12 months.
    - For conditionally discharged patients: Automatic referral after 24 months, and then every 4 years if they haven't applied directly.

113. Additionally, under Option 2:
    - For patients on a Community Treatment Order (CTO): Automatic referrals after two consecutive 6-month periods, followed by a 12-month period. Even though this could lead to more referrals, the overall number of CTOs is expected to decrease, reducing the total number of MHT referrals.

114. To estimate the cost impact, an assumption of 20% decrease in annual CTOs is expected by 2035/36, with a gradual decline over 5 years (see Annex E for details).

115. Key cost drivers of the proposed reforms include (all costs are presented in 24/25 prices and undiscounted):

    - Automatic referrals are expected to add £219 million in net costs to the justice system over 14 years.
    - The cost of automatic referrals at 3 months, 12 months, and annually for Section 3 patients is estimated at £29 million, assuming a 100% increase in yearly referrals.
    - Reducing the maximum detention period under Section 3 is expected to add £81 million due to a 37% rise in MHT applications.
    - Automatic referrals for Part III patients have the highest additional cost at £140 million, based on a projected 390% increase in receipts.
    - Proposals relating to CTOs could save an estimated £72 million over 14 years.
    - Automatic referrals for conditionally discharged patients are expected to add £41 million in costs over the same period.

Table 22. Costs, including legal aid, from implementing the automatic referrals, England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
Additional costs	0	0	0	0	0	0	23	18	20	19
Process cost savings	0	0	0	0	0	0	4	4	4	5
Total costs	**0**	**0**	**0**	**0**	**0**	**0**	**20**	**14**	**16**	**15**

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
Additional costs	23	19	22	21	21	21	21	21	21	22	**292**
Process cost savings	5	5	5	6	6	6	6	6	6	6	**73**
Total costs	**18**	**14**	**16**	**15**	**15**	**15**	**15**	**16**	**16**	**16**	**219**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes
Note: Totals may not equal the sum of the annual figures due to rounding.

Detention Criteria

116. Under Option 1, no changes are proposed, and the system continues as it currently operates.

117. Under Option 2, the Government proposes that patients detained under Section 3 of the Mental Health Act should be certified as still meeting the criteria for detention 10 days before their hearing at the Mental Health Tribunal (MHT). This change is aimed at reducing the number of MHT hearings cancelled within 48 hours.

118. Before considering how this change affects cancellation fees (fees incurred for assembling a panel that doesn't end up holding a hearing), it's important to note that:

119. The cost of this policy change is estimated by:

- First, predicting the number of Section 3-related cancellations in the future, based on current cancellation rates and future detention trends
- Assuming that 50% of these cancellations can be avoided with the proposed change.
- Then, multiplying the number of avoided cancellations by the sitting fees of tribunal staff to estimate the savings. More details can be found in Annex E.

Table 23. Costs of new detention criteria on the Mental Health Tribunal, England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Additional costs	0	0	0	0	0	0	0	0	0	0
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Additional costs	0	0	0	0	0	0	0	0	0	0	**0**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**1**
Total costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**-1**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Treatment Choice

120. Under Option 1, the MHT does not consider the patient's Care and Treatment Plan (CTP), where concerns have been expressed.

121. Under Option 2, the Government proposes to have the MHT consider as part of the papers to the Tribunal the patient's CTP, where concerns have been expressed. CTPs would become statutory for most patients detained under the MHA, including Section 2 patients.[30] For these patients we do not expect that this would affect the length of MHT hearings, as existing patient plans already include reports to MHTs. Costs have therefore not been estimated for this subset of hearings.

122. The cost of this policy is calculated by assuming reviewing the CTP takes 40 minutes as a central scenario. This is used to calculate the new length of hearings and therefore the reduced number of hearings which can be undertaken in one sitting day. The number of hearings which are applications for discharge (excluding section 2) are then summed up and used to calculate the number of new sitting days required which can be converted to a cost. Further details of this can be found in annex E.

[30] This excludes patients detained under "short-term" sections detention in a place of safety under emergency powers in sections 135 or 136 of the MHA, or where there is a direction for Part III patients under section 35 subsection (4), 36 subsection (3), 37 subsection (4), 38 subsection (4) or 45A subsection (5), as these patients are not detained long enough to obtain a benefit from a plan.

123. The estimated additional costs associated with the proposed legal changes are presented in the table below. The estimated additional cost of the proposed changes, to have the MHT consider a patient's CTP, over the period is £56 million as shown in Table 24.

Table 24. Costs of increased treatment choice on the Mental Health Tribunal England only (£millions, 2024/25 prices, undiscounted) - Central Scenario

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Additional costs	0	0	0	0	0	0	4	3	4	4
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total costs	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**3**	**4**	**4**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Additional costs	4	4	4	4	4	4	4	4	4	4	**56**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**0**
Total costs	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**56**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Expanded Powers

124. Under Option 1 (BAU), the current scope of tribunal powers mean that certain patients face difficulties in being conditionally discharged into the community when they are well enough to leave hospital, as the tribunal lacks a power to discharge patients with conditions that restrict their freedom in the community. This means they will continue to occupy bed space and obstruct transferring other people in from prison.

125. Under Option 2, the Government proposes to expand the powers of the MHT through three reforms for which costs have been estimated. This will give the MHT the power, during an application for discharge, to grant leave from hospital and transfer to a different hospital (currently it has the power to make recommendations) and extend the MHT's power to direct the provision of aftercare services.

126. The total estimated additional cost including legal aid of these policies over the period is £14m as shown in Table 25.

Table 25. Costs of expanded powers on the Mental Health Tribunal, including Legal Aid – England only (£millions, 2024/25 prices, undiscounted) – Central Scenario

	*2024/25**	*2025/26**	*2026/27**	2027/28*	2028/29*	2029/30*	2030/31*	2031/32*	2032/33*	2033/34*
Additional costs	0	0	0	0	0	0	1	1	1	1
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total costs	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**1**

	2034/35*	2035/36*	2036/37*	2037/38*	2038/39*	2039/40*	2040/41*	2041/42*	2042/43*	2043/44*	Total
Additional costs	1	1	1	1	1	1	1	1	1	1	**14**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**0**
Total costs	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**14**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Application for discharge

127. Under Option 2, during an application for discharge of non-restricted patients, the MHT should have the power to recommend that the relevant aftercare bodies make plans for the provision of aftercare services for the patient, where this is necessary to facilitate discharge at a future date. By conferring this power on to the MHT, it is considered that this will strengthen the MHT's role in reviewing a patient's detention and, where necessary, ensure earlier consideration is given to what services could be put in place for the patient.

128. The costs associated with this policy relate to the extra 2 hours of hearing time per case which would be required. Assuming that there are 10 cases which would be heard per year, this would require an additional four sitting days per year for the MHT. The additional estimated cost for these 4 days a year is around £0.2m over the appraisal period.

129. The Government additionally proposes that the MHT should have the power to review the conditions attached to the CTO when dealing with an application or reference by or on behalf of a community patient. It is also proposed that the MHT be able to recommend that the Clinician reconsider the conditions specified in a CTO in line with Section 17B(2) criteria. The Government proposes that the power to recommend should apply to all CTO conditions. This will again result in an estimate of additional judicial time of one hour per case for an additional 753 hearings, resulting in 151 extra sitting days for the MHT per year, assuming there are 5 hours per sitting day. This corresponds to an additional cost estimated at around £9.9 million over the appraisal period.

130. For a very distinct group of restricted patients the Government proposes that the MHT should have the power to discharge with conditions that restrict their freedom in the community, with a new set of safeguards. This reform would be those for whom the MHA is no longer providing therapeutic benefit by detention in hospital, but who pose such a significant risk to others they would need continuous supervision to be managed safely in the community. Costs arise from MHT reviews of these conditions.

Reviews

131. Under Option 2, a MHT should take place at 12 months after discharge, and then every two years. The patient can apply to the MHT between 6-12 months following discharge. In addition, the Secretary of State for Justice also holds a discretionary power to refer a patient to the MHT for review at any time.

132. The result is that there will be a stock of patients reviewed by the MHT after 12 months and then every 2 years, as well as small numbers of new patients each year. Data on this cohort are extremely limited, although the size is expected to be small. The modelling has used an indicative estimate of an initial stock of 220 individuals with an extra 10 per year; only half of stock patients will be reviewed in 2031/32 and half in the following year.

133. This results in extra sitting days per year for the MHT, meaning extra costs are incurred. It is estimated that these are minimal compared to the total additional costs for the Justice system. The estimated additional cost is therefore around £6 million (undiscounted), with an additional £2 million in estimated additional Legal Aid costs (undiscounted).

Legal Aid

134. Legal aid impacts have been provisionally estimated for all of the Government proposals, where possible. If a proposal results in a higher or lower MHT workload than would otherwise be the case, then legal aid expenditure will change in the same direction.

135. Most of the preparation work for an MHT hearing, for which providers can claim a preparation level fee, will be done more than 10 days in advance of the hearing date. Therefore, we do not expect the proposal which aims to reduce the burden of MHT cancelled at the last minute, to have much impact on the legal aid claim total. Regarding the proposal that would allow the MHT

to review the patients CTP, there is no expected impact on receipt volumes, so it has not been possible to estimate the potential legal aid costs associated with this recommendation. However, it is possible that it could increase the proportion of cases that escape the fixed fee scheme, which is the set fee legal aid providers can claim for the majority of their MHT work.

136. Most recommendations which alter either the volume of receipts for hearings at the MHT or the time required for hearing preparation, will likely have a legal aid cost impact. Therefore, where possible, the cost impact of legal aid has been individually calculated. For more detail, see Annex E.

137. The table below shows the total estimated cost for legal aid that can be claimed by providers as a result of potentially increased receipts in the MHT. It is important to note that the estimated costs shown are based on the indicative workload expected to start in each year of implementation. The legal aid claim total for each year is likely to differ as providers will usually submit a final bill after all work on a case has been completed, resulting in a lag between the hearing date and the legal aid claim. Over the 14-year implementation period it is estimated that the proposals could result in an additional legal aid cost of £73m as shown in Table 26.

Table 26. Costs for legal aid from increased receipts and hearings in the Mental Health Tribunal system (£millions, 2024/25 prices, undiscounted) - Central Scenario

	2024/25*	***2025/26****	***2026/27****	**2027/28***	**2028/29***	**2029/30***	**2030/31***	**2031/32***	**2032/33***	**2033/34***
Additional costs	0	0	0	0	0	0	7	5	6	5
Process cost savings	0	0	0	0	0	0	0	0	0	0
Total costs	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**5**	**6**	**5**

	2034/35*	**2035/36***	**2036/37***	**2037/38***	**2038/39***	**2039/40***	**2040/41***	**2041/42***	**2042/43***	**2043/44***	**Total**
Additional costs	6	5	5	5	5	5	5	5	5	4	**74**
Process cost savings	0	0	0	0	0	0	0	0	0	0	**0**
Total costs	**6**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**4**	**73**

*Cost profile is indicative - assumed commencement of policies is illustrative for modelling purposes

Note: Totals may not equal the sum of the annual figures due to rounding.

Non-monetised Costs

Non-monetised Costs - Health and Social Care System

Change to detention criteria

138. We have not modelled additional costs as a direct result of the changes to detention criteria for mental health patients which makes it clear that people will only be detained if they pose a risk of serious harm to themselves and/or others, and if they will benefit from the proposed treatment.

139. This is because the changes clarify the criteria and reflect existing guidance and so we do not expect to see a significant change in detention practice nationally. There may be individual cases where decision to detain or not is different due to the change in legislation, but we do not have relevant data, and assess the scale of these impacts to be limited. There may be some costs associated with ensuring the change to criteria works well and safely but these have not been monetised due to lack of data.

140. We have similarly not factored any impact of these changes to detention criteria into the modelling of reduction in detentions due to the reforms.

Improving discharge

141. Given the changes to the discharge protocol, to consult another professional, largely formalises best practice, we do not anticipate there to be substantial additional costs associated with this policy change.

142. However, there may be some increased process costs where the change improves adherence to good practice, which we think are likely to be modest overall. Costs relating to the patient's safety plan, which should be conducted as part of the patient's statutory Care and Treatment Plan (to be set out in secondary legislation), are already accounted for within the costs on Care and Treatment Plans. Again, safety management plans are already best practice for many Trusts.

Familiarisation training

143. There will be transitional costs to services associated with reforming the MHA with organisations having to update policies, procedures, and documentation. We expect there to be costs for familiarisation training for other staff groups beyond those which were modelled, including the wider local authority mental health workforce and healthcare staff in prisons.

144. CQC workforce groups will require training on the revisions to the Act and the new Code of Practice, as well as training in revised ways of working to deliver their statutory MHA duties and regulatory functions. The CQC MHA Operations team will need ongoing training throughout the whole implementation period, and training will also need to be provided to teams such as Senior Specialists and Inspectors as well as policy and strategy teams, the national contact centre team and other workforce groups who help deliver CQC's wider regulatory role. These costs have not been monetised due to a lack of data.

145. Familiarisation costs for these staff groups could not be monetised due to a lack of available data on the number of existing staff working on the MHA, however, it is expected that these groups will require less intensive training. There will also be costs associated with developing the training for the reforms, which have not been monetised due to lack of data.

Activity to drive culture change

146. Beyond costs of training for familiarisation with legislative changes, there will be costs associated with wider training/initiatives for the existing workforce to enable a change in culture and practice to accompany and support legislative changes.

147. Costs associated with cultural change activity have not been monetised as a) they go beyond the direct content of the legislation and b) we do not have data on the extent current practice already aligns with best practice.

Costs to Care Quality Commission (CQC) monitoring duties

148. CQC has a duty under section 120 of the MHA to monitor how services exercise their powers and discharge their duties under the Act, in addition to delivering statutory second opinions delivered by SOADs. These monitoring duties extend to three key areas: responding to complaints; regularly visiting places of detention to conduct interviews and review patient records; and reporting on providers' use of the Act and implementation of the Code of Practice. The CQC also monitors wider use of MHA powers outside of hospital settings, such as those relating to CTOs.

149. These duties require specialist MHA monitoring and operational teams. Under the reforms, these teams will need appropriate training and will incur implementation costs to deliver CQC's monitoring and regulatory functions.

150. In addition, under the reforms it is expected there will be costs for CQC in resourcing the increase in MHA complaints that are expected to occur from the hospital managers having a statutory duty to inform, on a more regular basis, patients of their right to complain.

151. In addition, CQC will be required to update their digital systems for data collection and reporting and support adequate oversight of services which carry out duties under the MHA. CQC will also have additional costs for their wider regulatory teams and the impacts of these reforms on their work, such as their inspection and policy teams.

152. These costs have not been monetised in this IA due to a lack of cost data for these teams and assumptions surrounding the expected increase in complaints.

153. In addition to the costs associated with monitoring duties, CQC expect there will be in increase in travel and subsistence costs as remote SOAD assessments will only be permitted for urgent ECT requests. These have not been monetised due to a lack of data to model the costs.

Learning Disability and Autism

154. The introduction of the C(E)TR and DSR reforms may lead to additional one-off costs (and potentially ongoing maintenance/monitoring costs) to support the increased use of C(E)TRs & DSRs. For example, this could be in the form of IT support to upgrade existing DSRs, and additional administrative support to assist with an anticipated increase in paperwork generated following the increased volume of C(E)TRs carried out. However, we do not include these costs in our estimates because they are highly uncertain and likely to vary significantly between ICBs.

155. In assessing the costs of the change in detention criteria for people with a learning disability and autistic people, we have assumed that some people who are discharged from inpatient settings, will need a new home to live in. However, we assume that people who avoid admission in future years (people who are no longer eligible for detention), who are already living in the community, instead only require housing adaptations to their existing home. This may be an underestimate of the actual need for new housing who are at risk of admission due to the consequences of living in unsuitable accommodation. Anecdotal evidence suggests that it is not uncommon for unsuitable housing to contribute to the crisis which would have in a baseline scenario precipitated an admission to hospital. We do not include these costs in our estimates due to uncertainties in understanding the scale of how many people are currently in unsuitable housing.

156. In addition, when costing community costs relating to housing, we have included a housing revenue line. We understand that in addition to this there may be specific "support" funding from local authorities provided. Our understanding is that provision of this varies by local authority and due to these uncertainties, this is not included in cost estimates.

157. The proposed reforms to the detention criteria for people with a learning disability and autistic people envisage more people receiving care and treatment in the community, rather than in hospital. To ensure that these individuals receive the right care and support, the Bill introduces new duties on ICBs to hold a register of those at risk of admission and for ICBs and local authorities to use this information when exercising their commissioning and market functions. Under the proposals, both ICBs and local authorities must seek to ensure that the needs of people with a learning disability and autistic people can be met without admission to hospital. In implementing these reforms, we will monitor the impact of the proposed detention criteria changes to ensure that they are having this intended effect and seek to mitigate any unintended consequences, such as increased use of the Mental Capacity Act as a means to detain a person in hospital.

Removal of police cells as a place of safety

158. The Bill will remove police stations as 'places of safety' under the MHA to ensure people experiencing mental health crisis or with severe mental health needs are not held in police cells but in a health-based place of safety.

159. Data suggests that the number of people in scope of this policy is small, and numbers are declining over time due to this already reflecting current policy. In 2022/23, 297 people were taken to a police cell as a place of safety in England[31]. We have therefore not monetised the potential health and justice system costs of this policy on the basis that costs are likely to be limited.

Removal of prisons as a place of safety

160. Similar to police cells, the Bill will remove prisons as 'places of safety'. We do not have reliable data on the number of people in prison as a place of safety. We have therefore not monetised the potential health system costs of this policy. We believe given the scale of the potential population in scope, the health and justice system costs of this change are likely to be limited.

Section 117 Aftercare

161. This policy clarifies which local authority is responsible for providing S117 aftercare, for example where ordinary residence, detention and discharge locations vary. It further requires that written notice if provided to the individual in receipt of aftercare when the decision to stop aftercare has been made.

162. As this policy is not expected to change entitlement to aftercare, we expect that there to be minimal impacts. Any impact on costs is likely to reflect a transfer between local authorities, therefore these have not been monetised.

Mental Health Act Managers

163. MHA managers are responsible for making sure the hospital and staff meet their duties under the MHA. Under the reforms MHA will have additional responsibilities including: the responsibility to provide patients and their Nominated Person with complaints information; the duty to refer all qualifying patients to advocacy (which is a wider group under the reforms); and ensure that Care and Treatment Plans meet the statutory requirements. These will likely include both one-off and ongoing costs.

164. Some costs for CTP requirements have been costed (see Annex C.VI) but for others it has not been determined how this would look in implementation and will depend on what systems a provider already has in place. Therefore, these costs have not been monetised.

Advance Choice Documents (ACDs)

165. There are expected to be costs associated with ensuring that ACDs can be stored securely and easily accessed by service users and staff (including community clinicians, AMHPs and healthcare staff working in prisons when required. This will involve setting up systems for storing ACDs in a place that is accessible in electronic records systems, as well as staff familiarisation, which together are likely to generate additional costs. There is ongoing work to digitise the mental health act, which may reduce the costs associated with this, but this impact has not been modelled as is expected to happen in the BAU scenario as well as Option 2.

166. There are expected to be costs to AMHPs associated with having to locate and use ACDs at the point of MHA assessment. Once a system is up and running to make ACDs available, we

[31] Other PACE powers, year ending March 2023 (second edition) - GOV.UK (www.gov.uk)

would expect these costs to be offset to some extent by other potential benefits of ACDs for AMHP time, such as the ability to more quickly indicate key information like who the Nominated Person is. An AMHP may also spend time with service users developing an ACD and conducting preventative work to reduce future admissions.

167. These costs have not been monetised due to uncertainty around the exact processes and lack of data to be able to estimate.

Transfers to hospital from prisons and other places of detention

168. This reform introduces a statutory time limit target of 28 days for the transfer of patients who meet the threshold for detention under the Mental Health Act from prisons, Immigration Removal Centres (IRCs) and other places of detention to mental health hospitals for treatment. It aims to further embed the good practice set out in NHS England's guidance on transfers and remissions published in June 2021[32] and increase accountability for the agencies involved in the transfer process to meet the deadline.

169. Costs for the measure have not been monetised because they are principally driven by wider systematic changes which are supported by the legislation, such as improved partnership working, as well as ensuring resources are available to achieve transfers within the time limit in a greater proportion of cases.

Supervised Discharge

170. The Bill includes a new power to allow for patients detained through the courts, who are subject to special controls by the Secretary of State for Justice to protect the public from serious harm, to be discharged into the community with conditions which amount to a deprivation of liberty. There will be no immediate 'new' patient intake related to supervised discharge as the patients that will be subject to these conditions are already being managed as restricted patients using long term escorted s17 leave.

171. Published statistics on the total number of restricted patients do not show a significant change in trend[33] meaning that the same numbers of patients will be subject to special controls by the Justice Secretary. Therefore, we do not expect to see a significant impact of the introduction of supervised discharge, so these costs have not been monetised.

Removal of remand for 'own protection' solely on mental health grounds

172. The Bill amends the Bail Act to prevent the remand of a defendant on own protection or welfare grounds where the sole concern is their mental health. Instead, courts will be directed to bail the defendant and work with local health services to put in place appropriate support and care to address risks to their safety.

173. We expect the number of people on remand solely for mental health reasons to be low and therefore health and justice costs relating to this change are likely to be negligible, and therefore have not been monetised.

Crown dependencies

174. The Bill includes reforms to improve the process of transferring people to and from hospital between the Crown Dependencies and England to ensure mentally unwell prisoners can access treatment in the most appropriate setting.

[32] NHS (June 2021), The transfer and remission of adult prisoners under the Mental Health Act 1983. Report template - NHSI website (england.nhs.uk)

[33] Restricted Patients Statistics, England and Wales - GOV.UK (www.gov.uk)

175. Data suggest the number of people detained under Part III in the Crown Dependencies is small, therefore we have not monetised the costs on the basis that these are expected to be limited.

Non-monetised Costs - Justice System

Recruitment campaign costs

176. The expected increase in hearings in the MHT will required additional judges and other judicial employees. It will therefore be necessary to conduct recruitment campaigns to ensure sufficient judicial resources are available in the Tribunal to meet the increased demand. The costs of these recruitment campaigns have not been modelled for this IA as it is unclear how much additional recruitment activity will be required over and above that which normally occurs.

Familiarisation costs

177. We expect that there may be costs for justice staff to familiarise themselves with the MHA reforms. These costs are expected to occur in the first years after Bill introduction but have not been modelled due to lack of data. We expect that the reforms should form part of the normal refresher training justice staff must undertake in Business as Usual.

Expanded MHT Powers

178. Several Government proposals would expand the powers of the MHT, to empower it to make decisions beyond determining an appeal for discharge. These proposals are discussed in the following three areas.

Displacement and overruling a Nearest Relative (Nominated Person)

179. The Government has considered whether the County Court's power to displace a NR should be replaced by an MHT power to overrule or displace a NP on the grounds that the MHT is better placed to make this decision. Considering the wider reforms and impacts on the MHT, we propose that the power to fully displace a NP should remain in the County Court. In addition, we propose that the Responsible Clinician (RC) should have the power to temporarily 'block' the NP (through a barring order) if the NP appeals Section 3 admission, or objects to a CTO or ordering a patients discharge, but the patient is considered dangerous to themselves or others. This is in-keeping with the existing approach set out in Section 25 of the Act, which enables the RC to bar the use of the NR's power to discharge the patient.

180. The MHT will only be involved if the NP is barred, and they later decide to use their right to apply to the tribunal (as is the case where the NR receives a barring order). In this way, the NP will still be able to retain their position and inform the patient's care and treatment, except for in the most extreme or serious circumstances e.g. where they pose a safeguarding risk to the patient, in which case the application can be made to the County Court to displace the NP. The cost would come from a potential small increase in applications to the MHT by the NP, we do not expect this number to be significant. We require further data to form appropriate assumptions and costs.

Additional training for panel members

181. The Government agreed in principle in its White Paper that training should be developed for MHT panel members in specialisms including children and young people, forensic psychiatry, learning disability, autism, and older people.

182. The Government agrees that the individual needs of the patient should be recognised. However, the judiciary, through the Judicial College, are responsible for setting and developing the training for MHT panel members. There could be a potential cost associated with this training, however, this is expected to be negligible so have not been monetised.

Length of detention

183. The Government proposed that where a person has been subject to detention under Section 3 within the last twelve months, an application for detention under Section 2 should only be made where there has been a material change in the person's circumstances. In addition, the Government proposed that the Code of Practice should make it clear that Section 3, rather than a Section 2, should be used when a person has been already subject to Section 2 within the last twelve months. Finally, the Government has proposed that the detention stages and timelines should be reformed so that they are less restrictive through extending the right of appeal for Section 2 beyond the first 14 days. These proposals have not been modelled in this iteration of the IA as there is currently insufficient data to inform estimates of the impact on the tribunal.

Impacts on the Court of Protection

184. It is possible that the proposed reforms to the detention criteria, , the new treatment safeguards and Nominated Person proposed in the Bill could result in new burdens on the Court of Protection, which is responsible for deciding whether a person has the mental capacity to make a particular decision for themselves under the Mental Capacity Act (MCA), and for adjudicating on whether a particular decision made on their behalf is in their best interests.

185. Appointment of a Nominated Person is contingent on the person's capacity to make the appointment at the time, and many of the new treatment safeguards are contingent on an advance decision to refuse treatment or decisions by a done appointed under a lasting power of attorney or a deputy appointed by the Court of Protection. While there is limited evidence upon which to base an assessment of the size of the impact it is expected that many of these changes pose a minimal risk of increased demand on the Court of Protection. These impacts have therefore not been monetised but are discussed further in the Risks section.

186. The proposed changes to the detention criteria will mean that civil patients with a learning disability and autistic patients can only be detained for treatment under section 3 if they have a co-occurring mental disorder that warrants hospital treatment. Some stakeholders have raised concern that alternative legislative routes could be used to detain people in hospital when section 3 is no longer an option. This includes use of the Mental Capacity Act, which would have impacts on the Court of Protection. We have not monetised these potential impacts due to lack of data.

Benefits

187. In terms of the benefits of the proposals, and using the work done by the Independent Review, we would expect that *"patients and service users should experience improved choice, less coercion and restriction of their liberties, care that is more consistently respectful, and meets their individual needs"* (p. 228). That is, patients should feel supported to share their wishes and preferences, that they have more control over their care and treatment, and that compulsory medical treatment is only used as a last resort when there is no alternative. These outcomes are difficult to monetise, but evidence indicates that they are highly valued by patients, improving health outcomes and quality of life, and that they are associated with the delivery of more appropriate and cost-effective services, including reducing length of inpatient stay.

188. Since improved patient experience due to increased participation in decisions regarding care and being treated with dignity and respect is not easily monetised, they should also be understood in qualitative terms. These have been investigated by the Independent Review and we use their words to summarise this point:

> *"We believe that improving patients' and service users' ability to make decisions about their own care and treatment is essential to upholding dignity. This theme runs throughout the report from start to finish. It underlies our recommendations, for*

example, on the importance of advance choices, and how these can become more common and more powerful. It is part of our recommendations on the right to advocacy, for those who find it difficult to make their wishes and preferences known and how these are particularly relevant for those at greater risk of discrimination, such as those from a minority ethnicity background. (…)
These recommendations are essential if we are to achieve a real shift in the balance of power between the patient and the professional, and make it easier for patients and service users to participate in decisions about their care. (…). Much of this merely reflects current best practice but, sadly, we are in little doubt that this is far from standard, and that without our recommendations bad practice will continue." (pp 18-19)

189. It is also likely that the impact of the reforms will be affected by other changes in service provision which could, for example, provide more opportunities for the sort of therapeutic care which patients may have preferences for, or enhance community mental health provision as an alternative to hospital admission.

190. In our approach to estimating benefits, we distinguish between:

- Monetised benefits to the Health & Social Care system, arising from a reduction in the number of inappropriate detentions and overall admissions due to the impacts of the reforms;
- Non-monetised benefits to the Health & Social Care and Justice systems;
- Non-monetised benefits to patients, including improved health outcomes and a better and more dignified experience of treatment under the MHA, for patients and carers – the primary aim of the proposals.

Monetised benefits

Benefits to the Health and Social Care system

191. Whilst some measures are expected to result in process cost savings which will partially offset the additional costs estimated, the monetised benefits presented in this IA reflect the impacts of avoiding inappropriate or unnecessary admissions and detentions in hospital. Here, a prudent approach has been taken: the only policy measures assumed to directly reduce admissions or detentions are changes to the ability to detain people with learning disabilities or autistic people without co-occurring mental health conditions, and the uptake of ACDs, reflecting the strongest logic or research evidence for a likely effect.

192. We have not modelled impacts on detentions due to the changes to the detention criteria beyond those particularly relevant to people with a learning disability and autistic people. The new provisions set out two new tests that must be met to fulfil the criteria for detention: firstly that "serious harm may be caused to the health or safety of the patient or of another person" and secondly that the decision maker must consider "the nature, degree and likelihood of the harm". Further guidance on this, including defining serious harm, will be provided in the Code of Practice. The current Code of Practice already guides clinicians to consider the 'nature' 'likelihood' and 'severity' of harm as well as the benefits of treatment to the patient. The new criteria will formalise these considerations, putting them into a clear and consistent legal footing to enable clinicians to determine when detention is appropriate. We do not expect to see an increase or decrease in detentions as a result of the revised criteria in these respects.

193. There are currently significant constraints on bed occupancy and health care resources, with a significant treatment gap for mental health patients, bed occupancy at over 90%, significant waits

in Emergency Departments and the community for beds, and out of area placements still used. This means that any reduction in admissions or lengths of stay for patients affected directly by these reforms would likely lead to releasing clinicians' time and hospital capacity to care for others who are waiting for a bed. This would represent an indirect health benefit from treating other people, and how these benefits will be realised will vary by area.

194. The monetised benefits are presented in Table 27 below for England and Wales, and England only. These are based on estimates of the reduction in admissions or patient numbers caused by the policies, combined with estimates of the total hospital costs per bed day for mental health patients – see Annexes CIII and D for more detail on methodology. These benefits should not all be understood as cashable savings but will in practice lead to health benefits. These values will require further investigation.

195. Many of the changes in the Bill are principally intended to improve patient experience and therapeutic outcomes, which should have health and wellbeing benefits. It has not been possible to quantify or monetise these effects, and they are described in the 'Non-monetised benefits' section.

Table 27. Summary of benefits, England and Wales (£millions, 2024/25 prices, undiscounted) – Central Estimate

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Benefits from fewer admissions due to ACDs	0	0	0	0	0	12	19	22	24	25
Benefits from fewer detentions due to reforms for people with a learning disability and autistic people	0	0	269	271	273	274	276	277	279	280
Total benefits	**0**	**0**	**269**	**271**	**273**	**286**	**294**	**299**	**303**	**306**

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Benefits from fewer admissions due to ACDs	27	28	29	29	30	30	31	31	32	33	**400**
Benefits from fewer detentions due to reforms for people with a learning disability and autistic people	282	283	284	286	287	288	290	291	292	293	**5,075**
Total benefits	**308**	**311**	**313**	**315**	**317**	**319**	**320**	**322**	**324**	**326**	**5,475**

Table 28. Summary of benefits, England only (£millions, 2024/25 prices, undiscounted) – Central Estimate

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Benefits from fewer admissions due to ACDs	0	0	0	0	0	11	18	21	23	24
Benefits from fewer detentions due to reforms for people with a learning disability and autistic people	0	0	242	243	245	246	248	249	251	252
Total benefits	**0**	**0**	**242**	**243**	**245**	**258**	**266**	**270**	**273**	**276**

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total

Benefits from fewer admissions due to ACDs	26	27	28	28	29	29	30	30	31	31	384
Benefits from fewer detentions due to reforms for people with a learning disability and autistic people	253	254	256	257	258	259	260	261	262	263	4,560
Total benefits	**279**	**281**	**283**	**285**	**287**	**288**	**290**	**291**	**293**	**295**	**4,945**

Impact of Advanced Choice Documents on hospital admissions

196. Research evidence on interventions that focus on involving service users in defining preferences and planning for their care in the event of a future mental health crisis, including ACDs, have been found to sometimes reduce the risk of hospital admissions[34]. It is assumed in a central scenario that 12.5% of those who would have been detained and would have already written an ACD at that point (following prior admission) under Option 1[35], would now not be detained. This calculation then informs the number of patients to which the wider 'process costs' of MH Act reform (which mainly affect detained patients specifically) are applied, reducing the estimated cost impacts.

197. Research suggests many patients who might avoid detention due to a crisis-planning initiative will be voluntarily admitted instead, and that other admissions besides detentions might be prevented. Therefore, a separate calculation assumes that 5% of baseline admissions (voluntarily or under detention) under Option 1for those estimated to have already written an ACD would now not be admitted at all. For these patients, benefits are estimated using an assumption that they would have spent 26 days in hospital (based on the median for detentions under Part II of the MHA in recent years) and information on the average costs per NHS mental health inpatient bed-day which include all hospital running costs, not just the minority associated with MHA processes.

198. For these patients it is assumed that they instead receive other forms of mental health care whilst in the community, including crisis-related services such as Crisis Resolution Home Treatment Teams[36]. For modelling purposes, it is assumed that this has costs equivalent to receiving daily mental health care contacts over a 2-week period whilst living at home, which offsets some of the benefits. These costs of community care have been presented in the monetised costs section.

199. It is likely that for some patients now receiving treatment/support at home rather than in hospital, there will be increased demands of social care and Voluntary, Community and Social Enterprise (VCSE) services. It has not been possible to model those here. It has not been possible to apportion the benefits and community provision costs from this transfer of activity out of hospitals across different workforce groups. The benefits are highly uncertain and depend on the availability of suitable mental health crisis provision.

200. More detail around the assumptions used in this modelling can be found in Annex C.III. We have captured uncertainty around the reduction in admissions using a range of estimates, which is discussed in the sensitivity analysis section.

[34] Molyneaux, E., Turner, A., Candy, B., Landau, S., Johnson, S. & Lloyd-Evans, B. (2019). Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open. 2019 June; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

[35] Estimates of MH patients with a learning disability and autism are removed from this BAU scenario for calculations of the impact of ACDs on admissions, because for many the change in detention criteria will have a more immediate impact on admissions.

[36] Rojas-García A, Dalton-Locke C, Sheridan Rains L, Dare C, Ginestet C, Foye U, Kelly K, Landau S, Lynch C, McCrone P, Nairi S, Newbigging K, Nyikavaranda P, Osborn D, Persaud K, Sevdalis N, Stefan M, Stuart R, Simpson A, Johnson S, Lloyd-Evans B. (2023), 'Investigating the association between characteristics of local crisis care systems and service use in an English national survey'. BJPsych Open. 2023 Nov 3;9(6):e209. doi: 10.1192/bjo.2023.595..

Table 29. Estimated reduction in flow of admissions following Advance Choice Documents (ACDs) (based on central detention scenario)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Central Scenario - (5% overall admission prevention and 12.5% detention prevention rate)										
Reduction in admissions	0	0	0	0	0	710	1,110	1,280	1,380	1,450
Of which detentions	0	0	0	0	0	910	1,420	1,630	1,770	1,860
Of which informal patients	0	0	0	0	0	-200	-310	-360	-390	-410

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Reduction in admissions	1,500	1,550	1,580	1,590	1,590	1,600	1,600	1,610	1,610	1,620	21,760
Of which detentions	1,930	1,980	2,030	2,040	2,040	2,050	2,060	2,060	2,070	2,080	27,910
Of which informal patients	-420	-440	-450	-450	-450	-450	-460	-460	-460	-460	-6,150

Note: These numbers have been modelled using data from England only. Numbers are rounded to nearest 10.

Reducing detention of people with a learning disability and autistic people

201. We expect that the change in detention criteria for people with a learning disability and autistic people will lead to a reduction in the number of detentions in this population. To model this, we have considered NHSE-provided monthly timeseries data for the number of admissions of people with a learning disability and autistic people, split into those with a Severe Mental Illness (SMI) flagged or not flagged within the data, as a proxy[37].

202. Under Option 1, we assume for modelling purposes that admissions of people with a learning disability and autistic people remain constant into the future (at a per capita rate) at an annual average figure for total Part II Section 3 admissions. This does not take into account ongoing policy and work to reduce inpatient numbers. We assume admissions remain constant due to high proportions of suppression within the available rounded data from NHSE (to minimise risk of disclosure), meaning more accurate trends and forecasts for future admission figures cannot be estimated within our analysis.

203. Under Option 2, we assume implementation occurs in 2026/27 – this is an arbitrary date chosen for modelling purposes only. It should not necessarily be seen as a target or as a likely timeframe for the change in detention criteria change. Upon implementation, only people with a learning disability and autistic people with a co-occurring mental health condition, meeting the detention criteria, should be admitted and detained under Part II Section 3. For modelling purposes, we assume future admissions under Option 2 remain constant into the future (at a per capita rate) at an annual average figure for Part II Section 3 admissions of people with a learning disability and autistic people with SMI flagged (used as a proxy). This leads to an estimated reduction in the number of admissions of people with a learning disability and autistic people of 7,030 over the appraisal period.

204. To note, our analysis on the *cost* impacts of the change in detention criteria for people with a learning disability and autistic people uses estimated projections on the change in total number of inpatients with a learning disability and autistic inpatients, rather than the change in admissions. This is because the reform may result in some immediate discharges when it is switched on (as some inpatients may now no longer be eligible for detention and therefore be discharged). Therefore, looking at admissions alone would miss the increase in discharges when

[37] NHSE unpublished internal analysis

the reform is switched on. Given this, we use total change in inpatients per year (i.e. a "stock" figure, rather than "flow" figures of admissions/discharges) to understand the overall impact of the reform. See Annex D for further methodological details on modelling inpatients with a learning disability and autistic inpatients and our resulting community cost estimates.

205. Within our analysis we have not produced high and low scenario estimates for the change in admissions of people with a learning disability and autistic people under Option 2 compared to Option 1 because NHSE data provides a fairly consistent view of the percentage of inpatients with a learning disability and autistic inpatients with an SMI flagged over time which is being used as a proxy for modelling purposes. Furthermore, our understanding of the reform on the change in detention criteria is that those without a SMI will no longer be detained following reform. We have however undertaken sensitivity testing in how we apply the inpatient volume estimates over time, to costs. Therefore, final cost figures have been through sensitivity testing and a range is provided.

Table 30. Estimated Reduction in number of admissions of people with a learning disability and autistic people (based on central detention scenario, compared to Option 1)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Central Scenario										
Reduction in admissions of people with a learning disability and autistic people	0	0	220	390	390	390	390	390	400	400

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Central Scenario											
Reduction in admissions of people with a learning disability and autistic people	400	400	400	400	410	410	410	410	410	410	7,030

Note: These numbers have been modelled using data from England only. Numbers are rounded to nearest 10.

Indirect health benefits

206. The monetised benefits above have been estimated as a direct benefit to the health and social care system based on a reduction in bed day costs but may in practice lead to health benefits for other patients due to high demand. These indirect health benefits have been estimated using a multiplier of around 4.7, which represents the marginal gain in social value for each NHS benefit (as is similarly applied to opportunity costs in the monetised costs section).

Table 31. Summary of total NHS benefits with and without health benefits – England only (£millions, 2024/25 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
NHS benefits (without health benefit)	0	0	242	243	245	258	266	270	273	276
NHS benefits (with health benefit)	0	0	1,128	1,136	1,143	1,202	1,240	1,260	1,276	1,289

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
NHS benefits (without health benefit)	279	281	283	285	287	288	290	291	293	295	**4,945**
NHS benefits (with health benefit)	1,301	1,311	1,322	1,329	1,337	1,345	1,353	1,360	1,368	1,376	**23,075**

Note: Totals may not equal the sum of the annual figures due to rounding.

Non-monetised benefits

207. In addition to the monetised benefits, there are expected to be benefits associated with Option 2 that have not been able to be monetised due to lack of available data and uncertainty around the expected impacts.

208. To give an indication of the benefits required to offset the costs of the policy in each year, we have undertaken breakeven analysis. These includes the potential benefits to the individual (in terms of health and wellbeing improvements) and potential benefits to the health system (in terms of reduced length of stay in hospital).

Benefits of improved patient experience

209. The main policy objectives of the reforms are to:
    - maintain the power to intervene and detain people under the Act when appropriate, to prevent harm to self or others;
    - modernise mental health legislation to give patients greater choice and autonomy over their care and treatment, and access to enhanced rights and support under the MHA;
    - ensure that the patient, their family and/or carer, and their Nominated Person are proactively supported to take part in decision making around care, treatment, and planning.
    - introduce new patient safeguards, such as granting informal patients access to an Independent Mental Health Advocate (IMHA);
    - improve existing patient safeguards, such as giving patients earlier access to the Mental Health Tribunal (MHT) and to a Second Opinion Appointed Doctor (SOAD);
    - reduce racial disparities under the MHA and promote equality;
    - ensure that patients receive therapeutic benefit from detention and that they are treated with dignity and respect, with a view to improving patient experience, improving recovery and therefore reducing the length of their detention; and
    - prevent longer term detentions for people with a learning disability and autistic people under the civil parts of the Act where they do not have a co-occurring mental disorder that would warrant hospital treatment.

210. While the patient benefits aren't monetised due to a lack of quantitative evidence, the benefits to patient experience form the principal rationale for the policy and are therefore important to consider and understand.

211. Qualitative evidence on patient experience under the MHA can provide an understanding of the gap for potential patient improvements and benefits of the MHA reform. The Independent Review describes the very negative patient experience associated with being detained for many patients.[38] A systematic review of patients' experiences of assessment and detention under mental health legislation found themes of fear and distress during detention.[39] Synthesis of evidence found often negative, traumatic impacts on emotional well-being and self-worth.[40] The research carried out by the Independent Review found that services are experienced as overly coercive, as not treating people with dignity, and as uncommunicative.[41]

212. Evidence on the link between patient experience and outcomes can illustrate the potential patient benefits from the reform. A study in England on 1,570 involuntary admitted patients follows interviews within the first week of admission and 1 year after.[42] The evidence shows that involving

[38] Modernising the Mental Health Act – final report from the independent review - GOV.UK (www.gov.uk)

[39] Akther SF, Molyneaux E, Stuart R, Johnson S, Simpson A, Oram S. Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open*. 2019;5(3):e37. doi:10.1192/bjo.2019.19

[40] A qualitative meta-synthesis of service users' and carers' experiences of assessment and involuntary hospital admissions under mental health legislations: a five-year update | BMC Psychiatry | Full Text (biomedcentral.com)

[41] Reforming the Mental Health Act - Centre for Mental Health

[42] Priebe S, Katsakou C, Amos T, et al. Patients' views and readmissions 1 year after involuntary hospitalisation. *British Journal of Psychiatry*. 2009;194(1):49-54. doi:10.1192/bjp.bp.108.052266

patients in decisions about their treatment under involuntary mental health treatment is associated with improved outcomes such as a lower likelihood of readmission, and that providing information, respect, empathy, and engaging patients in treatment planning and including their preferences in treatment decisions can improve treatment satisfaction. The main findings of the results are that patients who expressed a lower satisfaction with hospital care within the first week of involuntary admission are more likely to be involuntarily readmitted within 1 year. Overall, these findings suggest that involving patients in their treatment decisions could potentially improve patient satisfaction and adherence with treatment and lead to improved health outcomes, thereby reducing the likelihood of readmission.

213. The proposed changes to the MHA aim at improving patient's voice and experience and it is expected that these will bring beneficial impacts on wellbeing and health for patients who are detained under the MHA. For example, if patients draft an ACD, have increased access to IMHAs and SOADs, are automatically referred to the MHT on a more regular basis, then they will have more opportunities to voice any concerns and have their detention reviewed by the relevant professionals. Health impacts may be realised in the form of improvements to the patient's original condition as a result of more personalised and targeted treatments, or they could be gained through a reduction in the stress or anxiety that patients may face during detentions after the safeguards implemented by the policy improve the overall patient experience. As mentioned above, there is evidence that improvements in patient experience and patient engagement, both of which are aims of this policy intervention in their own right, are associated with increased adherence to treatment and have a beneficial impact on health outcomes. Strengthening patient involvement in their own care and treatment is intended to improve experiences of the MHA, improve autonomy, and provide dignity to those detained under the MHA. These are important outcomes, but they are not easily monetised. The extent to which the changes outlined throughout this IA will affect patient dignity is uncertain, and the value attributed to it is subjective and likely variable across patients.

214. If a patient refuses the chosen medical treatment, while it will be harder for the clinician to simply overrule the patient, it may still result in treatment being administered. The responsible clinician will be required to demonstrate that either there is no other alternative available, or that they have considered alternatives with the patient and/or those close to the patient, but the patient has not consented to them. However, before treatment can be administered against a patient's consent, a SOAD will be required to approve the necessary treatment and to ensure the clinician has taken all the necessary steps. Therefore, while patient engagement with treatment planning may not always align with preferences, it is the greater transparency in the overall decision-making process and the stricter criteria for actioning against preferences, which we think will contribute towards increased patient satisfaction. To support greater dignity and respect of patients, any reasons for deviating from their stated preferences will be explained by the clinical team. These improved outcomes would be expected to have some direct health and wellbeing benefits to patients. However, due to the wide range of the conditions and circumstances experienced by patients detained under the MHA, it has not been possible to quantify these benefits in terms of QALY or WELLBY gains. A breakeven analysis has been provided to illustrate the scale of benefits required to offset the costs of the policy, discussed in greater detail below.

Avoiding unnecessary or inappropriate admissions and restriction

215. In terms of impacts on the number of patients admitted and detained to start with, we have modelled the potential effects of ACD and CTO reforms and impacts to people with a learning disability and autistic people of changing detention criteria. As well as creating the impacts described in the 'Monetised Benefits' section, where detention or admission would have been inappropriate, the associated reduction in restriction to patients can be expected to improve patient and carer welfare.

216. Both the Independent Review[43] and the CQC annual reports on their monitoring of the uses of the MHA[44] have found that many patients are still not involved in the decisions involving their care, are not treated with dignity and respect, and are detained in low quality physical spaces. Many have spoken about their concerns or complaints, and about the trauma detention and treatment has caused them. The Independent Review concluded that often it is crisis rather than need that opens the door to services for patients. It reported that opportunities for early intervention are missed too often, which leads to a person confronting crisis unsupported, and a further consequence of that is that increasingly the first contact is with the police rather than with healthcare.

217. An evaluation conducted in one inner London NHS Trust[45] found assessments were less likely to result in detention when professionals other than the assessing team were in attendance (although this association weakened after adjusting for potential confounders). This concludes that local assessment processes could contribute to minimising detention rates, such as community team participation in assessments, although challenges are posed by limited resources.

218. One study by Camden and Islington NHS Foundation Trust aimed to demonstrate an alternative model of psychiatric care found that a 4-week trial of embedded mental health and physical health care for admission avoidance in the elderly was well received by staff and meant that three people who would otherwise have had potentially long and deleterious mental health admissions to inpatient care were cared for successfully at home with a cost saving. The trial displayed that through integration of care between community, secondary care and mental health services we can achieve better outcomes at lower cost for the patient group.

219. It is possible that some reforms, including shortening initial detention periods; increasing application opportunities and automatic referrals to the MHT; and supporting patients to understand and exercise their rights via increased use of advocacy, will lead to some patients being discharged sooner. Such impacts have not been quantified due to a lack of relevant research evidence and significant uncertainty over the effects, but this would likely bring additional benefits to patients who have been detained under the Act.

Impact of Advanced Choice Documents on hospital admissions and patient outcomes

220. The monetised benefits section described the approach to estimating the impact of Advanced Choice Documents on admissions and estimated in a central scenario that 12.5% of those who would have been detained and would have already written an ACD at that point (following prior admission) under Option 1 would now not be detained, but might still be informally admitted. This calculation then informs the number of patients to which the wider 'process costs' of MH Act reform (which affect detained patients specifically) are applied, reducing the estimated cost impacts.

221. The estimated reduction in admissions following ACDs (based on central detention scenario) is a total of 22,000 reduction in admissions and 28,000 reductions of detentions over the appraisal period. For example, in year 2033/34 an estimated reduction in admissions of 1,500, 1,900 of which are a reduction in detentions (the difference being an increase in informal patients).

222. Aside from the impact on hospital admissions, ACDs can provide qualitative benefits identified for patients from ACDs for crisis planning, which are separate from the wider benefits for inpatient experience mentioned in above section. Benefits of ACDs will vary for individuals, the principle

[43] Department of Health and Social Care. (December 2018). Modernising the Mental Health Act - Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Accessed at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

[44] Monitoring the Mental Health Act - Care Quality Commission (cqc.org.uk)

[45] Mental Health Act Assessment Process and Risk Factors for Compulsory Admission to Psychiatric Hospital: A Mixed Methods Study | The British Journal of Social Work | Oxford Academic (oup.com)

is to think about which elements of past illness experiences they consider having been most harmful to them and how ACDs can be used to minimise these harms in future.

223. International and national evidence[46] suggests that most people with severe mental illness are in favour of advance decision making, and research suggests people who have ACDs express feelings of self-determination, autonomy and empowerment[47]. It can give people who have ACDs a degree of independence when thinking about their care.[48] For some people, this may be about harnessing earlier intervention and mechanisms that helped, which could potentially prevent spiralling or reduce severity and/ or duration of an episode. It has been noted as helping to "take control" during situations of illness[48]

224. For others, this could be about using ACDs to ensure that treatment is accessed when unwell, even if individual knows from past experience that they may be unwilling[49]. This might not necessarily mean detention or inpatient treatment – it could be that simply having an ACD in place means that the individual will be more inclined to accept treatment. For example, there may treatments with the same outcomes but varied side effects, a particular individual may be less affected in terms of side effects by one treatment and therefore prefer to use this treatment.[48] This can lead to ensuring treatment is better targeted for the individual, which hopefully leads to better interventions and more well managed periods of illness.

225. ACDs also give the chance for individuals to give instructions about practical aspects of their life, such as domestic, financial,[50] caring and responsibilities (such as children or pets)48,which aids them to be looked after when unwell and aim to ease additional anxieties. They can also improve therapeutic relationships and trust in mental health professionals – there is evidence suggesting that ACDs may reduce negative coercive treatment experiences, which reduce willingness to interact with mental health services[51]. The collaborative approach of ACDs stimulate communication between health professionals and service users, which may aid in improving therapeutic relationships[52].

226. A case study of anecdotal evidence[53] from patients displayed filling out an ACD is therapeutic and that having an ACD can be a comfort for patients. Carer case study evidence filling out an ACD is helpful to do together so that the carer can better understand needs and instructions, as well as helping to spot signs that a psychotic episode might be imminent.

Reducing detentions of people with a learning disability and autistic people

227. Under Option 2, upon implementation, only people with a learning disability and autistic people with a co-occurring mental health condition should be admitted and detained under Part II Section 3. This is expected to lead to an estimated reduction in admissions of people with a learning disability and autistic people of 7,030, over the appraisal period used for the purposes of this IA.

228. Some people with a learning disability and autistic people detained under the Act may have experienced inappropriate care, a lack of specialised services tailored to their needs, overuse of

[46] G.S. Owen, T. Gergel, L.A. Stephenson, O. Hussain, L. Rifkin, A. Ruck Keene (2019). Advance decision-making in mental health – Suggestions for legal reform in England and Wales. International Journal of Law and Psychiatry. 2019; 64:162-177. doi:10.1016/j.ijlp.2019.02.002

[47] Zelle, H., Kemp, K. and Bonnie, R.J. (2015). Advance directives in mental health care: evidence, challenges and promise. World Psychiatry, 14: 278-280. doi:10.1002/wps.20268

[48] How can they help? — Advance Choice Documents

[49] Self-Binding Directives — Advance Choice Documents

[50] Money and Mental Health - a charity founded by Martin Lewis

[51] Zelle, H., Kemp, K. and Bonnie, R.J. (2015). Advance directives in mental health care: evidence, challenges and promise. World Psychiatry, 14: 278-280. doi:10.1002/wps.20268

[52] Jankovic, J., Richards, F., & Priebe, S. (2010). Advance statements in adult mental health. Advances in Psychiatric Treatment, 16(6), 448-455. doi:10.1192/apt.bp.109.006932

[53] https://www.advancechoice.org/

restraints, over-medication, and extended periods of detention54. The MHA reforms are intended to address this.

229. The MHA Code of Practice states that hospital detention is "rarely likely to be helpful" for an autistic person, and that for people with a learning disability, "evidence-based good practice is that most of their needs can best be met at home or in community settings"55. A Care Quality Commission (CQC) review of 43 specialist autism and learning disability hospital wards in 2020 concluded that most were not therapeutic environments[56]. In 2023, 31% of NHS trusts and 47% of private providers of learning disability and autism services received a "requires improvement" or "inadequate" safety rating.

230. Therefore, in addition to the benefits to the Health system associated from a reduction in admissions, there are expected to be significant additional benefits for people with a learning disability and autistic people in improvements in treatment, care and outcomes, which we have not been able to monetise.

231. In assessing the costs of the change in detention criteria for people with a learning disability and autistic people, some benefits arising from there being fewer people in inpatient settings have been monetised. However, the analysis includes only benefits per inpatient bed, and we understand there may be additional costs whilst an individual is in hospital as they may receive an Enhanced Care. Enhanced Care is put into place for patients who, without additional supervised observation, may be at risk of harm from e.g. falls, deterioration or isolation. Therefore, the monetised inpatient benefits may underrepresent the true inpatient benefits anticipated from this reform.

232. Putting C(E)TRs and DSRs on a statutory footing is expected to lead to an increase in the number of C(E)TRs being carried out, and an increase in the use of DSRs. Given that both C(E)TRs and DSRs aim to reduce the number of people in inpatient settings, there may be reductions in inpatients which are not captured in monetised cost estimates. We do not include these numbers in cost estimates because the impact is highly uncertain and we lack evidence to make assumptions on the scale of inpatient reduction, following the reforms.

Reducing the use of Community Treatment Orders

233. The use of CTOs is expected to reduce as a result of changes in the CTO criteria. In the central scenario, we assume that CTOs will decrease gradually to a total 20% reduction over a five-year period from 2031/32 relative to the baseline. This leads to an estimated reduction in CTOs of around 15,000 over the appraisal period.

234. It is expected that the reforms will help to address the well documented racial disparity in the use of CTOs. The standardised rate of Community Treatment Orders per 100,00 population is 7 times higher for Black or Black British (48.8 per 100,000 population) than for White or White British people (6.9 per 100,000 population)[57]. To some extent this reflects higher overall detention rates, but the number of CTOs as a proportion of overall detention numbers is higher for Mixed (14%), Asian or Asian British (13%), Black or Black British (20%), and Other Ethnicity (13%) people compared with White people (10%)[58].

235. Patients on CTOs are likely to have their liberty restricted for significantly longer periods of time[59]. Therefore, aside from the process costs savings associated from a reduction in the volume

[54] POST-PN-0722.pdf (parliament.uk)

[55] (2015). Mental Health Act 1983: Code of Practice for England

[56] Care Quality Commission (2020). Out of sight – who cares?: Restraint, segregation and seclusion review

[57] NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 3c

[58] NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 1c, Table 3c. To give CTO: overall detention ratios, crude CTO rates per 100,000 population from Table 3c are divided by crude detention rates (which include CTOs) per 100,000 from Table 1c.

[59] Effectiveness of Community Treatment Orders: The International Evidence - PMC (nih.gov)

of CTOs, there may be additional non-monetised benefits for patients. Overall, although some stakeholder views are positive, there is currently no robust evidence about either the positive or negative effects of CTOs on key outcomes, including hospital readmission, length of hospital stay, improved medication compliance, or patients' quality of life[6061]. Therefore, these benefits have not been monetised.

Benefits for the Health and Social Care System

236. Benefits associated with improving health outcomes covered above will also have an impact on the health & social care system. The proposals may help patients who previously were subjected to long-term detentions but would now have better access to appeals and more effective care treatment plans, potentially bringing a higher chance of earlier discharge. There is also evidence (from a systematic literature review of 55 studies) that improvements in patient experience are associated with reduced use of primary and secondary care resources (such as fewer hospitalisations, readmissions and primary care visits).[62]

237. Recent systematic reviews of qualitative evidence of patients' experiences of detention under mental health legislation and of interventions for involuntary patients using randomised controlled trials (RCTs) suggest that care planning interventions centred on the patient and increasing their involvement in decision-making, which are areas covered by the MHA proposed reforms (e.g., CTPs, ACDs), could improve patient outcomes, including reducing the likelihood of these patients relapsing and being involuntarily readmitted[6364].

238. Once the improved safeguards that allow patients to be more involved in the decision-making process are introduced, alongside more opportunities to review and challenge the detention and the replacement of the nearest relative with a NP, there is the potential for some detentions to be reduced in length. Since longer detentions have a direct cost pressure on NHS budgets, there could potentially significant benefits realised if the improved safeguards were to result in a reduction in the average length of a detention. This would mean a cost saving for the NHS which could then be put to use elsewhere in the Healthcare system and generate further direct health benefits in the form of QALYs elsewhere. This benefit has not been monetised due to the lack of clear evidence on exactly whether or how much length of stays are likely to be reduced by following the introduction of the policy changes outlined in this IA. As an illustration, the breakeven analysis section explores further the degree to which detention lengths would need to fall by for the costs of the policy to be offset by this benefit alone.

Benefits For the Justice System

239. It is known that for some mental health problems the earlier an individual receives mental health treatment the more effective it can be. This is because, if left untreated, especially in the wrong environment, the problem can worsen and become harder to eventually treat and take more time and resource to resolve for health providers. For example, lengthy delays in prisoner transfer to secure hospitals can lead to mental health conditions deteriorating and becoming more established. We anticipate that ensuring individuals are able to access appropriate care faster

[60] International experiences of using community treatment orders (psychrights.org)

[61] Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis - PubMed (nih.gov)

[62] Doyle, C., Lennox, L., & Bell, D. (2012) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013; 3(1). Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549241/

[63] Giacco, D., Conneely, M., Masoud, T., Burn, E., & Priebe, S. (2018). Interventions for involuntary psychiatric inpatients: A systematic review. European Psychiatry, 54, 41-50. doi:10.1016/j.eurpsy.2018.07.005. Also accessed at: Interventions for involuntary psychiatric inpatients: A systematic review | European Psychiatry | Cambridge Core

[64] Akther, S., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: Systematic review and qualitative meta-synthesis. BJPsych Open, 5(3), E37. doi:10.1192/bjo.2019.19. Also accessed at: Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis | BJPsych Open | Cambridge Core

will therefore lead to improved health outcomes, both short and long term, and help ensure treatment is more cost effective.

240. It is anticipated that commitments to ensure that those in the Criminal Justice system are able to access care as quickly and early as possible (such as increasing the timeliness of transfers and ending the use of prison as a place of safety) would also contribute to efficiency gains in other parts of the Justice system of England and Wales. Due to a lack of data, it is not possible to monetise the impact on justice system costs, or prisoner or His Majesty's Prison and Probation Services (HMPPS) staff health and welfare of these policies.

241. In terms of Justice system impacts, prisoners awaiting transfer to secure hospitals and those remanded to prison with severe mental health needs can be highly demanding of prison staff time as they often require intensive monitoring and individualised support. Tackling lengthy delays in prison transfers and ending the use of prison as a place of safety on the grounds of mental health could therefore alleviate pressure on staff time within HMPPS, which could be reallocated towards other priorities. We do not have reliable data to model these impacts but expect that the population affected is small, therefore in line with the decision to not estimate the health system impacts, we have we have also not monetised any corresponding savings to the prison system resulting from these changes due to these expecting to be limited.

242. The reforms to supervised discharge will provide a legal basis for the discharge of patients detained through the courts, who are subject to special controls by the Secretary of State for Justice to protect the public from serious harm, to be discharged into the community with conditions which amount to a deprivation of liberty. This will be clearer for the patient and Mental Health Tribunal and more transparent than relying on workarounds. It also allows for greater scrutiny of the number of people subject to such conditions and the reasons why they are necessary. The reform also responds to a gap left by a Supreme Court decision in 2018, which found that there was no route under the current Act to apply discharge conditions which amount to a deprivation of liberty, even if a patient consents to these.

Benefits for People with Relevant Protected Characteristics

243. The Independent Review[65] heard concerns around the disparity of access to, and experience of, mental health services for different disadvantaged groups, including LGBTQ+, ethnic minority communities, people with a learning disability or autistic people, and asylum seekers and refugees. This can influence the likelihood of detention in the first place, given varying access to and success of alternatives, as well as experiences when subject to the Act. NHS England's Mental Health Services Data Set[66] is the main source for information about uses of the Mental Health Act in England. It collects data on detentions by age, gender and race but does not collect data on other protected characteristics. These gaps in the evidence base limit our understanding of how certain groups are affected by the Act.

244. Broadly, it is anticipated that improved involvement of patients in treatment decisions (before or after the potential need for detention arises) could improve patient satisfaction and adherence with treatment, and lead to improved health outcomes[67][68], in the face of the specific needs for such disadvantaged groups. The reforms should also help ensure that people are aware of their rights under the Act and are appropriately informed and can actively participate in decisions around their care and treatment.

[65] Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983

[66] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

[67] Vahdat, S., Hamzehgardeshi, L., Hessam, S., & Hamzehgardeshi, Z. (2014). Patient involvement in health care decision making: a review. Iranian Red Crescent medical journal, 16(1), e12454. doi:10.5812/ircmj.12454 (also accessed at: https://pubmed.ncbi.nlm.nih.gov/24719703/)

[68] Doyle, C., Lennox, L., & Bell, D. (2012) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013; 3(1). Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549241/

245. It is anticipated that the reforms will have differential impacts for distinct groups of people. There are expected to be benefits for people with a learning disability or autistic people from reduced inappropriate admissions after the reforms, discussed in more detail in the monetised benefits section. Additionally, the reforms are expected to reduce the use of CTOs, which may help to address the well-documented disparities in their use. We have further explored the differential impacts of the reforms in the distributional and wider impacts section.

Wider economic benefits resulting from potential improvements in mental health outcomes

246. The Organisation for Economic Cooperation and Development (OECD) has published a series of reports outlining the significant economic burden of mental illness through the reduction in workforce participation through unemployment, sickness absence and lost productivity. People with a mental health condition have employment rates almost half of the general population (44% vs 80% in 2020-21)[69], with severe conditions cutting life expectancy by 15-20 years[70]. This translates into lost human capital and productivity. Mental health-related sickness absence alone costs the UK economy £9 billion per year[71], while economic inactivity affects 660,000 people who cite mental health as their main health condition[72].

247. The economic burden of mental ill-health has been estimated to be around £150bn per year, which is largely driven by lost output due to not being in paid work. There is a significant cost to the government, estimated at around £70bn each year from tax and national insurance forgone from being out of the workforce, plus NHS costs and benefits payments[73]. Mental health issues also create significant indirect economic costs through their impact on families, employers, and wider society. Individuals with mental health conditions, are more likely to experience absenteeism or presenteeism, diminishing productivity, reducing overall wellbeing, and leading to a greater incidence of anxiety and depression.

248. Under the proposed policy Option 2, these reforms are likely to support better mental health outcomes in the long term which could create economic gains. These gains could be driven by the improvement of human capital and increased labour market participation, reduced absenteeism, and the opportunity to explore volunteering and paid employment as part of recovery journeys, which can contribute to increased productivity and economic growth. The largest impacts will likely be for those of working-age (18 to 64), which accounted for 77% of all detentions in 2023/24[74].

249. However, gains are likely to be limited among patients with experience under the MHA, who are more likely than the wider population to be distanced from the labour market. Additionally, family members and friends may be providing additional unpaid care in the community as a result of the reforms, which could impact their labour market participation. These wider economic benefits have therefore not been monetised, as the impact is expected to be limited.

Breakeven analysis

250. The breakeven analysis described below seeks to estimate the non-monetised benefits required to offset the estimated net monetised impacts of the policy (which are negative in NPV terms in the central scenario). We use three ways to illustrate this: i) improved quality of life; ii) improved wellbeing; iii) reduction in the length of stay for detainees.

[69] The economic and social costs of mental ill health, Centre for mental health, (2022)

[70] Public Health England (2018). Severe mental illness (SMI) and physical health inequalities: briefing.

[71] The economic and social costs of mental ill health, Centre for mental health, (2022)

[72] Labour Force Survey data (Jul-Sep 2022)

[73] The economic cost of ill health among the working-age population, Oxera(2023) CentreforMH_TheEconomicSocialCostsofMentalIllHealth-1.pdf (centreformentalhealth.org.uk)

[74] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

251. Breakeven calculations have been carried out using the central NPV estimate, as well as the low NPV scenario estimated in sensitivity analysis. Breakeven analysis was not performed for the high NPV scenario which is positive. Results are shown in Table 32. It is important to consider that this breakeven analysis is illustrative only. Further detail on the calculations behind this can be found in Annex F.

Health benefits to patients

252. Patient benefits may materialise through detained patients responding better to treatment (due to more involvement in their care) or through patients experiencing less stress and anxiety resulting from a poor experience whilst being detained. These patient benefits are non-monetised but we can illustrate the improvement in patient health per detention needed to offset the negative NPV in the central scenario.

253. The measurement and valuation of a health intervention is typically performed by estimating the number of QALYs generated. The value society places on a QALY are estimated to be £70,000.[75]

254. **Based on the calculated NPV over the 20-year appraisal period for Option 2, we estimate that the in-year patient health gains per detention projected across the period would need to be equivalent to 0.003 QALYs in the 'policy on' scenario in order to produce discounted benefits commensurate with the monetised NPV. This is equivalent to a 0.04 point improvement in QALYs if delivered over a 26 day period (26 days being the median detention length for Part II patients in 2023/24).**

255. This QALY gain of 0.003 calculated in this breakeven analysis is equivalent to helping someone live for an extra 0.9 days in perfect health (i.e. health-related quality of life (HRQoL) of 1), or, live for an extra 1.9 days in a state of perfect health rather than in moderate health (if that were equivalent to a HRQoL of 0.5).

256. One of the most widely used preference-based instruments for the assessment of Health-Related Quality of Life (HRQoL) that can be used to generate QALYs is the EQ-5D. We can illustrate using the EQ-5D-5L to measure the health state of a patient.

- *For example, a health state of 23245 (slight mobility, moderate self-care, slight usual activities, severe pain/ discomfort, extreme anxiety/ depression) is equivalent to an EQ5D score of 0.247. If a patient moves to a slightly improved health state of 23234 (slight mobility, moderate self-care, slight usual activities, severe pain/ discomfort, severe anxiety/ depression), with the difference being from extreme to severe anxiety / depression, the EQ5D score equates to 0.251.[76] Therefore, over a year this patient has gained the equivalent of 0.004 QALYs ((0.251-0.247) x 1 year). This is a hypothetical example to show the extent of patients' health gains which would equate to similar (bigger) QALY impacts needed to offset the net monetised impacts of the policy.*

257. To contextualise, successful treatment through talking therapies is estimated to lead to QALY gain of 0.11.[77] 'The Economic and Social Costs of Mental Illness' published by the Sainsbury Centre for Mental Health (SCMH), June 2003[78] calculated coefficients for severe mental health and moderate mental health; severe mental health was 0.352 of a QALY, and moderate mental health was 0.098 of a QALY.

[75] Franklin150331Monetary-Valuation-of-a-QALY-2014-prices.pdf (dhsc.gov.uk); DH Title (dhsc.gov.uk)

[76] Valuing health-related quality of life: An EQ-5D-5L value set for England (euroqol.org)

[77] Microsoft Word - Talking therapies IA final.doc

[78] CentreforMH_TheEconomicSocialCostsofMentalIllHealth.pdf

Wellbeing benefits to patients

258. Improving patient experience of the MHA is a key policy objective of the Bill. Wellbeing is about how people feel. Patient experience, choice, and autonomy all feed into the wellbeing of the patients. Wellbeing outcomes are captured for an individual dependent on wellbeing, health, relationships, environment, living, finances, economy, governance, education, and work. Health is a subset of what is captured within wellbeing.

259. The idea of a WELLBY is about length of life and quality of life. The quality 'weight' is how satisfied people themselves say they are with their life. 1 WELLBY is one unit of life-satisfaction on a 0-10 scale for one person for one year, further detail is in Annex F.

260. Therefore, we have used WELLBYs to quantify the wellbeing of patients. This patient wellbeing is non-monetised (further detail in the non-monetised section) but we can illustrate the improvement in patient wellbeing needed to offset the NPV of the policy.

261. The standard value of one wellbeing adjusted life year on a WELLBYs is estimated to be £13,000.[79]

262. **We estimate that in order to offset the NPV of the policy and 'breakeven', an improvement in wellbeing of 0.012 points of life satisfaction (on a 0-10 scale) is required per detained patient over the appraisal period. This is equivalent to a 0.16 point (i.e. moving from 5.00 to 5.16 on a 1 to 10 scale) improvement in life satisfaction if delivered over a 26 day period (26 days being the median detention length for Part II patients in 2023/24).**

263. To contextualise, the effect of employment to unemployment is estimated as -0.46 WELLBYs in the UK[80]; improvement from moderate loneliness to mild loneliness is estimated as +0.7 WELLBYs[81][82]. The WELLBY decrease (difference between having the condition and not having the condition) in working age adults (20-65) for the following conditions have been estimated: OCD, 0.857; BPD, 1.21; eating disorders, 0.998; anxiety, 0.717; MDD, 0.968; Schizophrenia, 0.991; ADHD, 0.846.[83]

Reduction in length of stay

264. One of the potential benefits of the reforms may be a reduction in the length of stay for detainees. This may be from mechanisms including better access to reviews and appeals of detentions and more effective care treatment plans, potentially bringing a higher chance of earlier discharge. Here we consider only the health benefits of freeing up mental health beds (as monetised for patients diverted from hospital altogether in 'Monetised Benefits') rather than other impacts for the patients hypothetically experiencing shorter stays.

265. Focusing on the bed day costs associated with a period in detention from the NHS Cost Collection (which constitute the majority of costs), **we estimate that the proposals would require a 0.33 day reduction in all detainees' lengths of stay to breakeven.** For reference, the median length of a detention is estimated to be around 26 days (for part II patients)[84].

[79] Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf (publishing.service.gov.uk)

[80] Slides - Paul Frijters and Christian Krekel - Treasury Guest Lecture: Wellbeing Report seminar series: WELLBY cost-benefit analyses, principles and examples - 9 June 2022

[81] loneLINESS MONETISATION REPORT

[82] from 3 - "occasionally" lonely - to 2 - "hardly ever" lonely - on a 1 to 5 self-reported scale,

[83] CentreforMH_TheEconomicSocialCostsofMentalIllHealth.pdf

[84] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital Table 8a

Table 32. Summary of breakeven analysis with sensitivity analysis results incorporated for England and Wales.

Non-monetised benefit	Central NPV	Low NPV scenario from sensitivity analysis	Unit / description
Reduction in the length of stay for detainees	0.334	8.929	Reduction in length of stay (days) for detentions occurring from 2025/26 in appraisal period to produce health benefits to offset NPV of the policy
Increase in health benefits: QALYs	0.003	0.068	Health gain (QALYs) for each detention occurring from 2025/26 in appraisal period to offset NPV of the policy
Increase in health benefits: WELLBYs	0.012	0.308	Wellbeing gain (WELLBYs) for each detention occurring from 2025/26 in appraisal period to offset NPV of the policy

Risks and assumptions

Modelling uncertainties

266. The impacts which have been monetised in this IA consider the change in activities directly related to the reforms. Many impacts were not able to be monetised due to lack of data or research evidence, and furthermore given the 20-year appraisal period, there is a likelihood that input assumptions/estimates may change over the period in ways it is now possible to accurately predict now. Therefore, there is significant uncertainty around estimates of costs and benefits, as reflected in sensitivity analysis. Some key areas of uncertainty include:

- **CQC fees:** For instance, costs to CQC have been based on current SOAD fee rates. Any future fee increases would increase costs.
- **Use of CTOs:** The proposed reforms to the Bill aim to ensure that the MHA continues to get the right balance between patient and individual rights, and public and patient safety. Reforms to introduce greater scrutiny to CTOs and amend the CTO criteria in line with the new detention criteria are expected to have the effect of reducing CTOs by ensuring they are used in a more targeted way where someone is a risk to others rather than to their self. However, there is a risk that clinicians may be more risk averse in the public protection context and therefore more inclined to issue a CTO, which may negate the degree to which use of CTO decreases. Alternatively, it may make sure they are used in a more targeted way where someone is a risk to others rather than to their self.
- **Duration of community care:** the analysis on the change in detention criteria for people with a learning disability and autistic people assumes that the duration of community care required for an individual who avoids admission is equal to how long they would have stayed in hospital. This is a simplifying assumption made for modelling purposes, due to lack of evidence of what their expected duration of stay in community care would look like in practice following reform. As explained below, we have conducted sensitivity analysis on the community costs figures which present a wide range, reflecting the uncertainty.

267. As noted in the annexes, a large range of assumptions have had to be made in the absence of direct evidence – regarding patient uptake, staff time requirements for tasks, and which staff members may be involved in different processes – to estimate monetised impacts. It is also not certain how far some of the proposals already represent best practice in delivery organisations.

As such, sensitivity analysis has been conducted with respect to the proposed MHA reforms in the draft Bill, which varies the key assumptions used to monetise impacts in order the demonstrate the potential impacts on results.

268. The results of this sensitivity analysis and discussion of other risks are set out below.

Wider capacity & workforce constraints

269. The impacts discussed in this IA are dependent on wider system capacity and workforce constraints being addressed. For instance, realising the health service and patient benefits from diverting patients from hospital admission and detention will depend on the capacity in the system to safely shift people away from inpatient settings to the community, which is dependent on the investment and services costed in this IA being implemented. Similarly, depending on delivery models deployed, difficulties in building or securing appropriate housing, either associated with the planning and construction process or funding issues, would mean that the benefits from reducing detentions of people with a learning disability and autistic people may either not be fully realised, realised later than anticipated, or result in greater than expected costs.

270. For some workforce groups in particular the reforms are expected to lead to an increase in MHA-associated activity that is significant as a proportion of current levels, such as SOAD and advocacy activity. As such the need to increase capacity and risk of that meeting workforce supply constraints may be higher for these workforces than for other areas.

271. As stated in the 'Monetised costs section' the IA does not constitute a fully developed workforce implementation plan This IA has not set out a detailed workforce implementation plan but has, in approximate terms, estimated some of the marginal costs associated with an expansion in workforce (for example, training), in addition to ongoing resource costs, to accommodate the additional workload generated by the reforms. Regardless of whether budgets are available to pay staff, realising this expansion and these costs will require attracting sufficient new trainees or recruits to various roles in the health, courts, social work, wider local authority and VCSE sectors, and ensuring retention does not deteriorate. The reforms are not the only source of future demand that may require an expansion of the relevant workforces, but if workforce numbers are not sufficient to accommodate additional demands, then either the benefits of the proposals would not be achieved in full, or they may result in negative impacts where professionals must divert time away from other tasks.

272. Implementation timelines set out in this IA are indicative and actual commencement dates will depend on the progression of relevant processes, legislative and non-legislative actions, capacity in the system, or unforeseen circumstances. In some cases, certain reforms will not be commenced until we are satisfied that clear pathways are in place to safely enact the proposed reforms. This may mean that the profile of costs and benefits set out in this IA may vary in practice, or occur later than modelled here, but this flexibility provides a mitigation to the risks discussed above.

273. Increased demand on services as a result of the reforms may contribute to wider system pressures and delays, such as delays in people receiving a SOAD who can certify their treatment or delays in MHT proceedings.

274. The reforms to the MHT are expected to increase demand, potentially straining resources and leading to delays in proceedings. To manage this, the government plans to delay tribunal-related reforms until 2030/31, providing time to recruit and train personnel, upscale capacity, and address resource implications. This phased approach aims to ensure that the tribunals can meet increased demand without compromising decision-making quality or exacerbating system pressures.

Possible unintended consequences

275. **Mental Capacity Act and Court of Protection**: It is possible that the proposed reforms to the detention criteria, treatment safeguards for people with a learning disability and autistic people, the new treatment safeguards and Nominated Person proposed in the Bill could pose a small risk of increased demand on the Court of Protection, which is responsible for deciding whether a person has the mental capacity to make a particular decision for themselves under the Mental Capacity Act (MCA), and for adjudicating on whether a particular decision made on their behalf is in their best interests.

276. For instance, the proposed changes to the detention criteria will mean that civil patients with a learning disability and autistic patients can only be detained for treatment under section 3 if they have a co-occurring mental disorder that warrants hospital treatment. Some stakeholders have raised concern that alternative legislative routes could be used to detain people when section 3 is no longer an option, especially where adequate community care is not available. This includes use of the Mental Capacity Act, which would have impacts on the Court of Protection, or detention under Part III.

277. It is expected that the proposed reforms to the detention criteria should result in more people receiving care and treatment in the community rather than being detained in hospital through alternative routes. To ensure that these individuals receive the right care and support, the Bill introduces new duties on ICBs to hold a register of those at risk of admission and for ICBs and local authorities to use this information when exercising their commissioning and market functions. Under the proposals, both ICBs and local authorities must seek to ensure that the needs of people with a learning disability and autistic people can be met without admission to hospital. The proposed changes to the detention criteria for people with a learning disability and autistic people will only be switched on when systems are able to demonstrate sufficient level of community support to safely move inpatients from hospital back into their community. We will monitor the impact of the proposed reforms to ensure that they are having their intended effects and seek to mitigate any consequences, such as impacts on the Court of Protection and those associated with increased use of the Mental Capacity Act.

278. **Nominated Persons:** There is a risk that the Nominated Person policy leads to an increase in challenges against the suitability of the Nominated Person chosen by the patient, given that competence for under 16s can be difficult to judge. However, this is mitigated by a robust nomination process and the processes put in place to overrule or displace the Nominated Person where appropriate. A health or social care professional or advocate must witness the nomination and sign a statement to say that they have no reason to think that i) the patient lacks capacity (or competence if under 16) to make a nomination, ii) any fraud or undue pressure has been used to induce the patient to make the appointment, iii) the Nominated Person is unsuitable to act as an Nominated Person. Decisions made by Nominated Person can be overruled by Responsible Clinicians or AMHPs if they are likely to cause danger to the patient or others, and the Nominated Person can also be displaced by the courts if they meet criteria deeming them to be unsuitable.

279. **Timeliness of mental health treatment:** New treatment safeguards and measures such as ACDs are likely to require increased clinical input to support the patient to share their wishes and feelings, to engage with the wishes shared at the time or in advance, and/or to consult with those close to the patient to come to a decision on what may be best for the patient. There is a risk that in some cases this could delay the administration of treatment to the patient. However, we anticipate that as a result of these reforms, the final outcome of any clinical decision is likely to be more in line with the patient's wishes and preferences and therefore conducive to a more positive clinician-patient relationship and improve the patient's recovery. The reforms also do not prevent a clinician providing treatment when immediately necessary for the range of reasons covered in the urgent treatment criteria.

Housing risks

280. Developing housing, and in particular specialised supported housing where location and design is crucial, depends on several factors such as planning, infrastructure, the viability of the scheme and local authority backing. The successful delivery of complex supported housing schemes requires all the critical factors to be met at the right time.

281. The delivery of supported housing also works best when local services work together alongside providers. The Government will shortly implement the duty set out in the Supported Housing (Regulatory Oversight) Act 2023 requiring local housing authorities and social services authorities to formulate a supported housing strategy for the district. The strategies will enable developers to make informed decisions about where new supported housing schemes are most needed and for which groups, including people with a learning disability, autistic people and those with enduring mental ill health.

282. Risks to delivering the right accommodation in the right place can be mitigated by local partnership working, and at national level through joint boards such as the Supported Housing Programme Board which includes the Ministry of Housing, Communities and Local Government, the Department for Health and Social Care and the Department for Work and Pensions.

283. Other key risks to housing include:

- Capital Investment: Securing capital funding is often a significant barrier, especially where public finances are limited. The cost and availability of land, construction materials, and labour all contribute to a high initial outlay, making it challenging to build new properties to the design standards and at the scale required.
- Planning Permission: Obtaining planning permission can be lengthy and complex, with extra hurdles for securing permission for specialist accommodation. There are often delays due to local objections or changes in planning policies, which can significantly extend timelines.
- Feasibility in Practice: Even with capital and planning approval, the actual construction process can be delayed due to factors like supply chain disruptions, contractor availability, and regulatory compliance. This can impact delivery timelines and increase costs.
- Gaps and Lead Times: There is a high likelihood of gaps between the demand for housing and the delivery of new builds. Lead times for specialist accommodation can be particularly long due to the bespoke nature of the designs, which need to accommodate specific needs, such as accessibility features or sensory-friendly environments.
- Responsiveness to Demand: Public house building often struggles to keep pace with changes in demand, particularly in areas where housing shortages are already acute. This can be exacerbated by fluctuations in policy or funding priorities, leading to a misalignment between what is built and what is needed.

284. Given these potential issues associated with building new homes, we recognise there is a risk that the housing rent costs required to provide accommodation for people with a learning disability and autistic people who are no longer eligible for detention and are discharged from hospital, are higher with higher private sector housing revenue costs instead, because the building or purchase and retrofit of the homes will need to be funded via private lending (with the additional costs of borrowing built into the ongoing housing revenue costs, i.e. into the rents paid to the landlord). The private housing revenue costs are likely to be ~£16k (or more) higher (per person, per year, in 24/25 prices) than the social rents that would've been incurred, had the homes been funded via public sector capital investment. Therefore, there is a risk that if it is not feasible to build new homes or purchase and adapt existing homes via public sector capital funding (e.g. via the Affordable Homes Programme), then overall costs to the public purse could be higher than stated.

Sensitivity analysis

285. This section explores how sensitive the estimated net discounted costs over the appraisal period (i.e. the Net Present Value, NPV) are to potential variations in key input variables or assumptions.

Health System

286. There are the following main groups of uncertainties for the impacts to the Health and Social Care system:

- The magnitude of the future number of people admitted to hospital, detained or under CTOs, either in response to wider trends, or the impact of the proposed reforms;
- How much additional time from the health and social care workforce will be required to deliver the additional safeguards and how much current work will be re-adjusted or in line with the reforms;
- Counterfactual costs used for ACD diverted admissions are based on an assumption around a greater number of community mental health contacts for these people. This does not include the possible costs for social workers and VCSE staff, who may be additionally providing care, and therefore our cost saving/ benefit estimates may be an overestimate. We have accounted for the risk by including a scenario in which there are no cost savings associated with the policy.

Justice System

287. Some of the principal assumptions, and the associated ranges are set out below. Additional details can be found in Annex E:

- Detention periods: expected increase in Section 3 applications of between 25% and 49%, the central scenario employs the midpoint of 37%.
- Automatic referrals for Part III patients: expected increase in Section 71(2) referrals of between 355% and 420% due to varying estimation methodologies; the central scenario employs the midpoint of a 390% increase.
- Automatic referrals for people on conditional discharge: the annual volumes of referrals vary depending on the success rate of achieving absolute discharge (i.e., no conditions attached because the criteria for detention are no longer met) for the cohort of patients being automatically referred in previous years. These success rates differ depending on the duration spent on conditional discharge at the time of the tribunal hearing. At the 2 year point the success rate varies between 3% and 7%; the central scenario employs the midpoint of 5%. At the 6 year point the success rate varies between 30% and 36%, and the central scenario employs the midpoint of 33%.
- On certifying 10 days in advance of a tribunal hearing that a Section 3 patient continues to meet the criteria for detention: the estimated benefits are dependent on the assumption that, across all scenarios, MHT panel members can be reallocated in 50% of cancellations, which would mean that there are no cancellation fees to be claimed in these instances.
- CTP treatment choice: the additional costs are generated by the expected increase in hearing times from considering the statutory CTP. The extra time is put at 20 minutes in the low-cost scenario, 40 minutes in the central cost scenarios and 60 minutes in the high-cost scenario, as advised by HMCTS operational experts.

One-way Sensitivity Analysis

288. We present in the table below the key assumptions in each model for the central scenario and for alternative scenarios.

289. Due to the complexity of the modelling, we have limited this section to the important and uncertain assumptions – see Table 33 below. We then present the impact the NPV when each key assumption varies and all the other remain constant under a central scenario. This is followed by a summary section covering two scenarios (low cost and high cost) where we vary the key listed assumptions simultaneously and assess the impact on estimated NPV.

Table 33. Summary of key assumptions and sensitivities

	Assumption	Central scenario	Low NPV scenario	High NPV scenario
Volumes				
Baseline projections for detention volumes	Growth factor applied based on previous trends	Increase in line with population changes	Increase by average (population-adjusted) pre-pandemic growth rate in detentions (1.16%, observed from 2016/17 to 2019/20) until 2033/34, then increase in line with population changes thereafter	Increase by average (population-adjusted) growth rate (-0.87%, observed from 2016/17 to 2023/24) until 2033/34, then increase in line with population changes thereafter
Baseline projections for admission volumes	Growth factor applied based on previous trends	Increase in line with population changes	Increase by average (population-adjusted) pre-pandemic growth rate in admissions (0.57%, observed from 2016/17 to 2019/20) until 2033/34, then increase in line with population changes thereafter	Increase by average (population-adjusted) growth rate in admissions (-2.64%, observed from 2016/17 to 2023/24) until 2033/34, then increase in line with population changes thereafter
Policy impact				
ACD uptake and impact	ACD uptake	45%	60% (ACD uptake was modelled to range between 30-60%). However, when the impact of ACDs on detentions and admissions is low,	60% (ACD uptake was modelled to range between 30-60%). However, when the impact of ACDs on detentions and admissions is high,

			the lowest NPV is achieved when uptake is highest, when coupled with a low impact scenario on admissions)	the highest NPV is achieved when uptake is highest when coupled with a high impact scenario on admissions)
	Proportion of ACDs re-written after discharge where relevant	60%	80%	40%
	Impact of ACD on overall admissions	5%	0%	10%
	Impact of ACD on detention	12.5%	0%	25%
Policy impact on CTOs	Reduction in CTOs as a result of policy (assumed to occur gradually over 5 years from 2031/32)	20%	0%	40%
Uptake of advocacy	Proportion of detained and informal patients using IMHAs.	Detained patients: 85% Informal patients: 50%	Detained patients: 90% Informal patients: 60%	Detained patients: 70% Informal patients: 40%
MoJ assumptions Assumptions used for MoJ modelling [see above section] (excluding inputs from DHSC model that are varied in above scenarios)	See Justice System section above (paragraph 288) for details	Central MOJ input assumptions	MoJ inputs which result in highest justice system costs	MoJ inputs which result in lowest justice system costs
Costs				
Additional workload	Additional workforce times a result of reforms to AMHPs, IMHAs, Approved clinicians, Nurses, Key Workers, Social workers, community clinician, other clinician staff, SOADs Admin teams.	-	+20%	-20%

Community costs and inpatient benefits from changing the detention criteria for people with a learning disability and autistic people	Community costs estimates comprise various elements, including: housing capital costs, housing revenue costs, community care and support package costs for people discharged from inpatient settings and community infrastructure costs. Inpatient benefits relate to the change in inpatient costs arising from fewer people with a learning disability and autistic people being in hospital. In the sensitivity analysis, we have produced high and low costs and benefits figures.	See Annex D.X.	Exact change in costs/benefits varies by area. See Annex D.X for further detail on assumptions made. The Low NPV scenario compares a high-cost scenario, with a low benefits scenario.	Exact change in costs/benefits varies by area. See Annex D.X for further detail on assumptions made. The High NPV scenario compares a low-cost scenario, with a high benefits scenario.

290. Using the scenarios presented above, the impact of varying our key assumptions on the central net present value estimate are summarised in the table below. Process cost savings and monetised benefits depend on the assumed impact of reforms of the number of admissions, detentions, CTOs and tribunals.

Table 34. Impact of varying assumptions on the Net Present Value (NPV) in relation to the central scenario (2024/25 prices, discounted)

Assumption	Scenario	Modelled total NPV	Impact on NPV
Central NPV			
Baseline detentions	Central scenario	-£169m	
	Low scenario	-£240m	-£71m
	High scenario	-£98m	+£72m
Baseline admissions	Central scenario	-£169m	
	Low scenario	-£175m	-£6m
	High scenario	-£137m	+£32m
Policy impact on CTOs	Central scenario	-£169m	
	Low scenario	-£222m	-£53m
	High scenario	-£117m	+£53m
Policy impact on admissions (ACDs)	Central scenario	-£169m	

	Low scenario	-£500m	-£331m
	High scenario	+£200m	+£370m
Additional workload	Central scenario	-£169m	
	Low scenario	-£229m	-£60m
	High scenario	+£49m	+£218m
Uptake of advocacy	Central scenario	-£169m	
	Low scenario	-£207m	-£38m
	High scenario	-£82m	+£87m
MoJ assumptions	Central scenario	-£169m	
	Low scenario	-£235m	-£66m
	High scenario	-£22m	+£147m
Community costs and inpatient benefits relating to people with a learning disability and autistic people	Central scenario	-£169m	
	Low scenario	-£4,001m	-£3,832m
	High scenario	+3,119m	+£3,288m

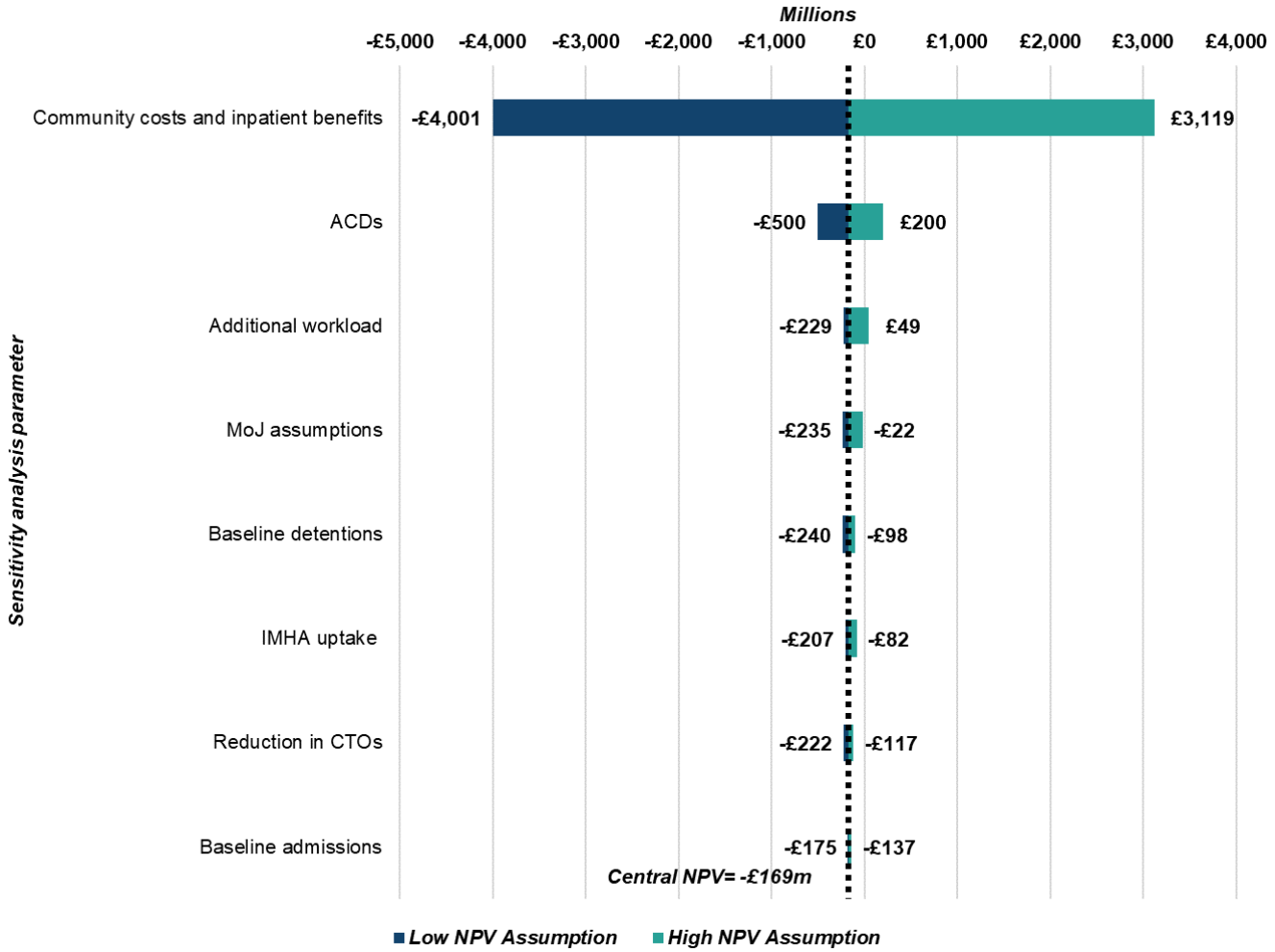


Figure 1. Impact of varying assumptions on the Net Present Value (NPV) in relation to the central scenario for England and Wales (2024/25 prices, discounted)

291. Uncertainty in community costs for people with a learning disability and autistic people has by far the most significant impact on the overall Net Present Value. However, there is also uncertainty related to other assumptions – the below chart excludes variation due to uncertainty in community costs to more clearly demonstrate the relative impacts of other assumptions on the overall Net Present Value.

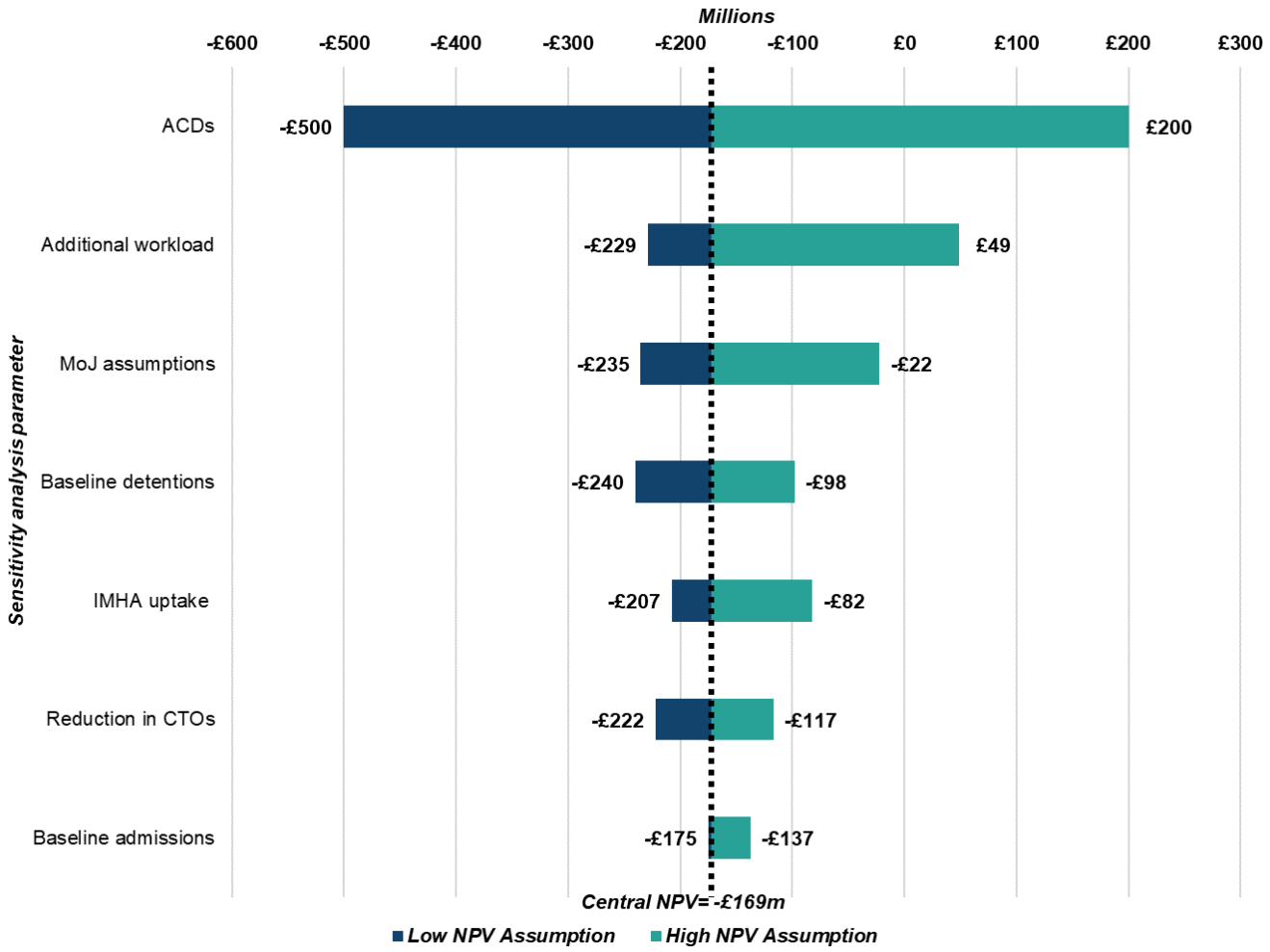


Figure 2. Impact of varying assumptions (excluding those regarding community costs for people with a learning disability and autism) on the Net Present Value (NPV) in relation to the central scenario for England and Wales (2024/25 prices, discounted)

Summary of Sensitivity Analysis

292. Using the estimated high and low costs and benefits described above for the proposed policies, we have combined these to provide low and high estimates of the NPV for both England and Wales.
293. To estimate the overall low NPV, we assume that all inputs are simultaneously set to the low NPV scenario (see Table 35). To estimate the overall high NPV, we assume all inputs are set to the high NPV scenario.
294. The analysis suggests that all the pessimistic assumptions (low costs plus high savings) could cause the total estimated net present value of Option 2 to fall by £4,666m (NPV=-£4,835m). The optimistic assumptions (low savings plus high costs) could cause the NPV to rise by £4,045m (NPV=£3,876m). In all cases, these NPVs do not include benefits for health and experience of the MHA patients.

Table 35. Summary of NPV for England and Wales (£millions, 2024/25 prices, discounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Central	£0	-£4	-£183	-£79	£61	£47	£7	-£1	-£5	-£2
Low	£0	-£7	-£532	-£398	-£191	-£206	-£269	-£280	-£283	-£275
High	£0	-£1	£149	£202	£277	£278	£247	£241	£233	£231

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Central	-£5	£2	-£1	-£0	-£0	-£1	-£1	-£1	-£1	-£1	**-£169**
Low	-£273	-£260	-£256	-£248	-£241	-£235	-£229	-£223	-£217	-£211	**-£4,835**
High	£223	£225	£216	£211	£205	£199	£193	£188	£182	£177	**£3,876**

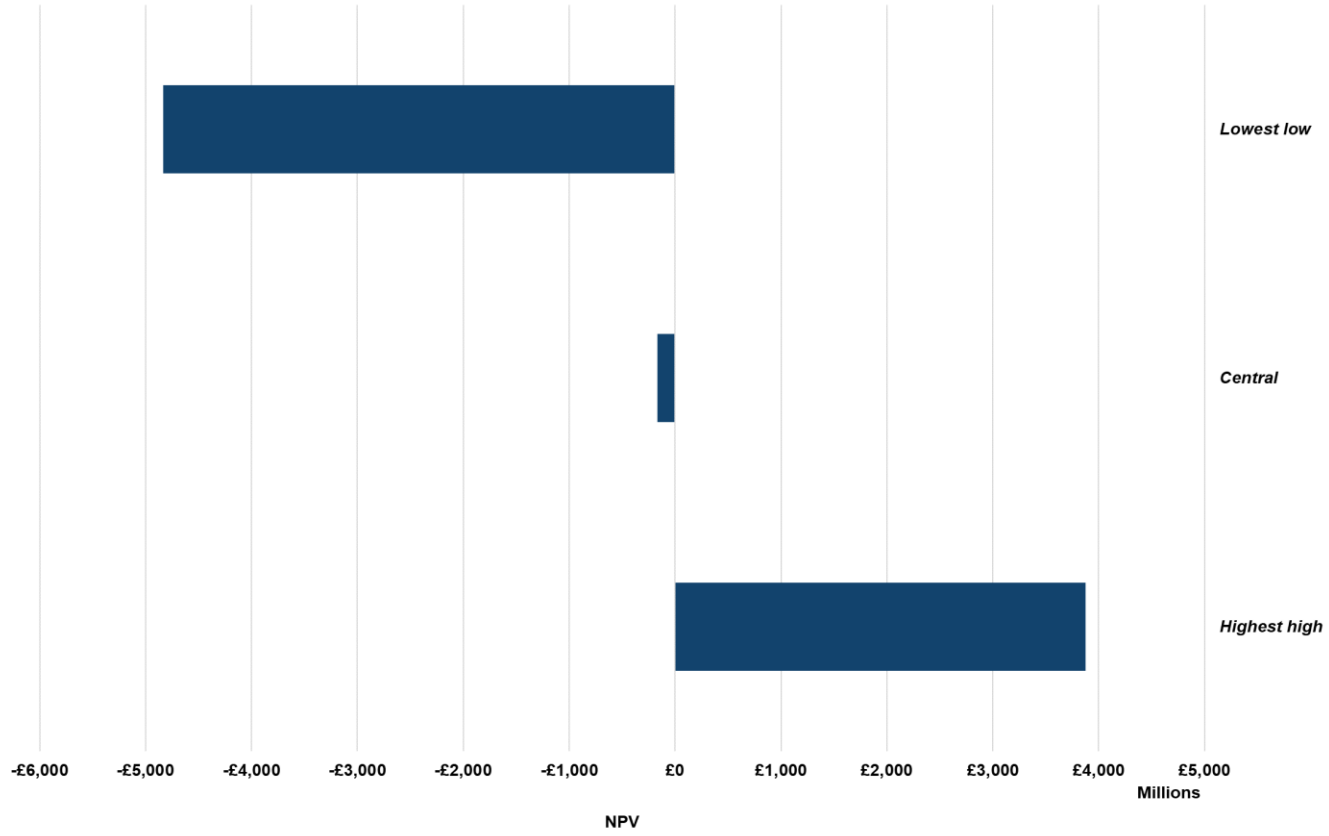


Figure 3. Summary of NPV for England and Wales (£millions, 2024/25 prices, undiscounted)

Summary and Preferred Option

295. Overall, Option 2 is the preferred option as the implementation of the Government proposals is expected to modernise the MHA and make it fit for purpose. In particular, the proposals are expected to bring significant benefits to patients interacting with the MHA through increasing patient choice and autonomy over their treatment, ensuring they are treated with dignity and respect, increasing scrutiny of detention, and promoting equality throughout the process. This also aligns with the general view from the responses to the public consultation[85] which took place in 2021, which overall supports the policy objectives that the reforms aim to achieve.

296. Over the 20-year time horizon, the estimated net benefit is estimated to be -£169 million in 2024/25 prices and in Present Value terms. The summary tables for all monetised costs and benefits have been discounted using a discount rate of 3.5% for all costs (see HM Treasury Green Book[86]).

297. This pertains to additional costs (excluding opportunity costs) estimated at £4,006 million and monetised benefits (excluding health benefits) estimated at £3,836 million, in present value terms for England and Wales. Whilst only a narrow range of cost savings have been monetised in this

[85] Reforming the Mental Health Act - GOV.UK

[86] HM Treasury (2022). The Green Book: appraisal and evaluation in central government. The Green Book: appraisal and evaluation in central government - GOV.UK (www.gov.uk)fisand

IA, the evidence of potential patient benefits of the reforms such as improved patient experience under the MHA and improved health outcomes suggests that there would be likely considerable tangible and intangible benefits associated with the legislation. These benefits are likely to accrue to different groups given differences in patient experience under the MHA. Breakeven analysis indicates that only relatively modest gains may be required to offset the net costs of the reforms. Option 2 is therefore expected to be an overall net benefit when compared to the counterfactual, Option 1.

298. We additionally present below the estimated NPV taking into account opportunity costs to health and social care spending, if provided from existing budgets, as well as the estimated health benefits from diverting admissions estimated using QALYs. These have been provided for England only, as it was not possible to apportion to different public sector bodies in Wales.

Table 36. Summary of discounted costs and benefits of preferred option (£millions, 2024/25 prices and present value)

	Excluding health benefits/opportunity costs			**Including health benefits/opportunity costs**		
	Monetised costs	Monetised benefits	NPSV	Monetised costs	Monetised benefits	NPSV
England	3,681	3,463	-218	15,991	18,945	2,954
Wales	325	373	48	-	-	-
England and Wales	4,006	3,836	-169	-	-	-

Direct costs and benefits to business calculations

299. These reforms may have direct impacts on the private sector, including charities, in three main ways:

a) Some provisions in the Health and Social Care system, both for treatment and the work of non-clinical professional groups responsible for delivering obligations under the MHA, is delivered by private organisations who are contracted to do so by the NHS or local authorities. These reforms are expected to increase the demand for this provision, which is costed in this IA; but, on the basis that this is delivered on behalf of public authorities, such impacts are not defined as direct regulatory business costs under the Better Regulation Framework;

b) A proportion, expected to be small, of treatment that takes place under the MHA or is affected by these reforms' provisions is incurred in private sector establishments and privately funded by or for patients. Costs affecting this treatment is taken here to be within scope of 'regulatory costs' under the Better Regulation Framework;

c) Private legal firms and solicitors will provide representation to patients as part of MHA processes. The legal aid costs of this are included in the costs estimated in this IA, but as explained below, this is also not within scope of regulatory costs under the Better Regulation Framework.

Health and Social Care System

300. This analysis focuses on the direct costs of the reforms to business. For the Health and Social Care system, the main costs are expected to relate to additional process costs for the professional groups supporting the implementation of improved safeguards: AMHPs, IMHAs, and social workers, who are mostly employed by Local Authorities; SOADs, who are employed by the CQC; and clinical teams and administrative staff employed either in the NHS or in the independent sector. That is, clinical staff (see section on costs for clinical teams) and administrative staff costs in health care providers are the main areas where the private sector

could potentially incur costs from changes in the MHA. It is not anticipated that the independent sector will incur any of the other costs of the reforms, such as costs relating to C(E)TRs or DSRs, as these are expected to be paid for by public bodies.

301. To estimate the impact to the independent sector, we use estimates of independent sector market shares for bed provision for private patients, since most of the process costs will be relating to those detained in hospital. Data from the 2023 LaingBuisson Healthcare Market Review report[87] was used to apportion the estimated healthcare costs by the private sector's share in mental healthcare (cost category 'b' above). The acute and secure mental health hospital bed capacity can be split by sector (public or independent sector supply) and by type of funding (public or private funding). In 2022, NHS beds were estimated to account for 67.8% of MH bed provision (public funding/public supply), whilst 29.4% of bed capacity was estimated to be for services outsourced by the NHS to the private sector (public funding/independent supply) and only 2.8% of bed capacity represented privately funded services in independent hospitals[88].

302. We assume a highly unlikely scenario that this same proportion of bed use for detentions is privately funded. We anticipate that informal patients are more likely to self-fund than detained patients, and therefore would expect the proportion of detainees that are self-funded to be lower than 2.8%. This is likely to represent an upper bound estimate for the costs to private sector, but we have taken this cautious approach to account for the fact that some of the reforms (e.g. ACDs) will affect informal admissions, and to compensate for not capturing potential CTOs for private patients in the independent sector.

303. The overall average additional cost of the reforms to clinical and administrative staff in England has been estimated at around £47 million per year over the appraisal period and at around £69 million per year once the reforms are fully implemented (2024/25 prices, undiscounted) for all detained patients, that is, including public and private funding for patients in the public and independent sector. To estimate the costs related to private funding and independent sector supply (cost category 'b' above), we applied the 2.8% market share to this overall cost, which gives an estimate of around £1.2 million per year over the appraisal period, on average.

304. To estimate the equivalent annual net direct cost to business (EANDCB) for assessment under the Better Regulation Framework for comparison against other regulatory provisions, these costs are expressed in 2019/20 prices and present value (as the costs are incurred over financial years), giving an EANDCB estimate of £0.7 million.

305. As discussed in the monetised benefits section, the benefits resulting from a reduction in the number of hospital admissions is unlikely to affect overall demand for hospital beds given significant constraints on bed occupancy and health care resources. There is expected to be additional demand for community and social care services as a result of the reforms, however, these would represent a small indirect benefit for private sector businesses and are therefore excluded from the EANDCB calculations.

Table 37. Estimated additional monetised costs to the private sector (£millions, undiscounted 2024/24 prices & EANDCB) - Central Scenario

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Direct private sector costs	0.0	0.0	0.1	0.1	0.0	0.1	0.6	1.5	1.6	1.6

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total

[87] Laing & Buisson (2023). UK Healthcare Market Review, 34th Ed. London

[88] Changes to regulations relating to the Care Quality Commission: regulatory impact assessment - GOV.UK Table 1

Direct private sector costs	1.8	1.7	1.8	1.8	1.8	1.8	1.8	1.9	1.9	1.9	**23.8**
EANDCB											**0.7**

Justice System

306. Increased MHT activity is expected to increase the demand for legal services delivered by the private sector. However, as legal firms/solicitors are usually paid for this type of work by Legal Aid, this has not been presented as a direct cost to business and this aspect of the reforms do not constitute a regulatory provision within scope of the Small Business, Enterprise and Employment Act 2015[89]. In other words, the private sector impacts for the Justice system are considered not to have direct cost to business.

Impact on small and micro businesses

307. The Bill applies to all organisations providing services required by the application of the MHA. Private sector impacts are expected to be most relevant for independent health and social care providers and advocacy services provided by the business/charity sector. It is expected that small and micro businesses play a more significant role in the latter.

Independent health and social care providers

308. The majority of the costs to business are expected to be incurred by large businesses. We do not expect that there are a significant number of independent healthcare providers affected by the reforms that qualify as small or micro-business. The 2023 LaingBuisson Healthcare Market Review reports the number of mental health private hospitals (2022) and beds (2022)[90]. The top four providers' bed numbers range from around 800 to around 2,500; for a combined bed capacity of 6,865; smaller providers have 3,262 beds in total. There may still be some providers within this group that classify as small or micro businesses, but it has not been possible to estimate how many.

309. Across the adult social care sector in England, approximately 90% of domiciliary care providers and 78% of residential care providers are SMBs[91]. The duties are on public bodies and although there may be small indirect impacts on SMBs, these would not be burdens. Reduced detentions could increase demand for community care which would represent an indirect benefit for private social care providers (benefitting their profitability). There are no direct costs on businesses from the legislation change relating to autistic individuals and individuals with a learning disability including any fixed costs that might have affected SMBs disproportionally. We also do not anticipate these impacts and resulting increased activity having any adverse distributional impact between SMBs or larger providers so expect no impacts on relative market share.

310. Most costs associated with these reforms are likely to be proportionate to patient numbers and, as described above, funded via contracts with the NHS or local authorities. It is possible that one-off transition costs would represent fixed costs that small providers would find harder to absorb under ongoing funding arrangements. Familiarisation costs have been estimated at £19m but, as described in the previous section, most of these costs will be experienced by the public sector, and of the remainder only a small proportion will be in respect of privately funded provision.

[89] http://www.legislation.gov.uk/ukpga/2015/26/section/22/enacted

[90] Laing & Buisson (2023). UK Healthcare Market Review, 34th Ed. London

[91] The size and structure of the adult social care sector and workforce in England, 2022 – Skills for Care

Providers of advocacy services

311. In the absence of readily available information on the size of providers of advocacy services, we held a workshop with providers of advocacy services to collect their views on the impact of the reforms in their organisations. Participants suggested that, consistent with the analysis in this IA, the reforms will bring an increase in demand for advocacy services, but it was hard to predict the precise scale of this demand. However, changes in the MHA were not seen as providing additional burdens (in net financial terms) to the organisations.

312. The size of providers of advocacy services is thought to vary substantially. The smallest will be micro-providers that just provide IMHAs to a small LA. The largest provide IMHA services alongside other types of advocacy to multiple LAs across multiple regions, and the view of participants was that the reforms would not have a differential impact on organisations with different sizes.

313. Most advocacy providers have a multi-advocacy model, i.e. they deliver multiple advocacy services in addition to IMHAs (e.g. Care Act Advocacy, Community Advocacy, Health Complaints Advocacy, Independent Mental Capacity Advocacy (IMCA), Independent Mental Health Advocacy (IMHA) and Self-Advocacy). The way IMHAs services are commissioned and funded by local authorities, and the amount of funding provided, also varies across commissioners – contracts can be for a certain number of hours of advocacy provision (not only Independent Advocacy), or block contracts, and fewer contracts are based on the number of people detained/needs assessment, which providers think is the preferred option. Funding is based on meeting the requirement for statutory advocacy provision, and that for IMHA over other advocacy provision tends not to be ring-fenced in delivery arrangements and providers have to prioritise between the different types of advocacy. This means that, generally, whilst advocacy providers may not face financial risk from varying demand for MHA-related advocacy, effective provision of advocacy depends on whether it is adequately funded by public authorities.

Distributional and Wider impacts

314. The Independent Review of the MHA heard concerns around the disparity of access to, and experience of, mental health services for different disadvantaged groups, including LGBTQ+, ethnic minority communities, people with a learning disability or autistic people, and asylum seekers and refugees. This can influence the likelihood of detention in the first place, given varying access to and success of alternatives, as well as experiences when subject to the Act. Broadly, it is anticipated that improved involvement of patients in treatment decisions (before or after the potential need for detention arises) could improve patient satisfaction and adherence with treatment, and lead to improved health outcomes[9293], in the face of the specific needs for such disadvantaged groups.

315. The following sections provide more detail on distributional implications where data are available on variation in application of the Act for: racial disparities, age and gender, people with a learning disability or autistic people, deprivation, and geographical variation. Statistical comparisons are derived mainly from MHA annual statistics.[94] Due to gaps in coverage of these data, total detention numbers and rates presented will understate the true picture nationally and small differences in figures should be treated with caution, but broad comparisons of relative rates for different groups remain valid[95].

[92] Vahdat, S., Hamzehgardeshi, L., Hessam, S., & Hamzehgardeshi, Z. (2014). Patient involvement in health care decision making: a review. Iranian Red Crescent medical journal, 16(1), e12454. doi:10.5812/ircmj.12454 (also accessed at: https://pubmed.ncbi.nlm.nih.gov/24719703/)

[93] Doyle, C., Lennox, L., & Bell, D. (2012) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013; 3(1). Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549241/

[94] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

[95] Mental Health Act Statistics, Annual Figures: Background Data Quality Report (digital.nhs.uk)

Racial disparities

316. There is a well-established correlation between ethnicity and diagnosis of psychoses such as schizophrenia and major depression, and strong evidence that severe mental health conditions are particularly elevated for people from black ethnic backgrounds[96]. People from South Asian, non-British white and mixed ethnicity groups are also at increased risk[97]. The rapid review of evidence on Ethnic Inequalities in Healthcare, undertaken for the NHS Race and Health Observatory, identified research evidence of barriers among ethnic minority groups to seeking and accessing treatment for common mental disorders, linked to a distrust of health care providers and fear of being discriminated against. Evidence from qualitative research suggests that the lack of appropriate interpreting services acted as a deterrent to seeking help. It also identified large and persisting gaps in access to secondary treatment for severe mental illness as well as worse recovery outcomes. People from black Caribbean, black African and black British backgrounds with severe mental illness experience higher rates of contact with the police and Criminal Justice system (both as victims and as offenders)[98].

317. This context is reflected in ethnic minority groups' experiences under the MHA. In 2023/24[99], all ethnic groups had higher rates of detention per 100,000 population than the White or White British group, similar to previous years. Around two thirds (60%) of detentions were amongst White or White British people, while a quarter (26%) of detentions were amongst ethnic minority people.[100] Those of black African and Caribbean heritage are particularly likely to be subject to compulsory powers under the MHA, whether in hospital or in the community: Black or Black British standardised detention rates (242.3 per 100,000 population) were over three and a half times higher than that of the White British group (68.4 per 100,000 population)[101].

Table 38. Recorded detentions by ethnicity (2023/24).[102]

	2023/24	Standardised rate per 100,000 population
Total Recorded Detentions	52,458	90.9
Total Recorded Detentions (with recorded ethnicity)	45,525	80.7
White	31,735	68.4
Mixed	1,935	177.1
Asian or Asian British	3,993	82.5
Black or Black British	5,693	242.3
Other Ethnic Groups	2,169	129.4

96 For example: Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. - NHS Digital

97 Halvorsrud, K, Nazroo, J, Otis, M, Brown Hajdukova, E & Bhui, K 2019, 'Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses', Social psychiatry and psychiatric epidemiology, vol. 54, no. 11, pp. 1311-1323. (Viewed on 4 February 2022)

98 Kapadia D, and others (2022) 'Ethnic inequalities in healthcare: a rapid review of the evidence', NHS Race and Health Observatory.

99 NHS Digital Mental Health Act Statistics, Annual Figures 2023/24 accessed here: Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

100 NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 1c. 13% of detentions did not have ethnicity information recorded.

101 NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 1c. 'Standardised rate' refers to the number of detentions for each ethnic group adjusted for differing age-gender structures across groups, giving a more like-for-like comparison considering the importance of these demographic factors for detention rates across the whole population.

102 Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

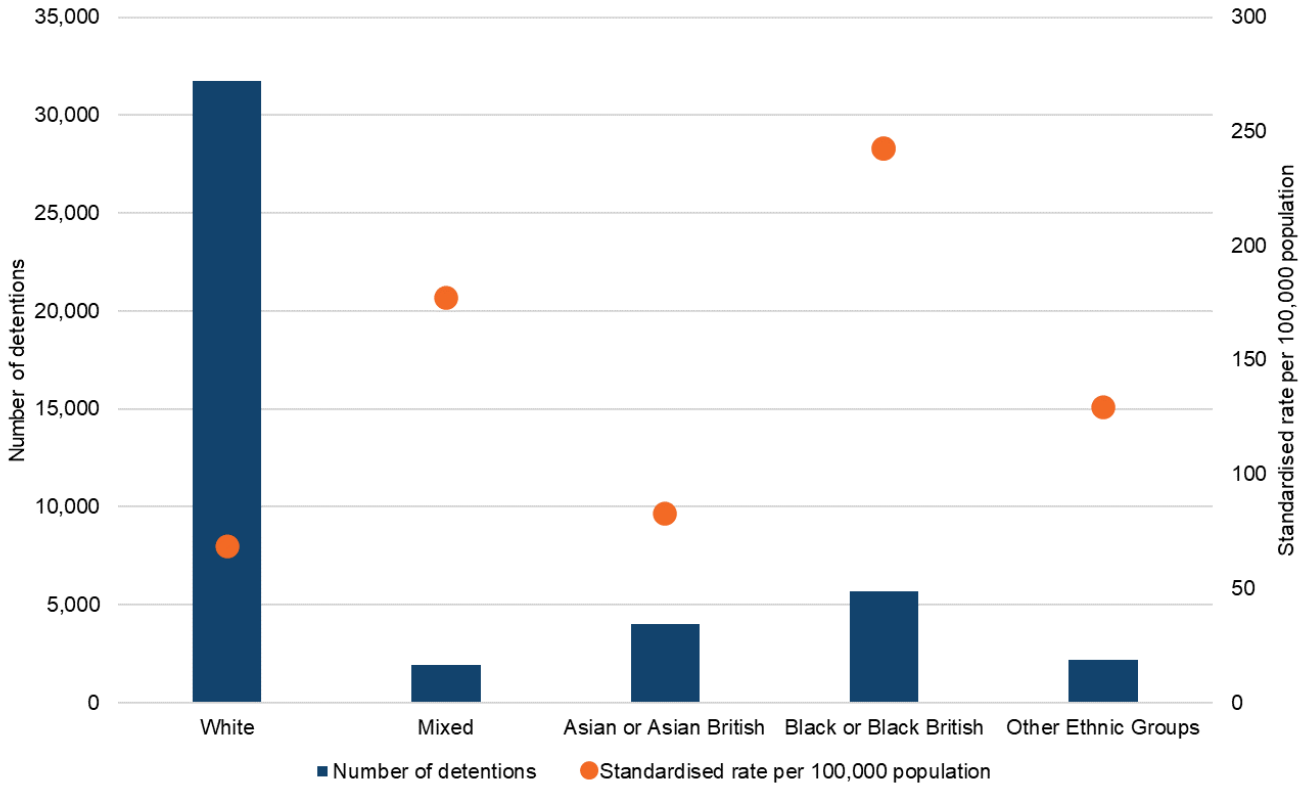


Figure 4 Recorded detentions under the MHA: number and standardised rate, England, by ethnicity, 2023/24.[103]

318. As explained in the benefits section, research findings suggest that involving patients in their treatment decisions could improve patient satisfaction and adherence with treatment, and lead to improved health outcomes. As ethnic minorities are disproportionately likely to be subject to the MHA, it is to be expected that these benefits will disproportionately accrue to these groups if they are affected by the reforms in similar ways to others. The patients statutory care and treatment plan must set out why detention is considered appropriate or why the use of force or compulsory treatment is justified, and it is shared with the patient and others involved in their care. This therefore provides the patient with more opportunities to appeal their detention at the MHT. The CTP is also to be reviewed and scrutinised during the MHT process. The MHT has the power to discharge or recommend changes to the restrictions placed on a patient. Increased transparency and scrutiny of decisions will improve the patients right to challenge and should therefore result in less disparity of treatment across groups by reducing the scope for biases to contribute towards treatment choices.

319. The Review[104] heard that mental health services are often inappropriate for minority groups as they are not equipped to understand their needs, beliefs, backgrounds or culture to be able to provide required care and support. This can prevent people accessing the services they need to prevent crisis and detention. A lack of understanding or even a basic appreciation of different religious and spiritual beliefs can negatively impact an individual's experience of assessment and detention under the MHA.

320. Advanced decision making, increased access to advocacy and care and treatment planning will help to ensure that patients are supported to express their wishes, preferences, beliefs and values and that these are followed as far as possible by the clinical team in charge of their care.

[103] NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 1c.

[104] Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (publishing.service.gov.uk)

321. Further, whilst implementation of the legislation will not be systematically varied across ethnic groups, it is possible that the non-monetised benefits described above will be particularly relevant to and valued by ethnic minorities, because these groups appear to suffer disparities in care once detained and the reforms are specifically designed to provide safeguards against unequal or unfair treatment. Black or black British people have longer periods of detention and more repeated admissions[105], and are also more likely to be subject to police holding powers under the MHA[106]. It is expected that the reforms will help to address the well documented racial disparity in the use of CTOs. The standardised rate of Community Treatment Orders per 100,00 population is 7 times higher for Black or Black British (48.8 per 100,000 population) than for White or White British people (6.9 per 100,000 population)[107]. To some extent this reflects higher overall detention rates, but the number of CTOs as a proportion of overall detention numbers is higher for Mixed (14%), Asian or Asian British (13%), Black or Black British (20%), and Other Ethnicity (13%) people compared with White people (10%)[108].

322. The Independent Review of the MHA asserted that a lack of dignity and trust that patients will be treated fairly inspires fear, discouraging early engagement with services[109]. In response, the reforms intend to strengthen patient voice, make treatment choices more tailored to individual circumstances, and provide safeguards to ensure decisions are made with patient needs and preferences at their heart. It is therefore possible that ethnic minority groups who are assessed and/or detained under the Act will disproportionately benefit from an improvement in treatment and engagement with it before and during detention, although there is a lack of direct evidence on this potential impact.

323. Specifically, studies from the United States and United Kingdom have shown that Advanced Choice Documents may be most effective among service users of black ethnicity compared to those of other ethnic backgrounds. ACDs resulted in black service users being more likely to have an increased sense of autonomy[110] and including them was more likely to be cost-effective for this group[111] compared to those of other ethnic backgrounds.

324. These measures are complemented by specific interventions aimed at reducing ethnic disparities. Whilst not within scope of costs and benefits assessed in this Impact Assessment, for context these are as follows:

- The need to ensure that culturally appropriate advocacy is provided consistently for people of all ethnic backgrounds has been recognised in the Independent Review of the MHA, in particular for individuals of black African and Caribbean descent and heritage. The Government is now piloting improved culturally appropriate advocacy services, so that people from ethnic minority backgrounds can be supported by people who understand their needs.
- The Government has introduced a new Organisational Competency Framework, which will support NHS mental healthcare providers work with their local communities to improve the ways in which patients access and experience treatment. NHS England published its

105 NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 1c, 3c.

106 Monitoring the Mental Health Act in 2020/21 - Care Quality Commission (cqc.org.uk)

107 NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 3c

108 NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 1c, Table 3c. To give CTO: overall detention ratios, crude CTO rates per 100,000 population from Table 3c are divided by crude detention rates (which include CTOs) per 100,000 from Table 1c.

109 Department of Health and Social Care. (December 2018). Modernising the Mental Health Act - Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Accessed at: https://www.gov.uk/government/publications/modernising-the mental-health-act-final-report-from-the-independent-revie

110 Elbogen, Eric & Van Dorn, Richard & Swanson, Jeffrey & Swartz, Marvin & Ferron, Joelle & Wagner, H. & Wilder, Christine. (2007). Effectively implementing psychiatric advance directives to promote self-determination of treatment among people with mental illness. Psychology, public policy, and law : an official law review of the University of Arizona College of Law and the University of Miami School of Law. 13. doi:10.1037/1076-8971.13.4.273.

111 Barrett B, Waheed W, Farrelly S, Birchwood M, Dunn G, Flach C, et al. (2013) Randomised Controlled Trial of Joint Crisis Plans to Reduce Compulsory Treatment for People with Psychosis: Economic Outcomes. PLoS ONE 8(11): e74210. doi:10.1371/journal.pone.0074210

first Advancing Mental Health Equalities Strategy in October 2020[112], aiming to bridge gaps for communities faring worse than others with regards to mental health services and tackle inequalities for Black, Asian, minority ethnic and other minority communities. A core part of the strategy is NHS England's Patient and Carer Race Equality Framework (PCREF) published in October 2023. It is the first ever anti-racism framework which is mandatory for all mental health service providers to embed across England from March 2025 as aligned to NHS Standards Contract 2024/25, ensuring they are responsible for implementing concrete actions to reduce racial inequality within their services. It will become part of CQC's and EHRC's inspection processes and 13 Pilot Trusts have already started to implement targeted changes in areas such as governance, data collection, staff training and community engagement to shift the dial on cultural awareness and ensure transparency.

- The Review identified gaps in the evidence around the use of the MHA and made a number of recommendations on the need for research to inform future policy. In 2020/21, the National Institute for Health Research Policy Research Programme (NIHR PRP), on behalf of DHSC, funded four research projects to explore how to tackle the rising rates of detention and understanding the experiences of people from minority ethnic backgrounds and family and friends of people who have been detained.
- NHS England is working with local mental health systems to embed equality indicators to improve their local data on access, experience and outcomes for Black, Asian and minority ethnic communities. Broadening the data available and improving data quality are intended to advance equalities in mental health – facilitating better performance monitoring, understanding of current disparities and designing appropriate service improvements.

Age and gender

325. Detention rates in 2023/24 were slightly higher for males (91.4 per 100,000 population) than females (83.0 per 100,000).[113] In terms of age, detentions for those under 16 are extremely rare, whilst those aged 16 to 17 also have relatively low rates, at 51.0 per 100,000 in 2023/24. Among adults, detention rates are highest among 18 to 34-year-olds (139.5 per 100,000) and lowest for those 65 and over (83.5 per 100,000). Although detention rates are slightly higher for males than females, in 2023/24, a higher proportion of females were detained more than once (18.7 percent compared to 17.0 percent of males).[114] These reforms are not intended to be applied differently across these groups, but these data suggest that young adults, of both genders, may be expected to be disproportionately affected by the changes.

326. Option 2 will place greater requirements on responsible clinicians to consult with people close to the patient, such as the parent, in relation to care and treatment decisions and their care plan, and with the patient themselves. Option 2 will give greater autonomy to children and young people, where they are well enough and have the capacity/competence to make decisions themselves.

327. Option 2 will allow young people aged 16 or 17, the same right to choose a nominated person (NP) as an adult, where they have relevant capacity to make the decision, within the definition provided by the Mental Capacity Act. Children younger than 16 will also have the right to choose a NP. Similarly, option 2 plans to extend eligibility of Independent Mental Health Advocate (IMHA) services to informal patients, which will positively impact children and young people.

[112] NHS England » Advancing mental health equalities strategy

[113] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital Table 1b.

[114] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital Table 6

328. Physical restraint on inpatient wards disproportionately affects women and girls – there were circa 138,000 physical restrictive interventions for female patients in 2022/23, and circa 73,000 for male patients[115]. This can be re-traumatising for the patient. The Women's Mental Health Taskforce[116] heard that, despite the high incidence of violence and abuse experienced by women, there is little evidence of trauma-informed care approaches, or an understanding of the dynamics of abuse and mental health demonstrated by services. One of the cornerstones of Option 2, proposed by the Review and reflected in the Bill is the principle of least restriction. The Bill seeks to legislate for a package of reforms that aim to improve the culture of inpatient units. Expansion of access to IMHAs, increased weight given to patient's wishes in Advance Choice Documents and Statutory Care and treatment Plans, and the right to choose your Nominated person will collectively ensure that patients have more agency in decisions around their treatment and recovery. Additionally, Option 2, seeks to reduce the number of Community Treatment Orders (CTOs), and to monitor their use going forward given the well-documented issues associated with their use. Whilst this is not aimed at ensuring gender parity in the use of CTOs, this should benefit males as they are almost twice as likely to be placed on a CTO[117].

Table 39. Recorded detentions per age group (2023/24).[117]

	2023/24	**Crude rate per 100,000 population**
Total Recorded Detentions	52,458	90.9
Total Recorded Detentions (with recorded age)	50,434	87.4
15 and under	274	2.6
16 to 17	689	51.0
18 to 34	17,121	135.9
35 to 49	13,101	117.3
50 to 64	10,213	91.6
65 and over	9,036	83.8

Table 40. Recorded detentions by gender (2023/24).[117]

	2023/24	**Crude rate per 100,000 population**
Total Recorded Detentions	52,458	90.9
Total Recorded Detentions (with recorded gender)	50,389	87.3
Male	25,849	91.4
Female	24,407	83.0
Non-Binary	53	-
Other	40	-
Indeterminate	40	-

115 MHB-2223-Reference Tables-England-Inpatients.xlsx Table 17

116 The Women's Mental Health Taskforce report - GOV.UK

117 Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

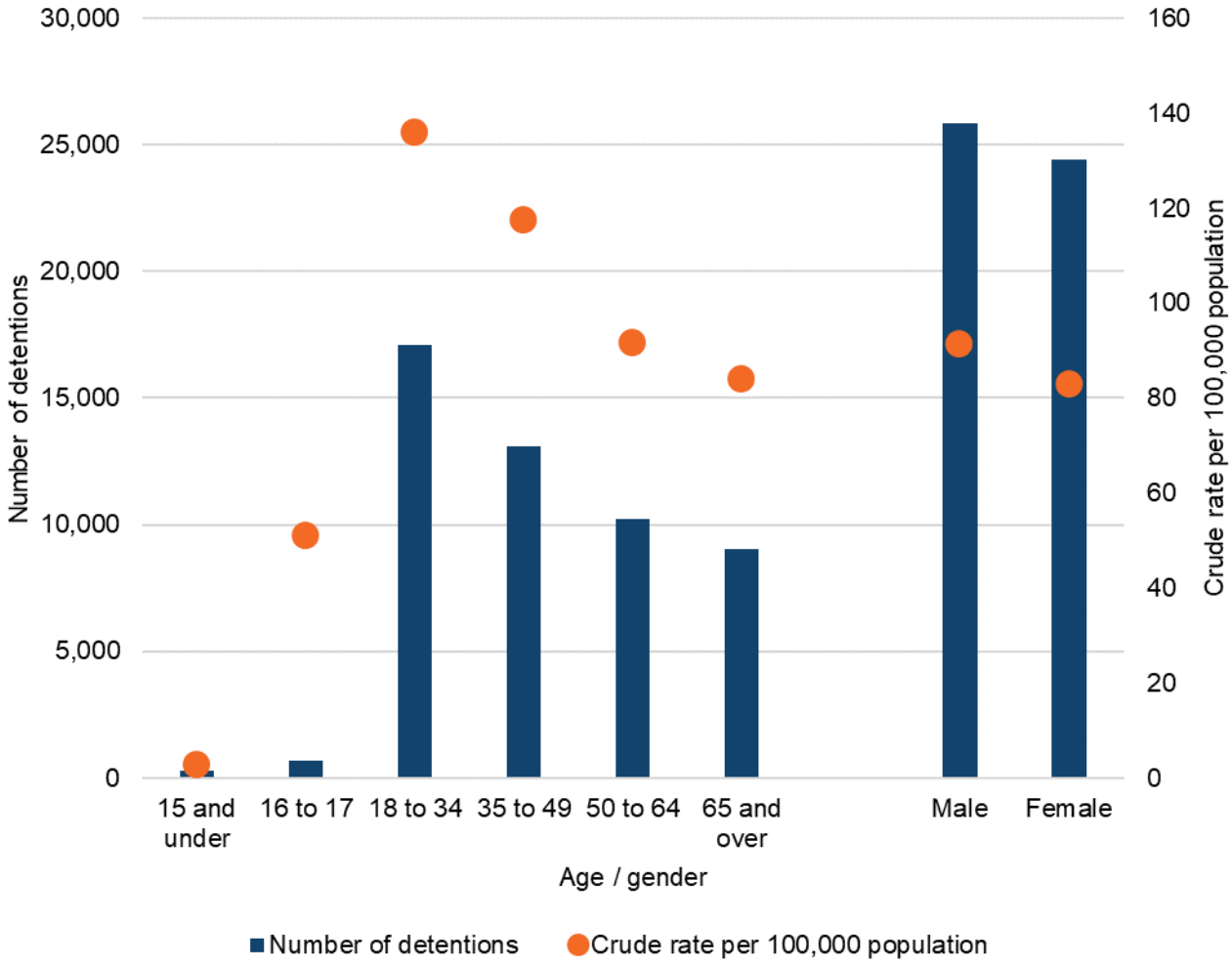


Figure 5 Recorded detentions under the MHA: number and standardised rate, England, by age and gender, 2023/24.[118]

Learning disability and autism

329. The Independent Review of the MHA heard that those with a learning disability or autistic people were at particular risk of not having their specific needs understood or considered in detention and treatment decisions[119]. It also identified that people with a learning disability and autistic people are more likely to be detained within inpatient settings without treatment that provides therapeutic benefit[120].

330. Since the Assuring Transformation data collection started in 2015, data has shown that around 90% of inpatients with a learning disability and autistic inpatients are subject to the MHA. In August 2024, there were 2,015 inpatients with a learning disability and autistic inpatients detained under the Act in England[121]. Comparing this to the wider population of inpatients, in July 2024, there were 16,317 people in mental health hospital services detained under the Act in England[122].

[118] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital Table 1b.

[119] Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (publishing.service.gov.uk)

[120] DHSC. Consultation Outcome Reforming the Mental Health Act. (2021). Accessed at: Reforming the Mental Health Act - GOV.UK (www.gov.uk)

[121] Learning Disability Services Monthly Statistics, AT: August 2024, MHSDS: July 2024 - NHS England Digital

[122] Mental Health Services Monthly Statistics, Performance July 2024 - NHS England Digital

There is evidence that the prevalence of mental health conditions in people with a learning disability and autistic people is higher than in the general population[123][124][125].

331. In addition to measures that aim to strengthen patients' voice and involvement in decisions more generally, the reforms aim to specifically limit the scope to detain people with a learning disability and autistic people under Part II section 3 of the Act where there is not a mental health condition that justifies the application of it. The reforms also place a duty on ICBs to hold registers of people with a learning disability and autistic people who are 'at risk' of admission to hospital. ICBs and local authorities would be under a duty to have regard to this information when exercising their commissioning and market functions and must seek to ensure that the needs of people with a learning disability and autistic people can be met without detaining them under Part II. These reforms are intended to reduce reliance on inpatient services for people with a learning disability and autistic people through development of community-based support.

Religion or belief

332. Measures in Option 2 around advance decision making, the clinical checklist and care and treatment planning are intended to help ensure that patients are supported to express their wishes, preferences, beliefs and values and that these are followed as far as possible by the clinical team in charge of their care.

Deprivation

333. Socio-economic status has a well-established association with wellbeing and mental health126. Research has found that economic disadvantage increases the risk of common mental disorders[127] and severe mental illness[128][129], alike, and that these impacts can be seen from childhood[130]. Data from the NHS Talking Therapies, for anxiety and depression [formerly known as Improving Access to Psychological Therapies initiative (IAPT)][131] shows that people living in the most deprived areas of England are more likely to be referred to NHS Talking Therapies, for anxiety and depression [formerly known as Improving Access to Psychological Therapies initiative services than those from the least deprived areas. However, the data also shows that people from the most deprived populations are less likely to use such services and less likely to have recovered by the end of treatment compared to those living in the least deprived areas. An analysis of mental health service data found similar patterns in 2014[132]. An evidence review commissioned for the Independent Review of the MHA found that those reliant on social benefits were subject to an increased risk of detention[133].

334. These patterns are reflected similarly in comparisons of detention rates under the MHA across areas ranked according to the Index of Multiple Deprivation (IMD)[134], a measure of living

[123] Mencap. Mental health. Accessible here.

[124] NHS England. GP Patient Survey. Accessible here.

[125] NHS England. Health and Care of People with Learning Disabilities. Accessible here.

[126] World Health Organization. (2014). Social determinants of mental health. World Health Organization.

[127] Patel V, Lund C, Hatheril S, Plagerson S, Corrigall J, Funk M, et al. Mental disorders: equity and social determinants. In: Blas E, Kurup AS, editors. Equity, social determinants and public health programmes. Geneva: World Health Organization; 2010.

[128] McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

[129] NHS Digital (16 December 2015). Health Survey for England, 2014. Accessed at: http://content.digital.nhs.uk/catalogue/PUB19295

[130] Gutman and others 'Children of the new century: mental health findings from the Millenium Cohort Study' (2015) Centre for Mental health and UCL. 'Mental health of children and young people in England' (2017) NHS Digital

[131] Office of Health Improvement and Disparities, Public Health profiles, Common Mental Disorders 2022

[132] Delgadillo J, Farnfield A, North A. Social inequalities in the demand, supply and utilisation of psychological treatment. Couns Psychother Res. 2018

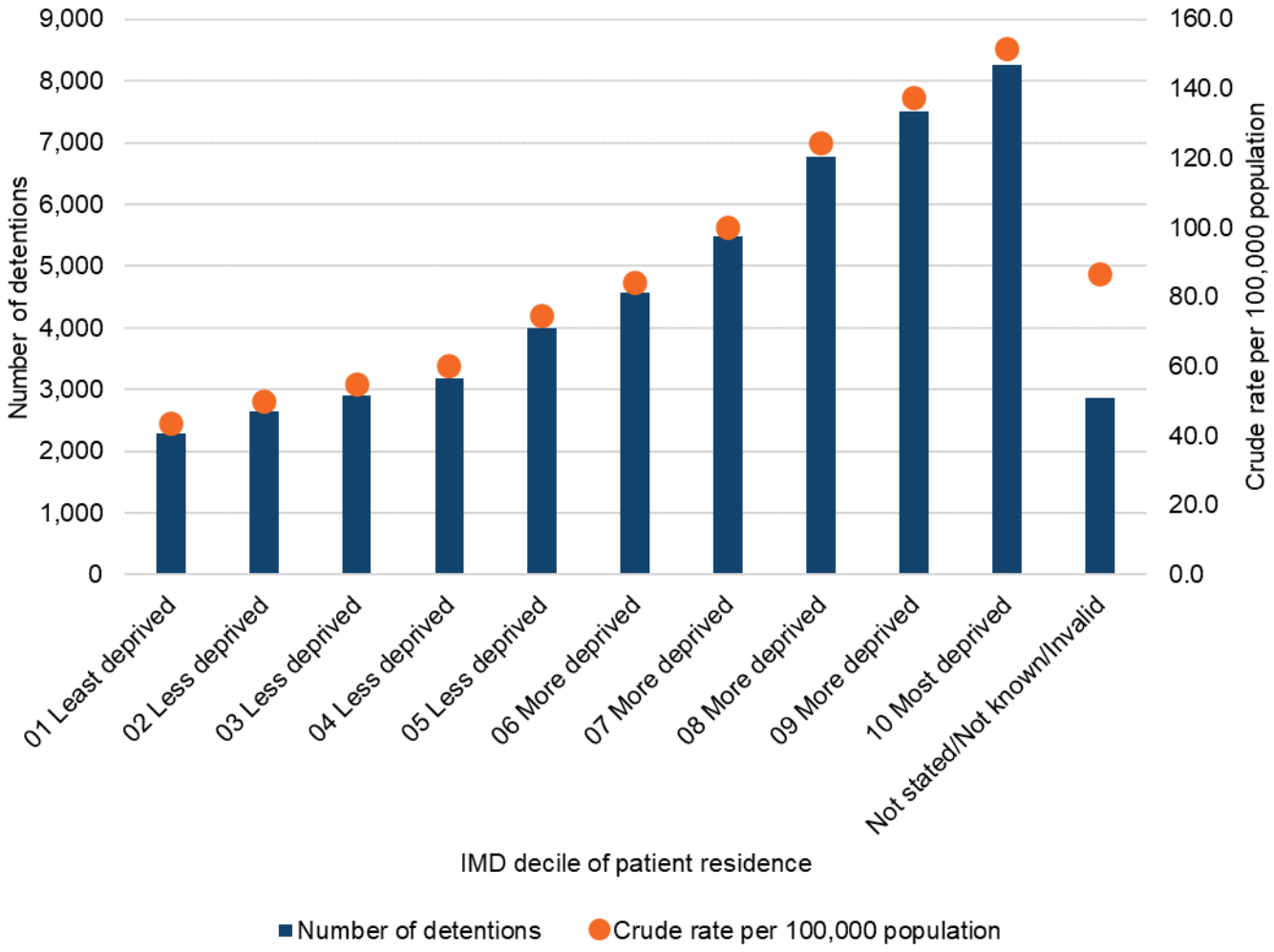
[133] Susan Walker, Euan Mackay,Phoebe Barnett, Luke Sheridan Rains, Monica Leverton,Christian Dalton-Locke, Kylee Trevillion, Brynmor Lloyd Evans, Sonia Johnson (2019), 'Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis', Lancet Psychiatry 2019, 6, 1039–53.

[134] English indices of deprivation 2019 - GOV.UK (www.gov.uk)

conditions for people living in a given area based on indicators of income, employment, health deprivation and disability, education and skills training, crime, barriers to housing and services, and living environment. In 2023/24, detentions in the most deprived areas had the highest rates of detention, three and a half times higher than the rate in the least deprived areas.[135]

Table 41. Recorded detentions by IMD decile (2023/24).[135]

	2023/24	Crude rate per 100,000 population
Total Recorded Detentions	52,458	90.9
Total Recorded Detentions (based on MHSDS)	50,437	88.3
01 Least deprived	2,292	43.4
02 Less deprived	2,637	49.9
03 Less deprived	2,906	54.9
04 Less deprived	3,178	60.0
05 Less deprived	3,993	74.4
06 More deprived	4,564	84.0
07 More deprived	5,477	100.1
08 More deprived	6,775	124.2
09 More deprived	7,499	137.2
10 Most deprived	8,254	151.3
Not stated/Not known/Invalid	2,862	86.7



[135] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital Table 1g.

Figure 6 Recorded detentions under the MHA: number and standardised rate, England, by IMD decile of patient residence, 2023/24.[136]

335. These reforms are not intended to be applied differently across individuals or areas subject to differing socio-economic circumstances, but it is to be expected that economically disadvantaged people, and those living in more deprived areas, will be disproportionately affected by the changes as a result of them being more likely to be at risk of requiring treatment under the Act in the first place.

336. As illustrated in the figure below, showing recorded detention rates in 2023/24, there tends to be significant variation in the number of detentions across England's Integrated care Board (ICB) areas relative to their resident populations. Rates vary year to year in a given area, but, over the last year of recorded data[137], the highest rate of detentions (of 100 or more per 100,000 population) have been seen in the cities of London, Manchester, Birmingham, Nottingham and also on the far north of England (Cumbria). Most ICB's areas showing rates of less than 50 per 100,000 population have been in the southeast and midlands. This is consistent with research suggesting a higher prevalence of severe mental illness in urban areas, although this overlaps significantly with the effects of deprivation[138].

[136] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital Table 1g.

[137] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital, Table 1d.

[138] Lee, S. C., DelPozo-Banos, M., Lloyd, K., Jones, I., Walters, J. T., Owen, M. J., O'Donovan, M. and John, A. (2020), 'Area deprivation, urbanicity, severe mental illness and social drift - A population-based linkage study using routinely collected primary and secondary care data. Schizophrenia research', 220, p. 130–140.

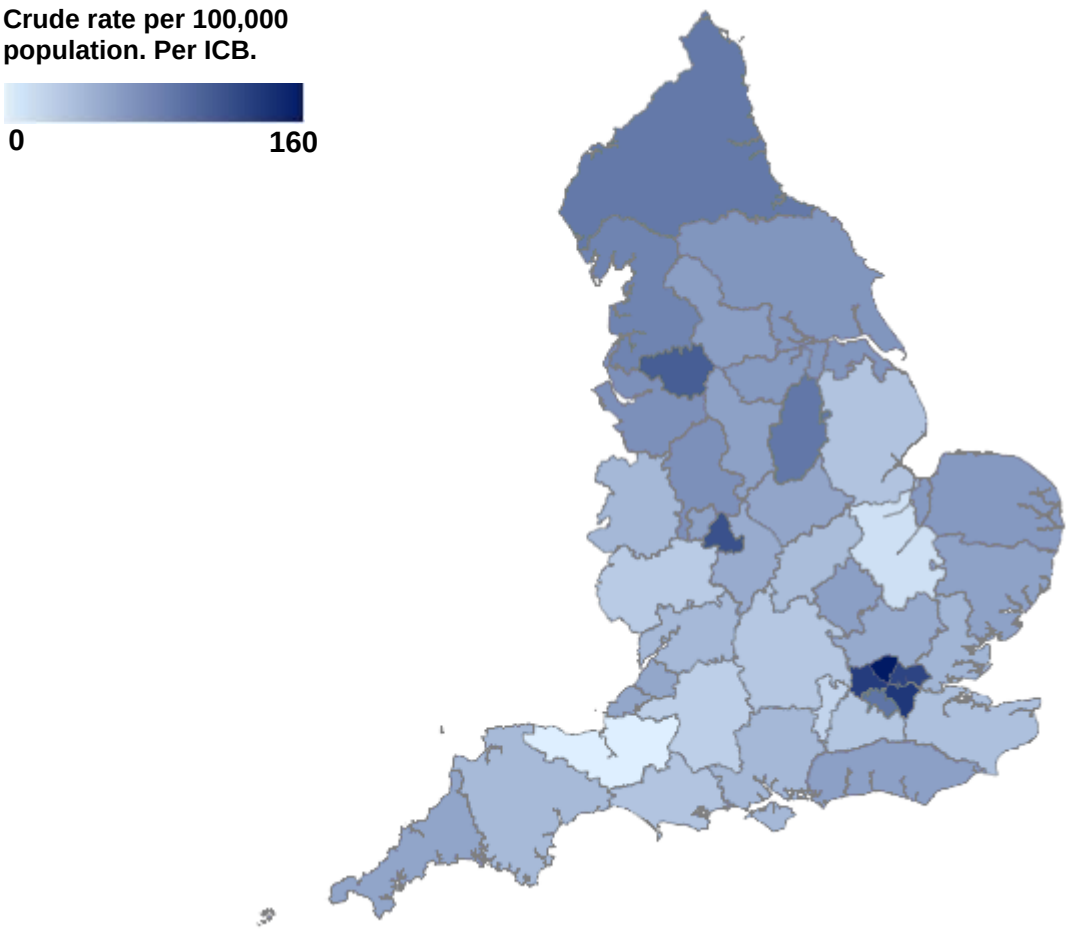


Figure 7 – Geographical variation in rates of detention under the MHA, England 2023/24.[139]

Monitoring and Evaluation

337. We will continue to develop a monitoring and evaluation strategy for the MHA reforms. Additionally, any regulations that are implemented in England using powers created by the Bill will be subject to review after 5 years, in the form of a post implementation review. Wales will consider their own arrangements. The review period for the measures in the Bill will be taken from the point when the reforms are 'switched on' (see Option 2: Implementation section).

338. It is expected that evaluating and monitoring the reforms will need to be a long term, staged exercise given the long period over which different reforms are expected to be sequentially commenced following initial primary legislation. An initial Theory of Change (ToC) is in development with stakeholder engagement to guide evaluation plans. This ToC aims to establish a clear framework illustrating how the MHA reforms are expected to achieve the intended outcomes: reducing the use of restrictive practices, enhancing patient empowerment and autonomy, and promoting equality by addressing disparities. Initial scoping work has identified the importance of evaluating the process of implementing changes, monitoring data relating to processes and outcomes, and understanding patient experiences. These are addressed in the following sections.

[139] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

Evaluation of implementation

339. We aim to understand how in practice the reforms established by legislation are implemented and how far they are likely to achieve the intended outcomes for patients. In most cases, the overall impact on patients and services will be influenced by a range of enabling factors that go beyond the direct impact of changing legislation, for instance:

- How far provision of community mental health and social services enable patients to be diverted from inappropriate hospital care;
- How far inpatient care quality improvements can ensure that Care and Treatment Plans are a means for enhancing therapeutic care;
- Whether workforce development provides the capacity to accommodate additional requirements in a way that improves health outcomes.

340. Understanding whether reforms are being implemented as intended, the role of these wider enablers, and the barriers to implementation, may require short term monitoring of process data (see below) and qualitative research with the wide range of organisations involved in service delivery, including: NHS mental health and other services, the CQC, social care and AMHP services, advocacy providers, the courts system, and housing providers. Specific qualitative methodologies may involve conducting interviews and focus groups with a range of stakeholders, as previously identified, to explore their experiences of the implementation of the reforms and to identify any barriers or successes they have encountered. Given the potential timeline for implementation, this may require a range of flexible evaluation activities that would contribute to a broader body of work, ensuring that the spirit, objectives, and cultural shifts of the reforms are fully considered.

Monitoring outcome and process data

341. The reforms would introduce several new processes to patient care pathways, and it may be valuable to track the frequency of their occurrence, ideally at patient level, to help assess whether reforms are being delivered as intended and uptake among patients. It will be important to assess whether new safeguards and support mechanisms are being equitably accessed, considering race, disabilities, age, gender and socioeconomic factors. This includes:

- Whether people have statutory (or current equivalent) Care and Treatment Plans and how frequently they are updated;
- Whether patients have an Advanced Choice Document (or current equivalent), and what sorts of preferences are recorded;
- Information about nominated persons or nearest relatives defined for patients;
- Use of advocacy (among both informal and formal patients);

342. For such cases, we will assess the extent to which existing data collections can be augmented to collect new information. Relevant here is the Mental Health Services Dataset (MHSDS)[140], which makes use of provider submissions of patient-level data for patients who are in contact with a wide range of mental health services, and the Assuring Transformation dataset holds information about people with a learning disability and autistic people who are receiving treatment or care as inpatients in a mental health hospital[141]. For this group of people, there are various metrics in the Adult Social Care Outcomes Framework that can provide general insight into aspects of quality of life, independence, safety, and continuity and quality of care. These aggregate metrics could be supported by qualitative studies for people discharged. The CQC carry out a range of monitoring activities, including but not limited to their inspections programme,

[140] Mental Health Services Data Set (MHSDS) - NHS England Digital

[141] Assuring Transformation (AT) - NHS England Digital

and produce an annual 'Monitoring the Mental Health Act' report which includes data on mental health tribunal activity, the work of the SOAD service, and thematic reviews of patient care[142]. The Ministry of Justice publish data on tribunals, other relevant courts activity in the for mental health provision, and statistics on police use of s135 and s136 of the MHA. These sources will be valuable for assisting in the evaluation of the delivery of the reforms. As the MHA is introduced, we will proactively seek new opportunities for additional monitoring data to enhance the metrics captured for this evaluation.

343. There are other cases where achieving the aims of the policy, or unintended consequences, may be reflected in data already collected by the sources listed above, for instance: changes in numbers of detentions and CTOs for patients of different characteristics, tribunal receipts and hearings, lengths of admission, use of restrictive interventions, provision of second opinions through the SOAD service, approvals for treatment, uses of the Mental Capacity Act and Court of Protection Activity. It will be important to isolate the specific impacts of reforms in context of wider drivers of outcomes including population prevalence of mental health conditions, capacity of community and inpatient services, and developments in clinical practice.

Evaluating impacts on patient and carer experience

344. Central to the aims of the reforms are the experiences of patients, their carers, and associated health outcomes. In many cases success of the policies will involve people still being detained but experiencing more tailored care with their dignity and wishes respected, and having their interests protected by visible safeguards. These features of care are unlikely to show up in administrative datasets and can be difficult to establish given the specific challenges for mental health patients in engaging with research and data collections. Given national roll-out of changes, to robustly evaluate impacts on these things it may be necessary to establish some baseline information drawing on the perspectives of patients and carers before reforms are implemented.

345. In light of this, DHSC commissioned a research study to explore the feasibility of capturing patient experience for evaluative purposes.[143] This outlined options and recommendations for how to obtain relevant insights, drawing on consultation with expert stakeholders, including through two online workshops: one for people with service user and carer lived experience; and one for a range of stakeholders, including people with academic, practice and lived experience expertise. The findings and recommendations include:

- feedback surveys should be brief to maximise inclusivity and response rate;
- questions should be phrased simply and clearly to maximise inclusivity;
- the suggested "most important" topics include overall questions about care and questions about specific aspects of treatment and care relevant to proposed MHA changes;
- a structured survey can only provide limited information about service users' and carers' experience. Including a free text response space within the survey and additional qualitative research are desirable;
- recommend an annual "national census", seeking data from all provider services from people currently detained, at discharge, and recently discharged over a defined, limited time period;
- people need to be assured that data collection is confidential;

[142] CQC (2024), 'Monitoring the Mental Health Act'. Monitoring the Mental Health Act - Care Quality Commission (cqc.org.uk)

[143] Lloyd-Evans, B., Ahmed, N., Bartl, G., Cooper, R. E., Grundy, A., Jeynes, T., Loizou, S., Nicholls, V., Nyikavaranda, P., Persaud, K., Olive, R. R., Saunders, K. R. K., Sheridan Rains, L., Stuart, R., Foye, U., Simpson, A., & Johnson, S. (2023). 'How to measure service users' and carers' experience of the Mental Health Act: Final Report - June 2023'. Mental Health Policy Research Unit. https://doi.org/10.13140/RG.2.2.30311.21924

- a range of ways to give feedback should be offered, including digital and paper options; and
- transparency about the findings from the survey and how the data will be used is essential to build trust and service users' and carers' engagement with the survey.

346. The findings of the study will inform evaluation planning. That will also take into account NHS England's developing approach to patient-reported experience measurement[144] and CQC's inspection framework[145], both of which may provide helpful sources of patient and carer insight.

347. In addition to enhancing patient experience and autonomy, a key aim of the reforms is to reduce inequalities in the application of the MHA, particularly by addressing racial disparities and the disproportionate detention of individuals with a learning disability and autistic people. We are exploring options for evaluating the impact of the reforms on these outcomes and may adopt a mixed-methods approach. This could include quantitative methods, such as collecting and comparing data on detention rates, service usage and health outcomes for ethnic minorities, as well as individuals with a learning disability and autistic people, both before and after the implementation of the Act. Qualitative elements may involve conducting interviews and focus groups to gather personal experiences and perceptions of care. Additionally, there may be the opportunity to engage with community organisations representing ethnic minorities and advocacy groups for individuals with a learning disability and autistic people to gain insights into the impact of the Act and to inform the evaluation process.

[144] NHS England » Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme

[145] The importance of people's experience - Care Quality Commission (cqc.org.uk)

Annex

Annex A. List of acronyms

ACD – Advance Choice Document

ADASS – Association of Directors of Adult Social Services

AMHPs – Approved Mental Health Professionals

AT - Assuring Transformation

AWE - Average Weekly Earnings

BAU – Business as Usual

BIT – Business impact test

CTR – Care and Treatment Review

C(E)TR – Care (Education) and Treatment Reviews

CO2 – Carbon dioxide

CPD – Continuous Personal Development

CQC – Care Quality Commission

CRHTT - Crisis Resolution and Home Treatment Teams

CTO – Community Treatment Order

CTPs – Care and Treatment Plans

CYP – Children and young people

DHSC – Department of Health and Social Care

DSR – Dynamic Support Registers

DWP – Department of Work and Pensions

ECT – Electro-Convulsive Therapy

FTE – Full-Time Equivalent

GDP – Gross Domestic Product

HMCTS – Her Majesty's Courts and Tribunals Service

HMPPS – Her Majesty's Prison and Probation Service

H&SC – Health and Social care

IA – Impact Assessment

IMHAs – Independent Mental Health Advocates

ICB – Integrated Care Board

IRCs – Immigration Removal Centres

LA – Local Authority

LAA - Legal Aid Agency

LDA - People with a learning disability or autistic people

LGA – Local Government Association

LGBTQ+ - Lesbian, gay, bisexual, transgender, and questioning (or queer).

MHA - Mental Health Act 1983

MHCS – Mental Health Casework Section

MHRTW – Mental Health Review Tribunal for Wales

MHSDS – Mental Health Services Data Set, NHS Digital

MHT – Mental Health Tribunal

MoJ – Ministry of Justice

NHS – National Health Service

NHS LTP – NHS Long Term Plan

NHSE – NHS England

NIHR PRP – National Institute for Health Research Policy Research Programme

NP – Nominated Person

NPV – Net Present Value

OECD - Organisation for Economic Co-operation and Development

ONS – Office of National Statistics

OT – Occupational therapist

PCREF - Patient and Carer Race Equality Framework

PLS – Pre legislative scrutiny

PV – Present Value

QALY – Quality adjusted life year

QI – Quality Improvement

RC – Responsible Clinician

RPC - Regulatory Policy Committee

SCMH - Sainsbury Centre for Mental Health

SMB's – Small or medium business

SMI - Severe Mental Illness

SOADs – Second Opinion Appointed Doctors

ToC – Theory of Change

VAT – Value added tax

VCSE - Voluntary, Community and Social Enterprise

WELLBY - Wellbeing-adjusted Life Year

Annex B. Methodological summaries of forecasts used in baselines

B.I. Forecasting the baseline number of detentions and admissions under the Mental Health Act and estimating their average cost

Background and proposed policy change

1. The number of detentions forecast under the MHA reforms is required to inform estimates of the Health and Social Care workforce requirements for the additional recommended safeguards and the volume of MHT activity.
2. How detentions could change in the future is included in Option 1, which pertains to the status-quo with no new national policies implemented. The number of detentions under the MHA anticipated in future years will directly affect the additional costs and potential savings estimates of implementing the policy under Option 2.

3. The number of admissions was also forecast to estimate the number of informal patients and ACDs written.

4. The BAU approach assumes that both detentions and admissions under the MHA would increase in line with weighted age demographic changes, assuming current detention and admission rates among different age groups remain the same.

Detentions

Main assumptions for Option 1 (BAU)

5. Since 2016/17, the number of detentions has fluctuated, with data showing that the number of detentions increasing up to 2020/21, then decreasing for the next two years, before increasing again in 2023/24.

Table B.1. Estimated detention increases

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Estimated Detention Increases (compared to previous year)	2.4%	2.0%	0.8%	4.5%	-5.7%	-7.7%	2.5%

6. Note that there are known limitations in the data quality for the number of detentions recorded under the Mental Health Act, with not all providers submitting data, and some submitting incomplete data. Hence, the above annual percentage changes are based on submissions from a subset of providers which have consistently submitted good quality detentions data in each of the last eight years.

7. The initial annual detentions are estimated at 52,458 detentions, based on 2023/24 MHSDS data.

8. Due to the uncertainty in trends in detention numbers, it is assumed that in the central scenario, current detention rates among each age-group will stay constant at the level observed in the most recent data for 2023/24. Accordingly, the overall number of detentions would grow in line with weighted demographic changes.

Table B.242. Recorded detentions per age group (2023/24)[146]

	2023/24	Crude rate per 100,000 population
Total Recorded Detentions	52,458	90.9
Total Recorded Detentions (with recorded age)	50,434	87.4
15 and under	274	2.6
16 to 17	689	51.0
18 to 34	17,121	135.9
35 to 49	13,101	117.3
50 to 64	10,213	91.6
65 and over	9,036	83.8

9. Low and high projections have also been produced to reflect the uncertainty in trends in detention numbers.

10. For the low projection, it is assumed that detentions continue to follow the overall average growth rate observed from 2016/17 to 2023/24 – this considers the significant decreases in the number of detentions observed in 2021/22 and 2022/23. Over this 7-year period, the number of detentions

[146] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

decreased by an average of 0.27% per year – adjusting for population growth over this period (average growth rate of 0.61% per year), this represents a 'real-terms' growth rate of –0.87% per year. This population adjusted growth rate is combined with projected population changes to project forward the annual number of detentions for the next 10 years (up until 2033/34)

11. For the high projection, it is assumed that detentions follow the average pre-pandemic growth rate observed between 2016/17 and 2019/20. In this period, the number of detentions increased by an average of 1.73% per year – adjusting for population growth (average growth rate of 0.56% per year), this represents a 'real-terms' growth rate of 1.16% per year. This population adjusted growth rate is combined with projected population changes to project forward the annual number of detentions for the next 10 years (up until 2033/34)

12. For both the low and high scenarios, it is assumed that from 2033/34 onwards (that is, for the last 10 years of the 20-year appraisal period), detentions will grow in line with weighted demographic changes (no 'real-terms' average growth rate is applied). This is due to the length of the appraisal period used and the difficulty in accurately forecasting detentions so far into the future.

Main assumptions for Option 2 (Policy on)

13. A reduction in the forecasted number of detentions is expected under the policy option due to changes to detention criteria for people with a learning disability and autistic people - we subtract the estimated number of reduced detentions in each year.

14. A further reduction in the forecasted number of detentions is also expected under the policy option due to the preventative effect of Advance Choice Documents (ACDs) – we subtract the estimated number of reduced detentions following ACDs in each year (see Annex B.VII for detail).

Admissions

Main assumptions for Option 2 (Policy on)

15. Since 2016/17, the number of admissions has also fluctuated, with data showing that the number of admissions increasing up to 2019/20, then decreased significantly in 2020/21 and 2022/23 (admissions remained fairly stable in 2023/24)

Table B.3. Admissions to a mental health hospital over time

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Admissions	119,504	121,259	123,059	123,632	110,420	109,900	102,366	102,738

16. The initial annual number of admissions is estimated at 102,738 admissions, based on 2023/24 MHSDS data[147].

17. As with detentions, due to the uncertainty in trends in admission numbers, it is assumed that in the central scenario, current admission rates among each age-group will stay constant at the level observed in the most recent data for 2023/24. Accordingly, the overall number of admissions would grow in line with weighted demographic changes.

18. Low and high projections have also been produced to reflect the uncertainty in trends in admission numbers.

19. For the low projection, it is assumed that admissions continue to follow the overall average growth rate observed from 2016/17 to 2023/24 – this takes into account the significant decreases in the number of

[147] Mental Health Bulletin, 2023-24 Annual report - NHS England Digital

admissions observed after 2019/20. Over this 8-year period, the number of admissions decreased by an average of 2.14% per year – adjusting for population growth over this period (average growth rate of 0.61% per year), this represents a 'real-terms' growth rate of –2.73% per year. This population adjusted growth rate is combined with projected population changes to project forward the annual number of admissions up until 2033/34.

20. For the high projection, it is assumed that admissions follow the average pre-pandemic growth rate observed between 2016/17 and 2019/20. In this period, the number of admissions increased by an average of 1.14% per year – adjusting for population growth (average growth rate of 0.56% per year), this represents a 'real-terms' growth rate of 0.57% per year. This population adjusted growth rate is combined with projected population changes to project forward the annual number of admissions for the next 10 years (up until 2033/34)

21. For both the low and high scenarios, it is assumed that from 2033/34 onwards (that is, for the last 10 years of the 20-year appraisal period), admissions will grow in line with weighted demographic changes (no 'real-terms' average growth rate is applied). This is due to the length of the appraisal period used and the difficulty in accurately forecasting admissions so far into the future.

22. The number of informal admissions in each given year, used later in the analysis, are calculated by subtracting the number of detentions from the total number of admissions.

Main assumptions for Option 2 (Policy on)

23. A reduction in the forecasted number of overall admissions is expected under the policy option due to the preventative effect of Advance Choice Documents (ACDs). A fall in overall assumed based on research evidence which finds that ACDs reduce detentions (and increases informal admissions). The number of detentions is forecast to reduce due to some people holding an ACD. This is based on research evidence which found a reduction in detentions. We subtract the estimated number of reduced admissions following ACDs in each year from baseline admissions figures (see Annex C.III for detail).

B. II. Estimating the number of Community Treatment Orders (CTOs)

Main Assumptions for BAU

24. Since 2016/17, the number of CTOs has fluctuated with latest data showing there were 5,618 CTOs issued in 2023/24. This is 10.71% as a proportion of total detentions in 2023/24.

25. To estimate the number of CTOs in future years, we have calculated the number of CTOs as a portion of total detentions for each year from 2017/18 to 2023/24. The average of this figure has been applied to the future detention forecast described in Annex B.I. Data before this period was not used due to data quality issues and data comparability between the MHSDS data and KP90.

Main Assumptions for Option 2 (Policy on)

26. Under Option 2, we have assumed that, after 5 years of gradual implementation of the change in criteria for CTOs in the MHA reforms, CTOs will decrease by a central estimate of 20%.

27. A low and high scenario of 0% and 40% has also been modelled in the sensitivity analysis given the uncertainty and lack of research evidence associated with this policy change.

28. This reduction will have process cost savings for staff requirements and workload which are described in Annex B. II.

Annex C. Methodological summaries of methods used in estimating costs and benefits of individual policy changes concerning the Health and Social Care System

C.I. Estimating the impact of changes to Community Treatment Orders (CTOs)

Background and proposed policy change

1. The Government proposes reforms to introduce greater scrutiny to CTOs and amend the CTO criteria in line with the new detention criteria are expected to have the effect of reducing CTOs by ensuring they are used in a more targeted way. They should only be used where there is a risk of serious harm self or others and where the community clinician agrees that it is necessary and appropriate for the patient. Earlier automatic referrals to the tribunal should also see people discharge from CTOs sooner. However, it is possible that clinicians may be more risk averse in the public protection context and therefore more inclined to issue a CTO, which may negate the degree to which use of CTO decreases overtime with our changes.

2. The additional costs and process cost savings consist of two opposing parts resulting from this policy change:
    - Additional workload: the Government proposes to introduce greater scrutiny and ensure that a CTO is only used when appropriate. Therefore, more professionals are required to be involved at critical decision points and additional responsibilities are needed. This will have additional costs to BAU.
    - Reduction in CTOs: the use of CTOs is expected to reduce following the changes in the CTO criteria. This will have cost savings compared to the BAU.
3. The professional groups affected are:
    - Clinicians
    - Community Supervising Clinicians
    - AMHPs
    - IMHAs

Main assumptions for Option 1 (BAU)

4. BAU assumes that for each CTO, an assessment and two renewals occur on average (at six and twelve months).

5. For assessment and renewals, a Clinician must be present at each decision point. A Community Supervising Clinician is assumed to only be present 50% of the time.

6. It is assumed that for each decision point, 3 hours on average is required by both Clinician and Community Supervising Clinician.

7. AMHPs are also required at each decision point where it is assumed that 12 hours on average is required by the AMHP at each point. Average travel time per decision point is assumed to be 1.4 hours (so 4.2 hours for three decision points). This was agreed after consulting with stakeholders.

8. It is assumed that for 50% of CTOs, an IMHA will be present at assessment. An average of 12 hours was agreed in terms of BAU workload.

Main assumptions for Option 2 (Policy On)

9. For IMHAs, Clinicians and AMHPs the workload remains the same as BAU.

10. The Community Supervising Clinician will be expected to attend every decision point for 100% of CTOs.

11. Under Option 2, the reforms aim to introduce greater scrutiny of CTOs and amend the CTO criteria in line with changes to detention criteria. This is expected to reduce the use of CTOs relative to the Business as Usual.

12. The central scenario assumes a 20% reduction in CTO's over our appraisal period due to the impact of the reforms. This assumption has been made more conservative since the IA produced for the draft Bill, to account for possible adjustment to behaviour changes in light of a focus on public protection. While CTOs are still expected to fall, we would expect that clinicians may be more focused on using CTOs appropriately.

13. This policy is expected to start for DHSC in 2031/32, and the impact on CTO volumes is expected to occur gradually, with a 4-percentage point reduction each year until it reaches a total 20% reduction in CTOs in 2035/36.

Output

14. This workload is then divided by the average number of working hours per year (accounting for holidays, sickness and training) to determine the additional number of FTE IMHAs, AMHPs and Clinicians required.

15. The additional FTE is then multiplied by the staff costs for each professional group (salary, oncosts and overheads). The additional FTE is also multiplied by the cost to train new staff. For AMHPs & IMHAs, costs to train new staff are assumed to be incurred in the same year they are recruited as training courses tend to be short (less than a year) and less expensive than clinicians' training.

16. In Option 2, the policy requires additional workload for the Community Supervising Clinician per CTO. However, there are fewer CTOs than the BAU which results in overall cost savings for the policy change. This is worked out by subtracting Option 1 (BAU) from Option 2.

C.II. Estimating the impact of Nominated Persons

Background and proposed policy change

1. The Government proposes that the patient should be free to choose their own 'Nominated Person', a role which will have increased powers under the reforms. This modernises the existing arrangement under which a family member is automatically appointed 'Nearest Relative' under the Act.

2. Under the new proposals, a detainee can choose and change their Nominated Person multiple times. There will also be additional duties for other staff groups in association with NP policy.

3. This policy groups affected are:
    - AMHPs
    - NHS administrative staff
    - Nurses

Main assumptions for Option 1 (BAU)

4. BAU assumes that for each detention, a Nearest Relative is automatically appointed once.

5. This involves time spent updating a patients record and providing information to the Nearest Relative for administrative staff. This was assumed to take 0.4 hours which was discussed with stakeholders.

Main assumptions for Option 2 (Policy On)

6. Since the detainee can choose their Nominated Person multiple times during each detention, it has been assumed that on average a Nominated Person will be changed 2.25 times per detention. This will involve the same time spent updating patient records and providing information to the Nominated by the administrative staff.
7. Under Option 2, an additional meeting with the patient, AMHP and Nominated Person is required before a CTO can be finalised. This is estimated to last two hours.
8. Under Option 2, it is expected that the Nominated Person will be consulted on the Care and Treatment Plan (CTP) where the patient is unable to or does not wish to engage with the plan. This is estimated to create one hour of additional workload for the nurse involved in liaising with the CTP.

Output

9. This additional workload by the administrative staff due to more frequent changes of the Nominated Person is then divided by the average number of working hours per year (accounting for holidays, sickness and training) of administrative staff to determine the additional number of FTE required.
10. The additional FTE is then multiplied by the administrative staff costs (salary, oncosts, and overheads). The additional FTE is also multiplied by the cost to train new administrative staff.
11. Similarly to administrative staff, the time for the additional meeting between the AMHP and Nominated Person for CTO is divided by average number of working hours per year by the AMHP to determine the number of FTE required which is then multiplied by AMHP staff costs.
12. In Option 2, more administrative staff, nurses and AMHPs are required and so the additional monetised costs are worked out by subtracting Option 1 (BAU) from Option 2.

C.III. Estimating the costs of production of Advanced Choice Documents (ACDs) and their impacts on admissions

Background and proposed policy change

1. Under the Bill patients have greater opportunity to inform clinical decision making through measures such as a personal Advance Choice Document (ACD). Mental health service users can record their wishes, feelings, beliefs, and values, including advance decisions to refuse specific medication in their ACD, such that these can inform clinical decision making when they are too unwell to express these things at the time.

2. Commissioning bodies will be under a duty to make arrangements so that people who are at risk of detention are informed of their ability to make an ACD and that those who wish to receive professional support to write an ACD, receive it.

Main assumptions for Option 1 (BAU)

3. Anyone is currently able to draft an ACD.

4. There may be a small number of people with ACDs, or equivalents, but in absence of available data it is assumed that there is uptake of 0%.

Main assumptions for Option 2 – ACD production, review and impact on admission

5. Anyone is able to draft an ACD but, for modelling purposes, people that are expected to be signposted and supported to draft an ACD by the duty are people at known risk of detention under the Mental Health Act, taken to be previously admitted patients (informal and formal detainees) who have been recently discharged from a mental health hospital, using baseline admissions and detentions scenarios (which include Part III detentions). The number of associated discharges is taken to be equivalent to 98% of the number of admissions in each year of the BAU projections.[148]

6. In practice, it will be for ICBs and other commissioning bodies to determine their approach to identifying patients to support with ACDs, and that may in practice involve a different set of patients who could be seen as having elevated risk including those who have not previously been admitted.

7. It is assumed that 45% of people who have been signposted will draft an ACD. This is a central estimate based on previous research of take-up of advance directives[149][150][151] (assuming a range of 30-60% uptake for sensitivity analysis).

8. The same take-up rate as above is applied to anyone who it is estimated has been previously admitted and discharged, which over time following introduction of the policy, may increasingly under-estimate the proportion of patients who will have already written an ACD if people who are signposted multiple times are more likely to write an ACD. The same assumptions on repeated admissions are used for the separate analyses of admissions and detention rates described below.
9. The proportion of discharged people who have had a previous admission since the introduction of the policy and who previously decided to draft an ACD are removed from the pool of people who might draft an ACD in each year. This is based on DHSC analysis of Mental Health Services Dataset data on the proportion of overall admissions (informal and detentions) in 2023/24 that represent people who have previously been admitted (including within that year) over varying backward-looking time horizons across a 7-year period. The proportion of repeat admissions going back further than this has been extrapolated based on the overall trend, assuming this reaches a steady state (as is suggested by the trend in the data). This approximation to the likely dynamics of ACD production therefore takes into account that as we move beyond the first year of policy implementation, a bigger proportion of patients identified as in scope by virtue of having been admitted previously will already have written one.

10. Workforce time assumptions around drafting ACDs are set out in the table below. The workforce groups involved in ACDs may be different than is illustrated here. For instance, this may include VCSE staff, or other local authority workforce not modelled. Below is a simplification for modelling purposes.

Table C.143. Workforce time assumptions

Activity	Length of appointment (hours)	Staff time requirement	Assumed workforce groups
Identification / initial signposting / referral / arrangement or follow-up	0.25 hours	• 0.25 hours x 1 role	• NHS key worker/care coordinator
Info session	1 hour	• 1 hour x 2 roles (i.e. 2 hours)	• NHS key worker / care coordinator and ACD facilitator

148 Based on average of 2020-21 to 2022-23 proportions from Mental Health Bulletin, 2022-23 Annual report - NHS England Digital

149 Tinland, A., Loubière, S., Mougeot, F., Jouet, E., Pontier, M., Baumstarck, K., ... & Troisoeufs, A. (2022). Effect of psychiatric advance directives facilitated by peer workers on compulsory admission among people with mental illness: a randomized clinical trial. JAMA psychiatry, 79(8), 752-759.

150 Swanson, J. W., Swartz, M. S., Elbogen, E. B., Van Dorn, R. A., Ferron, J., Wagner, H. R., ... & Kim, M. (2006). Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. American Journal of Psychiatry, 163(11), 1943-1951.

151 Easter, M. M., Swanson, J. W., Robertson, A. G., Moser, L. L., & Swartz, M. S. (2017). Facilitation of psychiatric advance directives by peers and clinicians on assertive community treatment teams. Psychiatric Services, 68(7), 717–723.

Meeting with service user to support them to decide ACD contents and support with drafting	1 hour	• 1 hour x 2 roles (i.e. 2 hours) • 1 hour x 1 role • 1 hour x 1 role	• NHS key worker / care coordinator and ACD facilitator • LA-employed social worker (in 50% of cases) • Psychiatrist (in 50% of cases)
Support with updating existing ACD	0.5 hours	• 0.5 hours x 2 roles (i.e. 1 hour) • 0.5 hours x 1 role • 0.5 hours x 1 role	• NHS key worker / care coordinator and ACD facilitator • LA-employed social worker (in 50% of cases) • Psychiatrist (in 50% of cases)
Admin support for uploading document etc	0.25 hours	0.25 hours x 1 role	• Band 4 admin staff

11. It is assumed that ACDs will not 'expire', but that 60% (range of 40% to 80%) of people who are admitted and then discharged with an existing ACD will decide to update this. It is assumed that updates to ACDs will be less resource intensive than drafting a new ACD, requiring 30 mins of support with updating contents and 15 mins of administrative support.

12. The estimated number of additional ACDs that are written each year are summarised in the table below, which informs the costs. The modelling of costs for this policy is subject to significant uncertainty and requires a range of assumptions, some of which are varied in sensitivity analysis.

Table C.2. Estimated volume of ACDs drafted and updated each year (central scenario)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	
Central Scenario - (45% ACD uptake rate and 60% ACD update rate)											
New ACDs drafted	0	0	0	0	0	55,071	38,342	37,142	36,482	36,065	
Existing ACDs updated	0	0	0	0	0	7,936	12,401	14,264	15,420	16,247	
	2034/35	**2035/36**	**2036/37**	**2037/38**	**2038/39**	**2039/40**	**2040/41**	**2041/42**	**2042/43**	**2043/44**	**Total**
New ACDs drafted	35,829	35,664	35,559	35,677	35,800	35,912	36,030	36,136	36,256	36,368	562,333
Existing ACDs updated	16,824	17,286	17,664	17,723	17,784	17,839	17,898	17,951	18,010	18,066	243,313

Note: *Totals may not equal the sum of the annual figures due to rounding.*

Estimating the impact of ACDs on informal admissions and detentions

13. A systematic review of such crisis planning estimated the pooled impacts of five studies and found a 25% (range from 7% to 39%) reduction in compulsory admissions among those receiving crisis-planning interventions compared with those who did not receive them[152]. These average impacts found in this meta-analysis were influenced by some small and non-UK studies. The only large pilot included from UK in recent years found a much smaller effect size (8% reduction in detentions) which was not statistically significant[153]. Some patients who are diverted from detention by ACDs are likely to be admitted to hospital voluntarily as an informal patient. This is supported by the same meta-analysis which examined the impact on overall admissions and found that this was much smaller (10%), due to an increase in voluntary admissions (which may of course still represent a positive outcome for patients).

152 Molyneaux, E., Turner, A., Candy, B., Landau, S., Johnson, S. & Lloyd-Evans, B. (2019). Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open. 2019 June; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

153 Thornicroft, Graham et al. (2013), 'Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial', The Lancet, Volume 381, Issue 9878, 1634 – 1641. Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial - The Lancet

14. Research evidence suggests that efficacy in terms of reducing admissions depends on buy-in and involvement from a patient's whole clinical team[154]. Meanwhile, the level of staff input being assumed in this IA in estimation of the costs of producing ACDs may not be as great as that involved in the pilots from which impact estimates are derived, and it is uncertain whether the impact of the new duty and legal obligations will have the same effect on implementation for patients as seen in prior research based on dedicated pilots. Therefore, to produce a conservative estimate of impact, it is assumed in a central scenario that holding an ACD reduces the chance of being detained by 12.5% and the chance of being admitted to hospital (which has greatest impact on estimated cost savings) overall by 5%.

15. These assumptions are applied to the number BAU admissions/detentions (less those for people with a learning disability and autistic people assumed to be already affected by detention criteria changes, who nonetheless are still included in ACD production estimates), which are estimated to involve a patient who has previously written an ACD (as above) to estimate impacts on admissions and detentions. This is used for (a) estimating the costs and cost savings associated with diverting patients from hospital care, (b) estimating the number of ACDs that will be reviewed by those who are admitted despite holding an ACD, and (c) wider costs of the reforms that are related to the number of detainees. These savings are highly uncertain and depend on the funding for and availability of suitable mental health crisis provision. In sensitivity analysis we use a more optimistic/'low cost' scenario of 10% (25%) reduction in admissions (detentions), and a more pessimistic/'high cost' scenario of no impact on admissions.

16. This approach differs from that used in the Draft Bill IA in that it takes a wider set of patients and outcomes as in-scope (all admissions, rather than only detainees), applies lower impact estimates (25% reduction in detentions was used in a central scenario previously) and takes more account of repeated admissions over a longer time horizon.

Main assumptions for Option 2 – costs and benefits from diverting patients from hospital care

17. The benefits from diverting patients from hospital depends on the treatment and length of treatment they would have received there. It also depends on what alternative provision they receive when not in hospital, which may be referred to in an ACD itself and could include some combination of crisis-focused mental health care (e.g. crisis houses, crisis telephone lines; support from Crisis Resolution and Home Treatment Teams (CRHTTs); other mental health care accessed whilst at home; and various forms of social care and VCSE-sector support[155]. These are highly uncertain, and it is not expected that patients for whom possession of an ACD could mean they avoid admission will be representative of the population of people detained in a given year.

18. The previous Draft Mental Health Bill IA estimated the counterfactual costs for ACDs based on research based on the NHS costs of service use by the population of SMI patients over a given year[156]. Following further review and feedback from stakeholders, the approach has been updated to take into account that patients diverted by having an ACD may have otherwise had shorter stays in hospital than previously assumed[157] and instead receive relatively intensive mental health care

[154] Tinland A, Loubière S, Mougeot F, et al. Effect of Psychiatric Advance Directives Facilitated by Peer Workers on Compulsory Admission Among People With Mental Illness: A Randomized Clinical Trial. JAMA Psychiatry. 2022;79(8):752–759. doi:10.1001/jamapsychiatry.2022.1627

[155] Rojas-García A, Dalton-Locke C, Sheridan Rains L, Dare C, Ginestet C, Foye U, Kelly K, Landau S, Lynch C, McCrone P, Nairi S, Newbigging K, Nyikavaranda P, Osborn D, Persaud K, Sevdalis N, Stefan M, Stuart R, Simpson A, Johnson S, Lloyd-Evans B. (2023), 'Investigating the association between characteristics of local crisis care systems and service use in an English national survey'. BJPsych Open. 2023 Nov 3;9(6):e209. doi: 10.1192/bjo.2023.595..

[156] Ride, J., Kasteridis, P., Gutacker, N., Aragon Aragon, M. J., & Jacobs, R. (2020). Healthcare Costs for People with Serious Mental Illness in England: An Analysis of Costs Across Primary Care, Hospital Care, and Specialist Mental Healthcare. *Applied health economics and health policy*, *18*(2), 177–188. https://doi.org/10.1007/s40258-019-00530-2

[157] Findings from an earlier pilot suggested that the mean lengths of stay for patients diverted from hospital by a crisis-planning intervention had lower average lengths of stay when admitted than the mean for the whole sample. Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K,

for a short period whilst at home (potentially a CRHTT). This has reduced the net savings estimated per diverted patient.

19. It is assumed that patients diverted from hospital would have stayed in hospital for 26 days (based on average over 2020/21 to 2023/24 of median lengths of stay for Mental Health Act Part II detentions[158]), at a cost equivalent to average mental health bed day costs (£513 per day in 2021-22[159], uprated for inflation for use in analysis). It is assumed that they instead remain at home, receiving 1 daily mental health community care contact for 14 days at a cost per contact equivalent to the average for community mental health services in NHS cost data (£249 in 2021-22, uprated for inflation over time[160]).

20. Overall, this implies a saving per diverted patient of around £11,400 in 2024/25 prices. This excludes potential costs to social care and VCSE organisations (some of which are funded by the NHS to support patients).

Output

21. The modelling of ACD production and review costs generates estimates of additional workload using the assumptions above, which are then then divided by the average number of working hours per year (accounting for holidays, sickness and training) to determine the additional number of FTEs required. The additional FTE is then multiplied by unit staff costs (salary, oncosts and overheads) as well as being multiplied by the cost to train new staff.

22. Projections of the numbers of people detained under Option 2, affected by this modelling, are fed into wider calculations to estimate the MHA 'process costs' of reforms, whilst the net savings from displacing hospital patients described above (which apply instead to the overall effect on admissions) are scored as negative costs.

C.IV. Estimating the impact of Opt-Out Advocacy

Background and proposed policy change

1. The Government proposes to increase the uptake of independent advocates among formal patients.
2. This policy affects the number of IMHAs required.

Main assumptions for Option 1 (BAU)

3. Current levels of advocacy uptake are 50% of people that are eligible.
4. People that are eligible are:
    - detainees with a length of stay greater than 72 hours
    - people in supervised Community Treatment Orders (CTOs)
    - Conditionally discharged restricted patients
    - People subject to Guardianship under the Act
    - Informal patients are eligible for IMHA services if they are being considered for Section 57 or Section 58A treatment (i.e., treatments requiring consent and a second opinion)

Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. BMJ. 2004 Jul 17;329(7458):136. Another study of alternative residential crisis care suggested that comparison patients in hospital had lengths of stay lower than the mean estimated in such research: M. Slade, S. Byford, B. Barrett, B. Lloyd-Evans, H. Gilburt, D. P. J. Osborn, R. Skinner, M. Leese, G. Thornicroft and S. Johnson (2010), 'Alternatives to standard acute in-patient care in England: short-term clinical outcomes and cost-effectiveness'.

[158] NHS England (2024), Mental Health Act Statistics, Annual Figures - NHS England Digital

[159] NHS England » 2021/22 National Cost Collection Data Publication

[160] NHS England » 2021/22 National Cost Collection Data Publication

- People under 18 and being considered for electro-convulsive therapy

5. Public data on Guardianships under the MHA and ECTs show that the number of patients in these cohorts is negligible. This has also been confirmed in discussions with CQC. The numbers therefore will be the same in BAU and the policy scenario. For this reason, they have been excluded from the modelling of this policy.

Main assumptions for Option 2 (Policy On)

6. People eligible for an IMHA is the same as BAU but the opt-out policy compared to the opt-in for BAU will mean uptake is assumed to increase from 50% to 85% of total detentions.
7. It is assumed that the IMHA hours worked per case will be the same as BAU for this policy. This is multiplied to 85% of total detentions.

Output

8. An advocate has a caseload of 100 cases per year. We have assumed an FTE IMHA works 1,513 hours per year. This considers annual leave, average days of sick leave and study/training days. We have divided 1,513 hours by 100 (caseload) to reach a BAU time worked by an IMHA per case of 15.13 hours. This is multiplied by 50% of detentions and 50% of CTO BAU forecasts.
9. This total workload is then divided by the average number of working hours per year to determine the number of FTE IMHAs required. The FTE is then multiplied by the IMHA staff costs (salary, oncosts and overheads).
10. The additional FTE in each year is also converted to headcount (assuming a HC:FTE ratio of 1.4:1) and multiplied by a one-off cost to train new IMHAs which is assumed to be approximately £1,600 per IMHA (based on averages fees for a Level 4 IMHA Qualification course).
11. In Option 2, the higher uptake of advocacy means that more IMHAs are required increasing costs. The additional monetised costs are worked out by subtracting Option 1 (BAU) from Option 2.

C.V. Estimating the impact of Informal Advocacy

Background and proposed policy change

1. The Government proposes to extend the statutory right to an IMHA to all mental health inpatients, including informal/voluntary patients; as is already the case in Wales.
2. This policy affects the number of IMHAs required.

Main assumptions for Option 1 (BAU)

3. BAU assumes that currently no informal/voluntary patients are eligible for advocacy.
4. As a result, nobody is taking up services and no IMHA staff are required.

Main assumptions for Option 2 (Policy On)

5. All informal patients are eligible for IMHA services and there will be a 50% uptake per informal admission.
6. It is estimated that this will create 6 hours of additional workload per informal admission.

Output

7. This additional workload is then divided by the average number of working hours per year (accounting for holidays, sickness and training) to determine the additional number of FTE IMHAs required.
8. The additional FTE is then multiplied by the IMHA staff costs (salary, oncosts and overheads). The additional FTE is also multiplied by the cost to train new IMHAs.

9. In Option 2, more IMHAs are required and so the additional monetised costs are worked out by subtracting Option 1 (BAU) from Option 2.

C.VI. Estimating the impact of changes to SOADs

Background and proposed policy change

1. This Government proposes a number of changes relating to SOADs which can be modelled in three sections:
    - **Bringing forward the SOAD's visit so that it happens earlier -** SOAD reviews are currently triggered after 3 months where a patient is in receipt of medication they have not consented to, either because they lack capacity or because they are refusing with capacity. The Government proposes bringing forward the need for a SOAD to certify treatment from 3 months to 2 months in the case of patients who lack capacity or competence to consent to medication. Where a patient is refusing medication with capacity or competence, or medication would conflict with an advance decision, or the decision of a donee[161] or deputy of the Court of Protection, but the treating clinician can demonstrate that there are 'compelling reasons' to override the refusal, then a SOAD must certify treatment before it can be given compulsorily. Whilst ACD implementation is due to commence in 2029/30, we have assumed that SOAD visits for patients refusing treatment via ACDs to commence at the same time as other SOAD changes, i.e. in 2030/31. This is to ensure that those refusing treatment in advance and those refusing (with capacity) at the time gain access to SOADs at the same time.

    - **Section 61 -** CQC will now be able to request Section 61 reports for patients consenting to medication. This is in addition to S61 reports made by the Clinician sent to the CQC where patients are not consenting to treatment. The timing around which s.61 reports must automatically be made and provided to the CQC for patients who are not consenting to treatment will stay the same.

    - **Urgent Electro-Convulsive Therapy (ECTs)** - SOADs will now be required to certify urgent ECT treatment where patients are not consenting to treatment (either refusing via Advance Choice Documents or lacking capacity at the time of treatment).
2. This professional groups affected are:
    - Second Opinion Appointed Doctors (SOADs)
    - Clinicians
    - Nurses
    - Other Clinical Staff

Main assumptions for Option 1 (BAU)

SOAD Visits

3. Under BAU, the cohort eligible for SOAD Visit:
    - Section 3 detainees refusing medication with a Length of Stay (LoS) beyond 3 months
    - Section 3 detainees lacking capacity with a LoS beyond 3 months
    - Section 3 detainees receiving ECTs
    - Part III detainees retained in hospital
    - Those on CTOs
4. The average proportion of SOAD visits for each type of SOAD visit was calculated from available CQC data across 2016/17 to 2022/23 (excluding 2019/20 data which lacked sufficient detail due to

[161] A donee is a person who is given a power of appointment.

focus on COVID-19). These proportions were then applied to the number of Section 3 detainees eligible for a SOAD visit and CTOs which gives the below rates of SOAD visits:

Table C.3. SOAD visits

Type of SOAD Visit	Average proportion of SOAD visits	Visits per Section 3 Detention
ECT	11.5%	0.03
CTO	9.5%	0.25
Medication Review – Refusals	9.0%	0.11
Medication Review – Lacking Capacity	70.0%	0.85

5. Each SOAD conducts an average of 65 visits per year which is assumed to stay the same in future years. Using data provided by CQC, the cost per visit is assumed to be approximately £360 (2024/25 prices), which is uplifted over the appraisal period to account for inflation.
6. As part of BAU, SOADs are expected to complete mandatory training each year as well additional shadowing involving attending two visits with a more experienced SOAD. New SOAD induction training is also expected as part of BAU.
7. It is assumed that for each detention requiring a SOAD visit, 1.5 hours is required by the Clinician, nurse and other clinical staff each.
8. It is assumed that for each decision point, 3 hours on average is required by both Clinician and Community Supervising Clinician. This was agreed after consulting with stakeholders.

Section 61

9. Under BAU, the volume of s61s reports has been updated using CQC data on the number of s61 reports written in previous years and converting this to a proportion of Section 3 detentions. This proportion has then been applied to detention numbers in future years to estimate number of s61 reviews conducted annually.
10. Each SOAD scrutineer conducts an average of 360 s61 reports per year which is assumed to stay the same in future years.

Urgent ECTs

11. Under BAU, SOADs are not required to certify urgent ECT treatment.

Main assumptions for Option 2 (Policy on)

SOAD Visits

12. Under Option 2, the cohort eligible for a SOAD visit includes the BAU and extends to:
    - All detainees refusing medication from first day of detention. This includes those detainees who have written an ACD previously. We have assumed that those detainees with ACDs will be entitled to SOAD access at the same time as when other SOAD reforms commence in 2030/31, despite wider ACD reforms commencing in 2029/30. This is to ensure that those detainees without an ACD who refuse treatment at the time receive access to SOADs at the same time as those with an ACD.
    - Section 3 and Part III detainees lacking capacity with a LoS beyond 2 months. Part III detainees are assumed to be eligible for SOAD visits at the same time as Section 3 detainees.
13. The caseload of each SOAD, new and mandatory training is expected to remain the same as BAU.
14. It is assumed that for each detention requiring a SOAD visit, the time required by the Clinician, nurse and other clinical staff is the same as BAU.

Section 61

15. CQC do not anticipate the proportion of s61s to change considerably due to the policy reforms being minor. Whilst the reforms mean that s61 reports can be requested for consenting patients, we anticipate that this will be rare and only in circumstances where there is other evidence to suggest that the patient's safety might be at risk. Hence, the additional burden as a result of the reforms is expected to be low.

Urgent ECTs

16. Under Option 2 (Policy on), SOADs will now be required to certify urgent ECT treatment. The preferred delivery model for an urgent service is for SOADs to work as they do currently, with staggered start/finish times. This should have a relatively low-cost impact as no contractual changes are needed to be made for CQC staff, however a premium fee rate will have to be paid to SOADs due to the nature of the work. It is assumed that the premium fee paid to SOADs for urgent ECTs is £748 per certification (2024/25 prices). This has been estimated using CQC data on the average fees paid to Lead SOADs and Principal SOADs and is uplifted over time to account for inflation.

17. The number of urgent ECT treatments occurring annually have been modelled by summing together the proportion of all ECTs that are urgent (assuming this is 32% based on the latest CQC data) and the proportion of ACDs where treatment is refused, of which will require urgent ECT (assuming this is 10%). ACDs policy reforms mean that patients can refuse urgent ECT treatment via an Advance Choice Document, which will trigger a SOAD certification, though the number of patients that will do so is largely unknown. However, the 10% assumption is based on CQC expectations on the number of Urgent ECT refusals via ACDs being relatively small. The number of urgent ECTs has then been multiplied by the premiums paid to SOADs to estimate the total costs of urgent ECTs annually.

Outputs

18. The wider scope of detainees eligible means an additional number of SOAD visits are required under Option 2.

19. A higher number of s61 reviews will also be required. The total number of reviews are then multiplied by unit costs per visit data (provided by CQC) to estimate total costs of s61 reviews.

20. The higher number of visits also mean more NHS clinical staff (such as responsible clinician, nurse and other clinical staff) are required. The number of visits is then divided by the average number of working hours per year to determine the additional number of FTE for these professional groups required. The FTE required is also used to estimate the number of FTEs that will require training. Training costs have been costed using data provided by CQC and include additional shadowing involving attending two visits with a more experienced SOAD and 1 day training for new staff. Mandatory refresher training costs have not been monetised as they would be incurred in a 'Business as Usual' scenario and aren't an additional burden as a result of the reforms.

21. The additional monetised costs are worked out by subtracting Option 1 (BAU) from Option 2.

C.VI. Estimating the impact of changes to Care and Treatment Plans (CTPs)

Background and proposed policy change

1. The Government proposes that all formal patients (excluding those under short term sections, like Section 4) receive a timely plan on their care and treatment and how they will be progressed towards discharge.
2. The patient should be supported by clinical staff who will be required to put the plan in place by day 7 of the person's detention and update it as and when required to reflect the patients progress. Patients' plans should be subject to a regular audit by the hospital.

3. In addition, where the patient is unable to, or does not wish to engage, those who care for the patient's welfare, such as the Nominated Person, should be consulted on the plan.
4. This professional groups affected are:
    - Clinicians
    - Nurses
    - Administrative Staff
    - IMHAs

Main assumptions for Option 1 (BAU)

5. BAU assumes that currently there is a 50% uptake of versions of CTPs.
6. In total, this is assumed to contribute to 6 hours of time for IMHAs and 4 hours of time for Clinicians.

Main assumptions for Option 2 (Policy On)

7. Under Option 2, CTPs will be statutory and so it is assumed 85% of total detentions will have CTPs.
8. The time to complete tasks for CTPs for both the IMHA and Clinician is expected to stay the same as BAU.
9. Under Option 2, CTPs should be reviewed at various points including: if they are due to be discharged; if a patient is due to go under another section of the Act; following a change in the patient's condition which the practitioner considers significant; following a C(E)TR; and if a patient is due to go to the MHT to have their detention reviewed.
10. For the purposes of modelling, it is assumed that each CTP will be reviewed once during each detention on average. This is expected to create 0.5 hours of additional work for a nurse. This is an assumption and in reality, this is likely to be reviewed more than once for a number of patients, and not reviewed at all for some patients.
11. Under Option 2, CTPs will also be subject to a regular audit by the hospital. The extra resource for this is dependent on existing systems a Mental Health Trust has in place and so will vary across hospitals. This has been modelled following the below:
    - Around 25 Mental Health Trusts will require setting up an automated system. This will involve around 26 hours of administrative time in the year the CTP policy commences.
    - After this, all the Mental Health Trusts/Independent Mental Health Providers will need to create a CTP audit report. This is calculated by multiplying 77 trusts by 22 hours of administrative time per month.
    - A further manual audit will be required by administrative staff (likely the Mental Health Act Manager) which is expected to take on average between 12.5 minutes (range 10-15 minutes). This is applied to 38% of CTPs that are completed.

Outputs

12. For IMHAs and Clinicians the workload is divided by the average number of working hours per year to determine the additional number of FTE required under both options. This is then multiplied by the staff costs (salary, oncosts and overheads). To estimate the training costs of expanding the workforce, FTE numbers are then converted to headcount terms and multiplied by the costs to train the respective professionals.
13. Under Option 2, more IMHAs and Clinicians are required because CTPs will be compulsory and so the additional monetised costs are worked out by subtracting Option 1 (BAU) from Option 2.
14. The same method is applied to administrative staff group to determine the additional number of FTE required to account for the regular and manual audit of CTPs under Option 2.

C.VII. Estimating the health and social care impacts of changes to tribunals

Background and proposed policy change

1. The role of the Mental Health Tribunal (MHT) is to act as the ultimate safeguard for a patient in detention. It forms part of HM Courts and Tribunals Service (HMCTS) and provides judicial oversight of detentions made under the MHA. The MHT has the power to consider whether the conditions for continuing treatment under compulsory powers are met and it may authorise treatment orders that specify the detention of a patient in a specific hospital or to reside at a specified place (when not able to reside at home).
2. The Bill proposes increasing the frequency with which patients can make appeals on their detention and will ensure that those who do not appeal themselves will nevertheless receive hearings. The Bill will also reduce the burden of hearings cancelled at the last minute due to Section 3 patients no longer meeting the criteria.
3. Several professional groups are affected by increases in the number of tribunals. For each additional tribunal, the required activities (and respective time required) for each professional group is as follows:
    - Clinicians
    - Nurses
    - Key workers
    - Administrative Staff

Main assumptions under Option 1 (BAU)

4. Three staff are assumed to be potentially present at each tribunal: a Clinician, nurse and care co-ordinator - this is considered to be worst-case-scenario because usually only the clinician and a nurse or a key worker will attend, not both.
5. Staff time per tribunal is assumed to remain the same pre- and post- policy implementation: 7.5 hours (one full day of work) each for profession.
6. It is also assumed that responsible clinicians are also required for certification for the tribunals – assumed to take 30 minutes per tribunal.
7. Additionally, administrative staff are required to set up the tribunal – this is assumed to take 75 minutes per tribunal.

Main assumptions under Option 2 (Policy on)

8. Under Option 2, the workload for professional groups remains the same as Option 1.

Output

9. For all staff groups, the workload is divided by the average number of working hours per year to determine the additional number of FTE required under both options. This is then multiplied by the staff costs (salary, oncosts and overheads). To estimate the training costs of expanding the workforce, FTE numbers are then converted to headcount terms and multiplied by the costs to train the respective professionals.
10. Under Option 2, more staff are required because of the additional tribunals and so the additional monetised costs are worked out by subtracting Option 1 (BAU) from Option 2.

C.VIII. Estimating the impact of increased Section 3 Renewals

Background and proposed policy change

1. The Government will shorten the initial period that patients under certain sections can be kept in detention for treatment. This change will mean that a patient's initial detention period will expire sooner, or it must be reviewed and renewed sooner.
2. Clinicians are affected by the proposed policy change.

Main assumptions under Option 1 (BAU)

3. Under Section 3 of the MHA, a patient can be detained for up to six months before renewal or discharge.

Main assumptions under Option 2 (Policy on)

4. Under Option 2, a patient detained under Section 3 will have their initial detention period shortened to three months where a review will be undertaken by a Clinician responsible for their care.
5. Data from 2023/24 shows that 40.5% of Section 3 detentions are detained for over three months. Therefore, under the policy change these will require an assessment/renewal by a Clinician. This will require 4 hours of additional workload by the Clinician.

Output

6. This extra workload by the Clinicians is then divided by the average number of working hours per year to determine the additional number of FTE required under Option 2. This is then multiplied by the Clinician's staff costs (salary, oncosts and overheads). To estimate the training costs of expanding the workforce, FTE numbers are then converted to headcount terms and multiplied by the costs to train Clinicians.

C.IV. Estimating additional workforce training, familiarisation and backfill costs

Familiarisation & associated backfill costs

1. To help facilitate the planned changes, we have considered that existing staff will need additional familiarisation training to bring them up to a working knowledge of the reforms.

2. In this IA, we have monetised familiarisation costs for staff where data was available to estimate the size of the existing MHA workforce. This included some NHS staff (Approved Clinicians, Section 12 doctors, MHA managers), Local Authority Staff (AMHPs and IMHAs), and SOADs. We expect that these workforce groups will require the most familiarisation for the reforms.

3. The IA published with the draft Bill[162] estimated that there would be around 10,700 Section 12 doctors in 2024/25 based the number on the Mental Health Act Approval register[163]. We estimate that of this number, around 6,000 are Approved Clinicians[164]. Based on advice from NHS England, we estimate that there are around 1,000 MHA managers. Skills for care suggest there are 3,800 existing AMHPs,[165] and we estimate around 1,000 IMHAs will require familiarisation based on an ADASS and NHS Benchmarking Network data collection of the Mental Health Social Care workforce[166]. We estimate that there are around 130 SOADs, based on advice from CQC.

4. Assumptions around familiarisation time have been developed using stakeholder advice. We estimate that Approved Clinicians, SOADs, AMHPs and IMHAs will require 2 days familiarisation, and that Section 12 doctors (who aren't Approved Clinicians) and MHA managers will require 1 day familiarisation for the reforms. Familiarisation training for NHS staff groups has been costed at £254 per day (2024/25 prices) based on Section 12 refresher training[167], in absence of other data. For AMHPs and IMHAs, we have assumed that familiarisation training would take 2 days, costing £200

[162] Page 27 Mental Health Act Draft Bill: impact assessment (publishing.service.gov.uk)

[163] Section 12 Doctor Database (nhsbsa.net)

[164] Estimating the impact of Mental Health Act reforms on the workload of psychiatrists_StrategyUnit_211015.pdf (strategyunitwm.nhs.uk)

[165] Approved Mental Health Professional (AMHP) workforce (skillsforcare.org.uk)

[166] https://www.adass.org.uk/our-work/

[167] Registration: Section 12(2) Refresher (rcpsych.ac.uk)

per day per professional (in 24/25 prices). Familiarisation for SOADs is estimated to cost £914 per day, which includes the cost of training and an additional fee for SOAD visits.

5. We have also modelled associated backfill costs whilst staff are on a familiarisation training program by estimating per day salaries of covering staff. In 2024/25 prices, this gives an estimated cost of £200 for AMHPs, £115 for IMHAs, £499 for ACs and S12 doctors, £120 for MHA managers, and £360 for SOADs.

6. Familiarisation training has been assumed to occur for 50% of the relevant staff in 2026/27 and 50% of staff in 2027/28. This is a simplification for modelling purposes which may not align with implementation.

7. It is assumed that the reforms will form part of ongoing refresher training beyond this initial familiarisation, therefore ongoing costs have not been modelled.

8. We additionally include a cost of £350k (24/25 prices) to establish an online MHA training hub, which should enable familiarisation for other NHS staff who may require less intensive training. This estimate was developed using advice from NHS England.

Training costs associated with expanding the workforce

9. In this IA, we have estimated the training costs for staff groups where we have modelled estimates of additional demands split by workforce (which does not cover all impacts). These estimate the potential costs were the workforce to be expanded in order to accommodate the additional demands modelled. In all cases, the timing of these impacts largely follows the modelled workforce demands of the policies, and in some cases the estimated profile of those may entail a simplification (for example, not fully accounting for graduate transitions to full impacts) or the omission of some relevant professionals not listed here. Also considering the time lags involved in recruitment pipelines, these initial estimates should not be taken as a precise financial forecast for a recruitment programme. The following describes the approach in the case of each workforce group:

    - **AMHPs:** Training additional AMHPs is assumed to cost ~£6,100 per person (24/25 prices). This comprises of a pre-AMHP course costing £1,500 plus £4,600 for an AMHP course which is based on average tuition fees.

    - **IMHAs:** Training additional IMHAs is assumed to cost ~£1,600 per person (24/25 prices). This is based on the average costs for a Level 4 Advocacy Qualification.

    - **SOADs:** Training of new SOADs is short, and it is assumed that SOADs needed in a given year are trained in that year. Costs that have been modelled include training for new SOADs and additional shadowing involving attending two visits with a more experienced SOAD which have been costed based on data provided by CQC. Training new SOADs is expected to cost £554 per new SOAD whilst shadowing visits is expected to cost £576 per SOAD (24/25 prices). Mandatory refresher training and appraisal costs have not been monetised as they would be incurred in a 'Business as Usual' scenario and aren't an additional burden as a result of the reforms.

    - **NHS Workforce (Clinicians, Nurses, Other Clinical Staff, Key Workers, Community Supervising Clinicians):** To estimate the costs of training new NHS staff due to additional workforce being required, we have used evidence from the Personal Social Services

Research Unit (PSSRU)[168] to inform unit costs of training qualifications: The PSSRU paper provides staff unit costs per hour with and without 'qualifications. The difference between the two, the 'qualifications cost' is equivalent to apportioning the estimated cost of training an individual to a given profession/grade (including tuition, subsidies for training placements, and some salaries) across their working life – this is a proxy for the additional cost of obtaining their output associated with needing to train them in the first place.

- **Social Workers:** To estimate the costs of training new social workers (employed by Local Authorities), the same approach that was used to estimate training costs for NHS-employed staff has been applied.

10. This hourly cost associated with staff qualifications is then multiplied by the annual hours worked by each respective staff group to give an annual training cost per staff group. In the IA, only training costs incurred over the appraisal period are accounted for.

11. Given most staff will spend the majority of their time on other tasks (creating benefits for patients) beyond those assessed in this IA and may work well beyond the time horizon assessed here, this approach ensures that only the marginal impact on training costs of the additional workforce demands of the reforms are captured here. In practice, a recruitment programme to create the capacity needed in time for implementation could involve higher costs, with a more front-loaded profile, but would create significant wider benefits not assessed here.

12. Consultant psychiatrists require additional training to achieve Approved Clinician/Responsible Clinician status, not included in the PSSRU estimates. Costs associated with this additional training have not been monetised in this IA, due to a lack of available cost data, but on the other hand these costs include those associated with the first few years of undergraduate study for doctors, which in many cases will not represent an additional economic/public cost as the individual would likely have pursued a different degree course if not one in medicine. A relatively small proportion of ACs are non-medical professionals so may incur slightly lower training costs. However, given a lack of information on training costs for non-medical ACs, in this IA, we have modelled all costs for ACs, including training costs, on the basis that they are medical doctors.

13. Costs to train Admin staff are not included in PSSRUs' estimates and have not been monetised in the IA.

14. For the NHS workforce, the costs for training additional staff have been estimated by modelling the total FTE required in each year and multiplying the relevant costs. For AMHPs and IMHAs, we have used the *difference* in additional staff required annually (for instance from y1 to y0) to estimate training costs, given training courses for AMHPs/IMHAs are relatively short and will be trained in the same year they are required.

15. The years in which training costs are expected to be incurred can be seen by the table below:

Table C.4. Estimated Additional Training Costs, by Staff Group for England only (£million, 2024/25 prices, undiscounted) - Central Estimate

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
AMHPs	0	0	0	0	0	0	0	0	0	0
IMHAs	0	0	0	1	0	0	0	0	0	0
Social Workers	0	0	0	0	0	0	0	0	0	0
Approved Clinicians	0	0	0	0	0	1	5	8	8	7
Nurses	0	0	0	0	0	0	0	1	1	1

[168] Personal Social Services Research Unit: p106, The unit costs of health and social care_Final3.pdf (kent.ac.uk)

Key Workers	0	0	0	0	0	2	1	1	1	1
Other Clinical Staff	0	0	0	0	0	0	0	0	0	0
Community Supervising Clinician	0	0	0	0	0	0	0	0	1	1
SOADs	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**1**	**0**	**3**	**7**	**10**	**11**	**10**

	2034/35	**2035/36**	**2036/37**	**2037/38**	**2038/39**	**2039/40**	**2040/41**	**2041/42**	**2042/43**	**2043/44**
AMHPs	0	0	0	0	0	0	0	0	0	**0**
IMHAs	0	0	0	0	0	0	0	0	0	**1**
Social Workers	0	0	0	0	0	0	0	0	0	**5**
Approved Clinicians	7	7	7	7	6	6	6	6	6	**92**
Nurses	1	1	1	1	1	1	1	1	1	**8**
Key Workers	1	1	1	1	1	1	1	1	1	**18**
Other Clinical Staff	0	0	0	0	0	0	0	0	0	**2**
Community Supervising Clinician	1	1	1	1	1	1	1	1	0	**7**
SOADs	0	0	0	0	0	0	0	0	0	**0**
Total	**10**	**9**	**10**	**9**	**9**	**9**	**9**	**9**	**8**	**133**

Annex D. Methodologies for Learning Disability and Autism Reforms

D.I. Estimating costs for changing the detention criteria for people with a learning disability and autistic people

Background and proposed policy change

1. An individual can currently be detained under the Mental Health Act (MHA) if they have a mental disorder[169], which includes people with a learning disability (where associated with "abnormally aggressive or seriously irresponsible conduct") and autistic people. Under Part II Section 3 of the MHA a person can be detained for up to 6 months initially. This detention can then be renewed. People with a learning disability and autistic people have been identified as being more likely to be detained within inpatient settings without treatment which provides therapeutic benefit[170].

2. Under the proposed policy changes, people with a *learning disability or autistic people will no longer be able to be detained under the MHA Part II Section 3 unless they have a co-occurring mental health condition that warrants hospital treatment. These people should instead receive alternative support, within community settings.*

3. For the Impact Assessment, we have aimed to model the number of people who will no longer be detained under Part II Section 3 following the change in detention criteria, compared to a baseline forecast within the Business as Usual (BaU) scenario. This allows us to estimate the number of people affected by the policy reform who will require community care. We can then calculate the associated cost implications of providing community care for these groups of people, compared to the BaU scenario where they would have otherwise received inpatient care.

4. In summary:
    - In the BaU scenario, people with a learning disability and autistic people can be detained under the MHA Part II Section 3 if they have a mental disorder including if they have a learning disability and are considered to have abnormally aggressive or seriously irresponsible conduct.

[169] 'Mental disorder' means any disorder or disability of the mind.

[170] DHSC. Consultation Outcome Reforming the Mental Health Act. (2021). Accessible here.

- In the policy reform scenario, we assume people with a learning disability and autistic people will no longer be detained under the MHA Part II Section 3 unless they have co-occurring mental health condition that warrants hospital treatment.

5. In terms of inpatient numbers, the change in detention criteria for people with a learning disability and autistic people is expected to result in:

    - Immediate discharge of those inpatients with a learning disability or autism, currently detained, who are no longer eligible for detention under the Act once the reform has been implemented. In practice, some of these discharges may not be immediate and there may be delayed discharges, but for modelling purposes to assess potential impacts, this impact assessment assumes this group of people are immediately discharged.
    - Avoided admissions thereafter, of people with a learning disability and autistic people who are in the community who in a BaU scenario may have been detained under MHA Part II Section 3, but post-reform, instead continue receiving community care. These individuals may be admitted under section 2 for a short period of time but ideally would receive support in the community as modelled.

Methodology

Identifying inpatients with a learning disability or autism who will be discharged or avoid detention due to detention criteria change.

6. There are two key national datasets that report figures on inpatients with a learning disability and autism – the Mental Health Services Data Set[171] (MHSDS) and the Assuring Transformation[172] (AT) dataset. There are known data quality issues in the way patients with a learning disability and autistic inpatients are recorded by providers in MHSDS and identified by NHS England for reporting due to low compliance on the use of clinical coding. We also know that AT does under-report some patients (e.g. short lengths of stay, and some instances where the person is not known prior to the admission or is on a general mental health ward and has not got a firm diagnosis). Furthermore, figures can change due to late reporting. However, given the data quality issues with MHSDS and the fact that AT is the main published dataset that is specific to people with a learning disability and autistic people within a mental health hospital setting, the AT dataset was used for all data on inpatients with a learning disability and autistic inpatients.

7. AT published data does not provide a granular breakdown of inpatients required for this analysis, and instead NHSE were able to provide us with more detailed monthly timeseries data drawing from the AT data collection. This has formed the basis of our estimates as it was considered to be representative for illustrative modelling purposes. NHSE provided us with inpatient, admission and discharge data for those detained under MHA Part II Section 3, split by:

    - Learning disability and autism category (learning disability, autism, learning disability and autism)
    - Age (under 18 or adult)[173]
    - Presence of Severe Mental Illness (SMI)[174].

8. The data provided by NHSE was rounded and suppressed for values below five to maintain anonymity. Due to the inpatient population of people with a learning disability and autistic people being small and the subsequent high proportion of suppressed data, we are only able to break down inpatient estimates and forecasts by age (either under 18 or adult) and cannot break down

[171] NHSE. Mental Health Services Monthly Statistics (2024). Accessible here.

[172] NHSE. Learning Disability Service Statistics, Assuring Transformation (2024). Accessible here.

[173] Adult data was provided from March 2015 onwards. Under 18s data was only provided for March 2017 onwards.

[174] Presence of SMI data was provided from April 2021 onwards. SMI was defined within NHSE's data collection as "having a diagnosis of Mental Disorder, an Eating Disorder or Personality Disorder at admission or during an inpatient stay".

or present volumes by each learning disability and autism category within the Impact Assessment.

Step 1: Business as Usual scenario – Identifying and forecasting the baseline number of inpatients with a learning disability and autistic inpatients.

9. Firstly, we know that within a BaU scenario, inpatients with a learning disability and autistic inpatients can be detained under MHA Part II Section 3 if they have a MH condition, or if they have a learning disability and are considered to have abnormally aggressive or undertake seriously irresponsible conduct, or if they are autistic. To estimate the number of people currently detained under MHA Part II Section 3, we can firstly use the NHSE provided historic data for total inpatients.

10. Once we reach the latest month of available data (July 2024), we begin forecasting the BaU number of inpatients with a learning disability and autistic inpatients into the future. Through discussions with NHSE, we understand the figures tend to be revised upwards in the months following publication, as the dataset is not static and there is known late reporting, partly due to diagnosis of patients as having a learning disability or as autistic after admission to hospital. Therefore, to forecast figures forward, we ignore the latest 8 months of data, and calculate an average inpatient number from the 12 months of timeseries data preceding this point (December 2022 – November 2023). We do this separately for under 18s and adults, to get the most recent annual average for the number of under 18 and adult inpatients.

11. Due to a high proportion of suppression and small inpatient cohorts, as discussed above, we have assumed that into the future, the rate of inpatients with a learning disability and autistic inpatients per million of the population remains constant at the latest annual average number of inpatients. We finally adjust the future forecasted inpatient figures from 2024/25 onwards to account for future population changes. To do so, we have taken population projections as forecasted by the ONS[175] and calculated the percentage change between each future year compared to a present base year (2023). We then multiply each future inpatient estimate by the expected percentage change in the population between the base year to the relevant future year. This means future inpatient figures fluctuate slightly, however are kept constant on a per capita basis. Figure D1 shows BaU inpatient estimates and future forecasts for under 18s and adults. This analysis does not account for ongoing policy and work to reduce inpatient numbers.

[175] Zipped population projections data files, England - Office for National Statistics (2024). Accessed here.

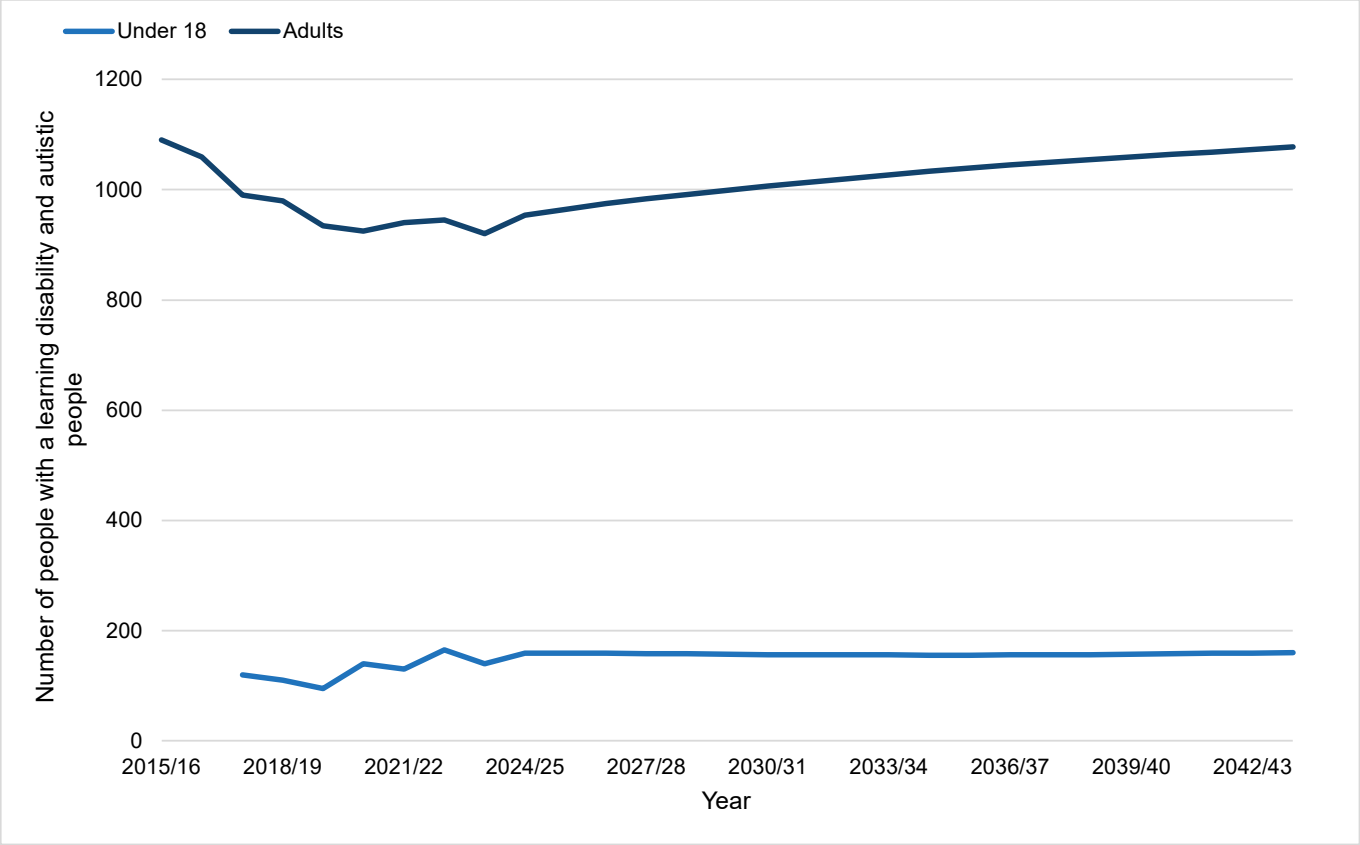


Figure D.1. Total number of under 18 and adult inpatients detained under MHA Part II Section 3 within a Business as Usual (BaU) scenario, adjusted by population change over time.

Step 2: Policy reform scenario – Identifying the number of inpatients with a learning disability and autistic inpatients immediately discharged upon implementation of the detention criteria change

12. Within the policy reform scenario following the detention criteria change, inpatients with a learning disability and autistic inpatients will no longer be detained under the MHA Part II Section 3 unless they have a co-occurring mental health condition that justifies the application of the act. To estimate those affected by the detention criteria change, we have to consider the number of people who are currently in inpatient settings and would be immediately discharged upon implementation of the reform.

13. Within our analysis, inpatient estimations and forecasts are identical to the BaU scenario up until the point of policy implementation. We note that this may be an overestimate of the number of inpatients with a learning disability and autistic inpatients, as impending reforms could drive a reduction in inpatient numbers ahead of any changes coming into effect. We have assumed implementation in September 2026 (financial year 2026/27) for modelling purposes. To note, this commencement is provided for illustrative purposes only on cost and savings estimates and should not necessarily be interpreted as fixed timelines or commitments. Actual commencement dates may vary depending on the progression of relevant processes, legislative actions, or unforeseen circumstances.

14. To calculate the number of people who will be immediately discharged, we consider the inpatient population flagged within the AT data as having no SMI (used as a proxy for illustrative modelling purposes), as these are the people who will no longer fall under scope of MHA Part II Section 3. We have used the NHSE provided data to calculate an annual average inpatient number for those without an SMI, using data from December 2022 to November 2023 (due to late reporting in the data, as explained in step 1). To calculate the total inpatient number upon policy

implementation, we subtract this annual average from the baseline number of inpatients in the Option 1 scenario (see Figure D2).

Step 3: Policy reform scenario – Identifying and forecasting the number of people with a learning disability and autistic people who avoid admission following implementation of the detention criteria change.

15. Following the immediate discharges, we must then consider the number of future inpatients, as there will be people with a learning disability and autistic people who avoid being admitted due to the change in detention criteria. Due to small numbers and suppression, we have been unable to estimate future inpatient numbers using admission and discharge forecasts because of uncertainties within the available data. As a result, once immediate discharges have taken place, we instead assume that the total inpatient number remains constant into the future, at a per capita rate. To adjust to a per capita rate, we have accounted for forecasted population change into the future. Figure D2 below shows the total number of under 18 and adult inpatients within the policy reform scenario. As above, this analysis does not consider wider actions to reduce inpatient numbers not directly linked to MHA reforms.

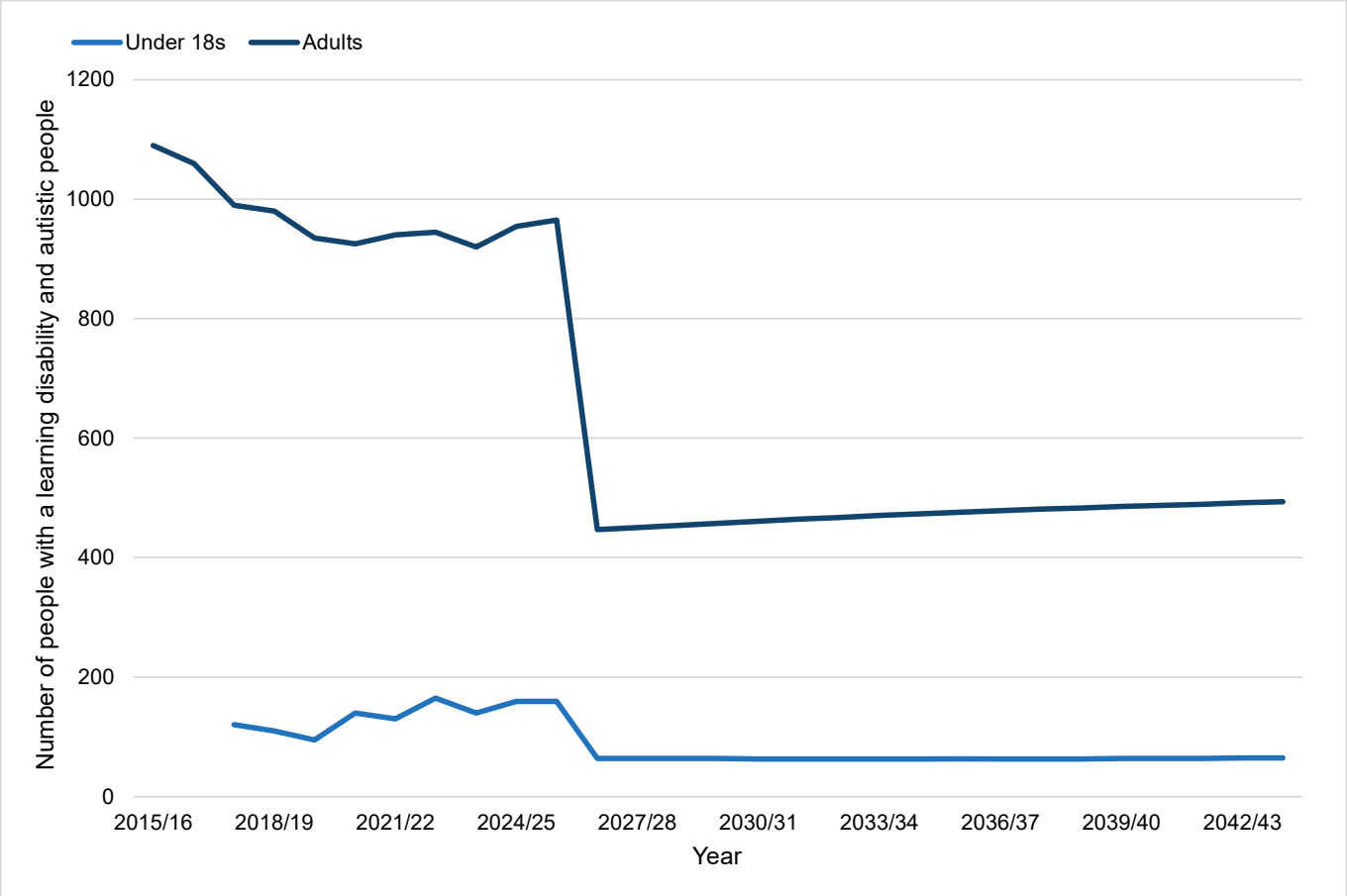


Figure D.2. Total number of under 18 and adult inpatients detained under MHA Part II Section 3 within a policy reform scenario, adjusted by population change over time, assuming implementation in 2026/27.

Identifying and forecasting the number of admissions for C(E)TR analysis

16. Inpatient volume estimates have also been modelled to feed into two other parts of overall analytical work within the Impact Assessment. These are:
    - Care (Education) and Treatment Reviews (C(E)TRs) and Dynamic Support Registers (DSRs) being placed on a statutory footing under the reformed MHA.

- Incorporating inpatients with a learning disability and autistic inpatients into the modelling and estimation of overall MHA detentions.

17. As part of the proposed MHA reforms, C(E)TRs and DSRs will be placed on a statutory footing (see Annex DXI and Annex DXII for further detail). In order to estimate the costs associated with this, we must first estimate the number of people with a learning disability and autistic people who will be admitted to inpatient settings, under both BaU and policy reform scenarios. In sum, for the purposes of this modelling:
    - Under BaU, we assume total inpatient admissions will continue at a constant rate per capita into the future.
    - Under policy reform, we assume total inpatient admissions *minus the avoided admissions under Part II Section 3* will continue at a constant rate per capita into the future.

18. Our methodology for estimating and forecasting these admissions is set out in steps 4 and 5 below.

Step 4: Calculating total admissions of people with a learning disability and autistic people across all parts of the Mental Health Act in a BaU scenario

19. To calculate and forecast the number of total admissions within a BaU scenario, we first take the total admissions data as published each month within the Assuring Transformation (AT) dataset. We repeat the methodology set out within Step 1 for inpatients under MHA Part II Section 3, but instead for total admissions.

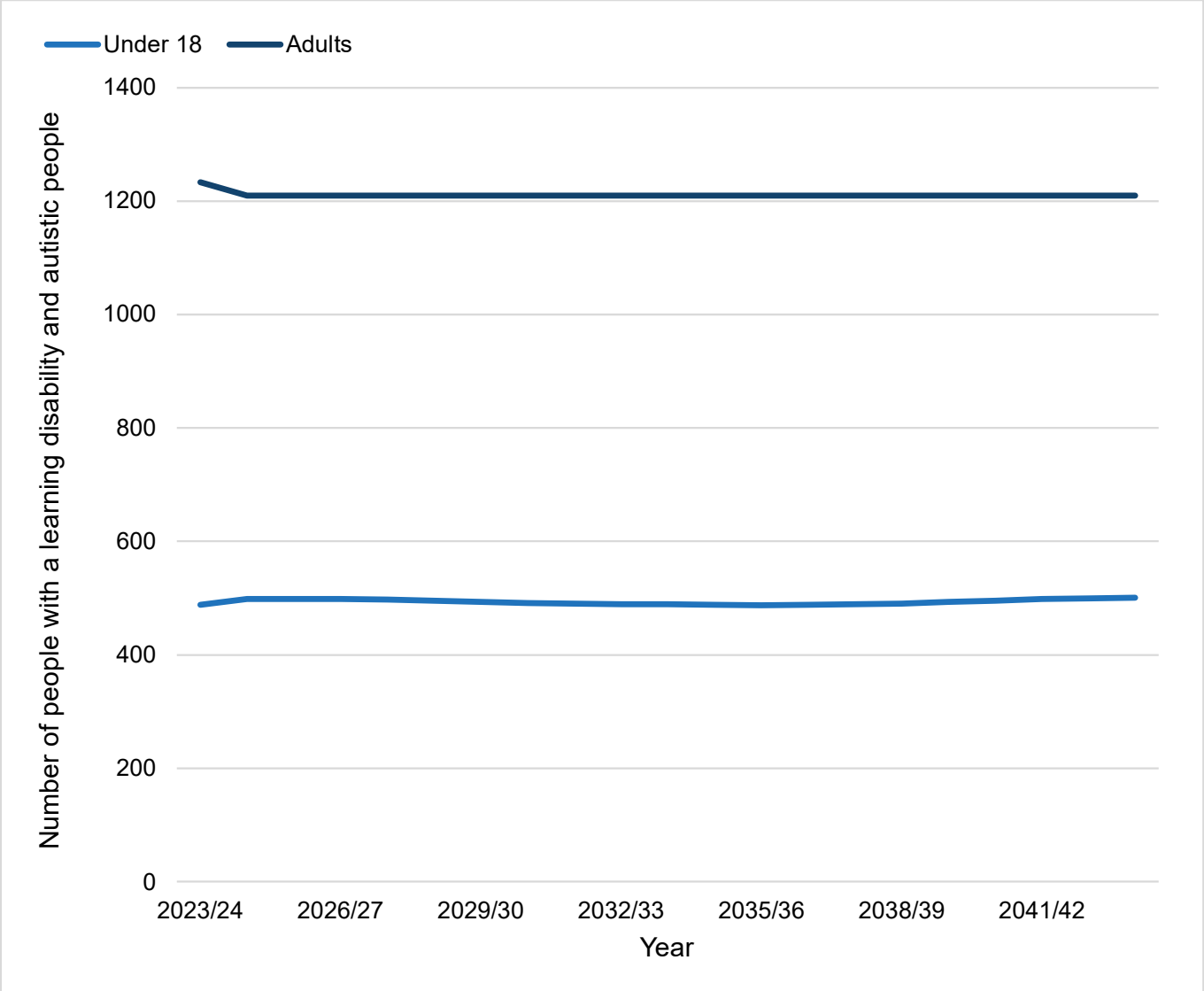


Figure D.3. Total number of under 18 and adult admissions within a BaU scenario

Step 5: Calculating total admissions in a policy reform scenario with the detention criteria change

20. To calculate and forecast the number of total admissions of people with a learning disability and autistic people within a policy reform scenario, we must consider the impact of the detention criteria change on future admissions. Post-implementation, only those with a co-occurring mental health condition that warrant hospital treatment should be admitted and detained under Part II Section 3.

21. We first assume that admissions remain identical as in the BaU scenario up until the assumed policy implementation date (currently September 2026 for illustrative purposes). To model the change in admissions in a policy reform scenario, we use NHSE provided data on Part II Section 3 admissions for those with no SMI flagged as a proxy for illustrative modelling purposes, as these are the people who would no longer be admitted. We then calculate an annual average number of admissions within this cohort using data from December 2022 to November 2023 (due to late reporting in the data, as explained in step 1). We assume that upon implementation, the number of avoided Part II Section 3 admissions will remain constant at this annual average into the future.

22. To calculate the overall impact of this on total admissions across all parts of the MHA, we subtract the estimated number of avoided admissions from the total admissions within the BaU scenario for each year into the future, within the appraisal period.

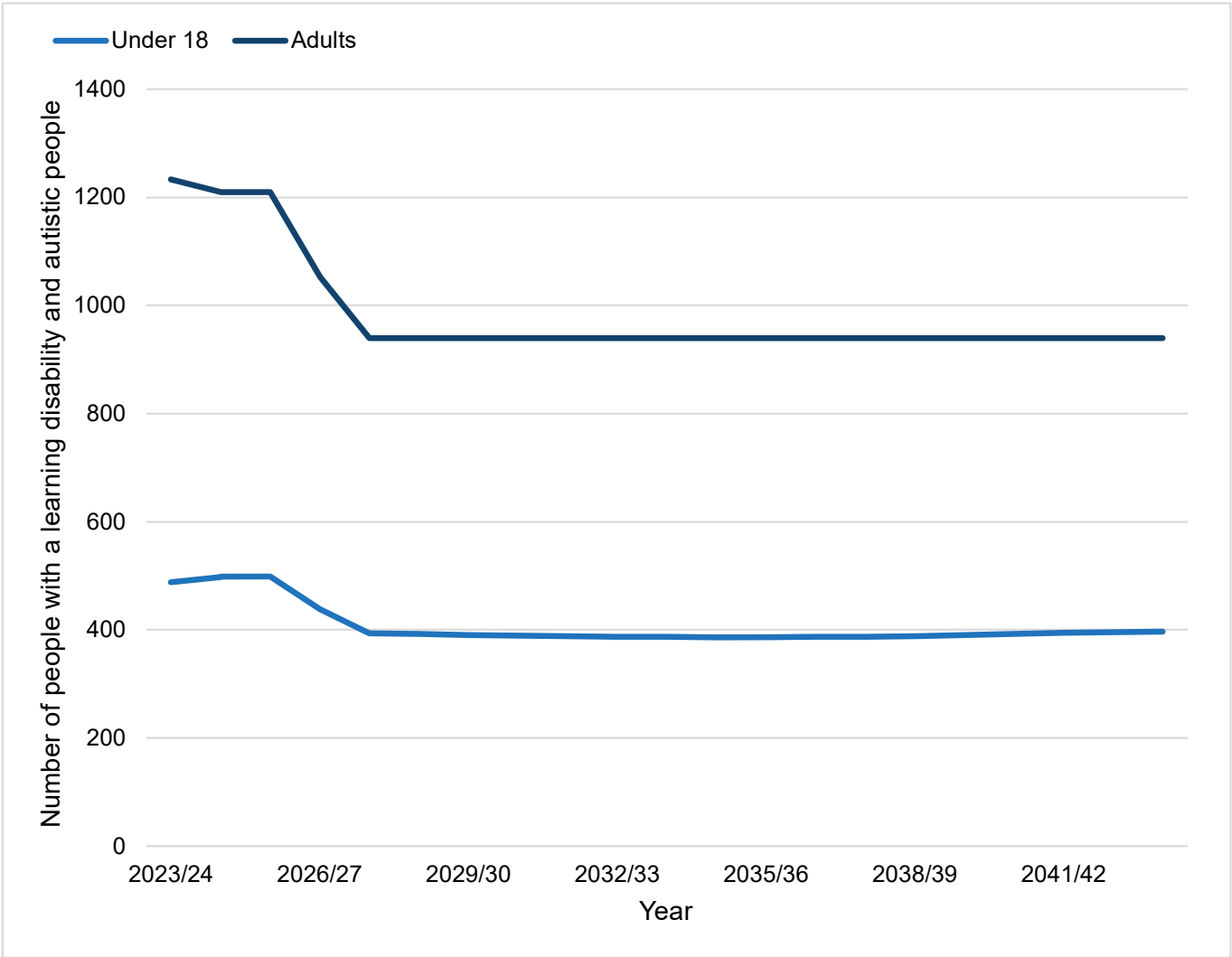


Figure D.4. Total number of under 18 and adult admissions within a policy reform scenario, assuming implementation in 2026/27.

Incorporating inpatients with a learning disability and autistic inpatients into overall mental health detentions in wider Impact Assessment modelling

23. As part of wider modelling across other aspects of MHA reform, overall detention figures have been estimated and forecasted into the future. To ensure inpatients with a learning disability and autistic inpatients are captured within this aspect of the analysis, we have assumed admission figures of people with a learning disability and autistic people are a proxy for an inpatient detention. Within BaU and policy reform scenarios, forecasted admissions of people with a learning disability and autistic people under Part II Section 3 have been subtracted from total MH detention figures to avoid double counting.

Step 6: Estimating the cost and benefit implications of the change in detention criteria.

24. To estimate the cost implications of the change in detention criteria, we need the outputs from the steps above i.e. the number of people who are immediately discharged when the policy change is implemented, and the volume of people who avoid admission thereafter. For the purpose of this analysis, we look at how these two changes in volume are reflected in the total number of inpatients per year in a policy reform scenario vs a BaU scenario.

Calculating a unit cost figure for community care

25. When calculating the community care cost, we consider there are different costs in year 1 (as this includes people who were immediately discharged) compared to later years (as this is comprised of people who have avoided admission).

26. When considering how to calculate community care costs for this group, we recognised there would be health related costs, and social care/local authority related costs. Through further engagement with ICBs and LGA/ADASS, the picture became increasingly complex for several reasons:

    - Community costs are intrinsically challenging to produce a unit cost figure for, as individuals have unique needs, which require unique care packages and support to be implemented. These needs can also evolve and change over time, meaning support needs can also evolve and change over time.

    - Community costs will differ for people who are discharged from inpatient settings, compared to people who are in community settings already, but require an augmented package of care as an alternative to being detained once the reforms have taken place.

    - There are various legal frameworks that may interplay with an individual's community care arrangements and package, including DOLs, Community DOLs and Guardianships, which affect their community care costs.

    - Housing costs will vary depending on various factors, such as whether the individual moves into independent living, moves in with family or residential care.

27. Given these complexities with building a bottom-up picture of community care unit costs for individuals, we have taken a hybrid top-down/bottom-up approach to estimating community care costs.

Community costs for people with a learning disability and autistic people who are immediately discharged from hospital settings, and who avoid admission, when/after the reform is implemented.

28. For the purposes of the analysis, we assume we see a sudden group of immediate discharges on the date that the detention criteria change is switched on. This is assumed for illustrative purposes only. In practice, we recognise that discharges may be more gradual in practice, and the timeline shown here is an illustration for modelling purposes.

29. For groups of people who we assume do not require a new home to be built for them, we assume that the source of capital funding for housing is likely to be from private sources of borrowing, and thus the costs would be in the form of ongoing housing revenue costs (rents). In practice, we recognise that some housing may be funded by the public source of capital grant and/or discounted public land, so would incur lower social rents, instead of the higher private provider revenue costs. However, due to uncertainties in the split, we have assumed the higher housing revenue costs are incurred in all of these cases.

30. To note, housing benefit, is often used to cover the rental costs of housing for people with a learning disability and/or autistic people. Although we do recognise that people with a learning disability may have their own flat, house, bungalow, live with family or choose to rent. For the purposes of this IA, we have assumed all individuals' housing revenue costs are publicly funded via housing benefits.

31. We understand the housing adaptation costs for adults may be lower than the cost estimates used in the table below[176] however, alternative sources only show costs for adults in general, rather than adults with a learning disability and autistic adults, who may have more complex needs and who therefore may need more extensive and expensive adaptations. Therefore, we have taken a cautious approach in using the higher housing adaptation costs noted in the table below.

32. In addition to the unit cost figures outlined below, there is an additional lump sum we have included in the total community cost figures to account for community infrastructure costs. This includes a range of support services including intensive support teams, community forensic teams, children and young people's keyworker services, adult keyworker services and community crisis services. NHSE provided high level England-wide cost estimates based on current need (i.e. in a baseline scenario). Therefore, to assess the *additional* community infrastructure costs associated with reform, following discussions with NHSE, we have applied 0%, 10%, and 25% uplifts to these figures in low, central and high scenarios respectively.

33. The costs we include for adults and CYP **who are immediately discharged** are shown below (where unit costs shown are the central case figure used, in 24/25 prices, undiscounted unless stated otherwise). Please note, length of stay estimates come from NHSE unpublished internal analysis.

34. All adults:
    - **Community care and support package** for the individual upon their discharge, assume this cost only happens for 1.4 years (because adults with a learning disability and/or autistic adults without SMI have average length of stay in hospital of 1.4 years), ~£550k per person, per year[177]. This cost is assumed to be split 50/50 between local authorities and the NHS.

35. Adults (without a home to move into):
    - 56% of adults who are immediately discharged are assumed to need a home to move into[178].
    - **Capital housing cost** where the cost of building them a home is annualised, ~£34k per person, per year[177.]

[176] Room to improve. The role of home adaptations in improving later life.pdf (ageing-better.org.uk)

[177] NHSE unpublished internal analysis

[178] Learning Disability Services Monthly Statistics, AT: August 2024, MHSDS: July 2024 - NHS England Digital

- **Revenue housing cost (public funded)** where this group's revenue housing costs are included for 1.4 years (because adults with a learning disability and/or autistic adults without a SMI have average length of stay in hospital of 1.4 years), ~£22k per person, per year[177].

36. Adults (with a home to move into):

- 44% of adults who are immediately discharged are assumed to have a home to move into already (given 56% figure above).
- **Revenue housing cost (privately funded)** where this group's revenue housing costs are included for 1.4 years (because adults with a learning disability and/or autistic adults without a SMI have average length of stay in hospital of 1.4 years), ~£38k per person, per year.[177]

37. All CYP:

- **Community care and support package** for the individual upon their discharge, assume this cost only happens for 1.2 years (because CYP who have a learning disability and/or autistic CYP, without a SMI have average length of stay in hospital of 1.2 years), ~£550k per person, per year[179].

38. CYP without a home to move into

- 7% of CYP who are immediately discharged are assumed to need a home to move into.[179]
- **Capital housing cost** where the cost of building them a home is annualised, ~£34k per person, per year.
- **Revenue housing cost (public funded)** where this group's revenue housing costs are included for 1.2 years (because CYP who have a learning disability and/or autistic CYP, without a SMI have average length of stay in hospital of 1.2 years), ~£22k per person, per year.[179]

39. CYP without a *suitable* home to move into

- We understand that 24% of CYP do not have a suitable home to move into upon discharge,[179] and 7% do not have a home to move into at all. Therefore, we assume the difference (17%) require housing adaptations to make their current home suitable for them to move into.
- **Capital housing cost** relating to house adaptations as they're already in the community so assume they have a home/somewhere to live, £75k per person, per year[180].
- **Revenue housing cost (privately funded)** where this group's revenue housing costs are included for 1.2 years (because CYP who have a learning disability and/or autistic CYP, without a SMI have average length of stay in hospital of 1.2 years), ~£38k per person, per year.[179]

40. CYP with a home to move into

- 76% of CYP who are immediately discharged are assumed to have a home to move into already (given 24% figure above).
- **Revenue housing cost (privately funded)** where this group's revenue housing costs are included for 1.2 years (because CYP who have a learning disability and/or autistic CYP, without a SMI have average length of stay in hospital of 1.2 years), ~£38k per person, per year.[179]

41. The community costs for people with a learning disability and autistic people **who avoid admission** to inpatient settings, after the reform is implemented are assumed to be different, as these individuals are already in community settings. The housing costs we include are the

[179] NHSE unpublished internal analysis

[180] Microsoft Word - DFG Report Final 16.06.17.docx (foundations.uk.com)

same for adults and CYP (and to note these costs are expected in each year of the appraisal period). Note that costs shown are the central case figure used, in 24/25 prices, undiscounted unless stated otherwise:

- **Social care costs** for adults and CYP, ~£54k[181] and £154k[182] respectively, per person, per year.
- **Capital housing cost** relating to house adaptations as they're already in the community so assume they have a home/somewhere to live, ~£75k per person, per year[183].
- **Revenue housing cost (privately funded)** which is annualised to give ~£43k per person per year[184], including an uplift of ~£90-£100 per week for maintenance costs.

42. Multiplying the volume of inpatients in each year who are no longer in inpatient settings, by the costs above, as well as adding the lump sum amount for community infrastructure costs, produces the following results for adults and CYP community costs over time. We have modelled a low, central and high-cost scenario to reflect the high level of uncertainty in community costs for this group.

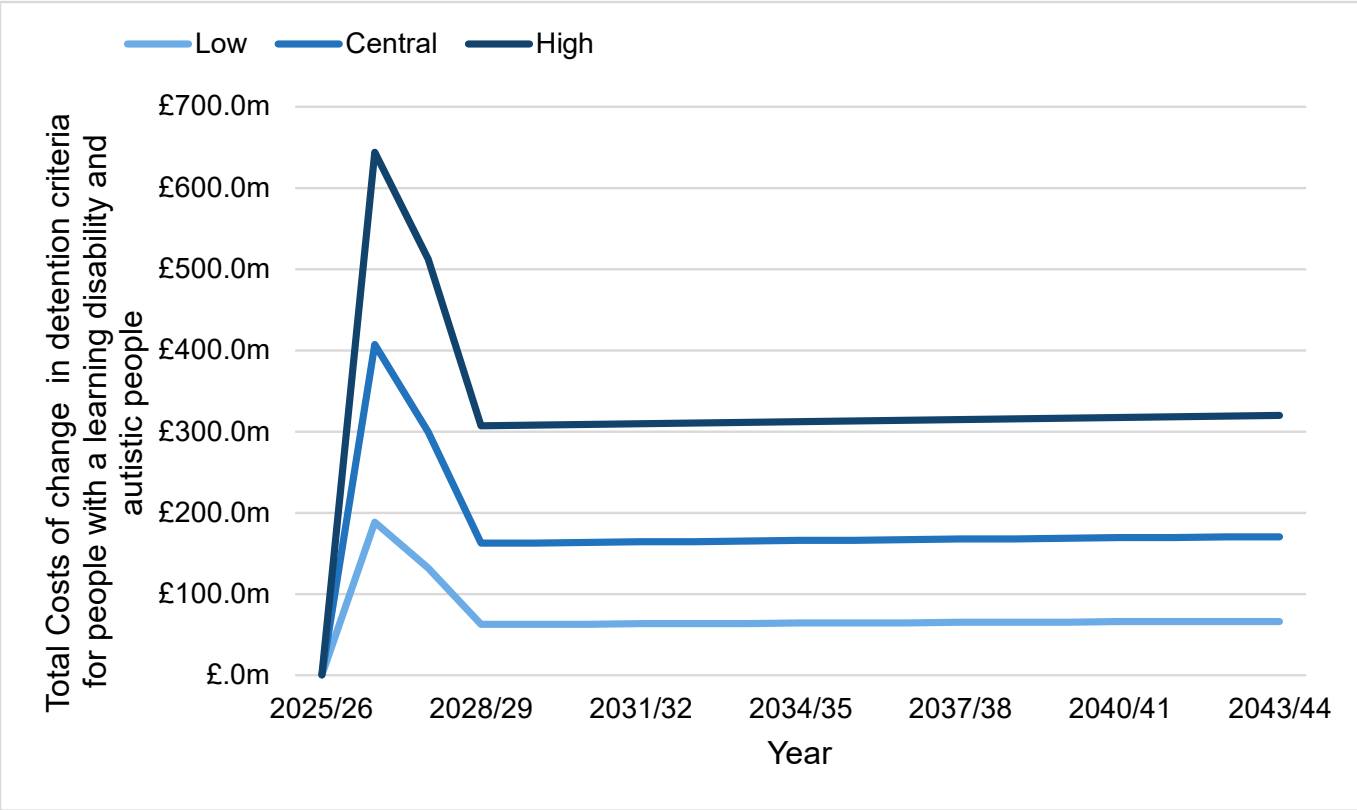


Figure D.5. Community costs for CYP and adults, under low, central and high reform scenarios, 24/25 prices, undiscounted

Calculating benefits from fewer people being in hospital settings

43. Inpatient bed costs for adults and CYP, per person, per year are assumed to be ~£388k[185] (24/25 prices) and we decrease/increase this figure by 50% to produce low/high estimates respectively. However, these values would not all be cashable savings and will require further investigation. We have modelled these low, central and high scenarios to reflect the different

[181] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2022-23

[182] Performance Tracker 2023: Children's social care | Institute for Government

[183] Microsoft Word - DFG Report Final 16.06.17.docx (foundations.uk.com)

[184] NHSE unpublished internal analysis

[185] Learning Disabilities Annual Benchmarking Toolkit 2022/23. NHS Benchmarking Network, 2024. Available to members of the NHS Benchmarking Network, here: https://members.nhsbenchmarking.nhs.uk/outputs/17

types of inpatient bed that an inpatient with a learning disability or autistic inpatient may occupy – where the range covers low/medium secure learning disability and autism beds.

44. To note, the analysis includes only costs per inpatient bed, and we understand there may be additional costs whilst an individual is in hospital as they may receive an Enhanced Care package. Enhanced Care is put into place for patients who, without additional supervised observation, may be at risk of harm from e.g. falls, deterioration or isolation. Therefore, the benefits from having fewer people in inpatient settings, may be an underrepresentation of the true benefits from this reform.

Sensitivity analysis

45. Due to high uncertainty around community costs and inpatient benefits, we have undertaken sensitivity analysis to see what happens to the Net Present Value (NPV) when we combine a high cost/low benefits scenario (i.e. Low NPV) and a low cost/high benefits scenario (i.e. High NPV). To note, as mentioned above, the sensitivity range on community infrastructure costs was calculated slightly differently, as this was calculated as a lump sum uplift on existing community infrastructure costs. In the Low NPV scenario, we assume that a 25% uplift is required, and in the High NPV scenario we assume a 0% uplift is required.

46. The assumptions made on the remaining cost/benefit elements in the low/high NPV scenarios are shown below.

Table D.1. Assumptions in the low and high NPV scenarios.

Area	Cost or Benefit?	High NPV (low cost, high benefits)	Low NPV (high costs, low benefits)
Community care and support	Cost	-50%	+50%
Housing capital cost, and revenue cost (private and public funded)	Cost	NHSE unpublished internal analysis	NHSE unpublished internal analysis
Social care (CYP)	Cost	-50%	Estimate of high-cost CYP social care placement[186]
Social care (adults)	Cost	-50%	+50%
Inpatient costs	Benefits	-50%	+50%

DII. Estimating the impact of putting Care (Education) Treatment Reviews on a statutory footing

Background and proposed policy change

1. A Care (Education) and Treatment Review (C(E)TR) is a person-centred review to ensure the care (education) and treatment and support needs of the individual person and their family are met, and that barriers to progress and/or discharge are challenged and overcome[187].

2. C(E)TRs are conducted for both adults and children and young people (CYP), where education considerations are additionally included for CYP, and for both inpatients and individuals in the community who are at risk of admission. The proposed reforms will formally require a C(E)TR to be undertaken in most cases after an admission and will make recommendations from C(E)TRs for inpatients (which can include recommendations about community support) be placed on a statutory footing, for certain detained patients, meaning that they must be taken into account as part of someone's care and treatment.

[186] High-cost children's social care placements survey | Local Government Association

[187] Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf (england.nhs.uk)

3. C(E)TRs are important in helping to ensure that when people with a learning disability and autistic people are detained under the Mental Health Act (MHA), there is a clear therapeutic benefit and discharge is a priority from the first day of detention. Despite C(E)TRs being part of current NHS England policy, the recommendations made by C(E)TRs are not always implemented fully, meaning their benefits are not fully realised.
4. Under the proposed reforms, responsible commissioners will be under a duty to ensure that CYP and adult inpatients with a learning disability and autistic inpatients receive a C(E)TR within specified timeframes - this is within 14 days of admission for CYP and 28 days for adults.
5. We intend to set out in regulations that any information obtained from a C(E)TR will also be included in an individual's Care and Treatment Plan, and their dynamic risk register entry, which Integrated Care Boards and Local Authorities will have regard to when commissioning services.
6. As a result of these changes, individual's care, treatment and support needs will be better met and barriers to progress challenged and overcome, supporting faster discharge back into the community.

Methodology

Step 1: Identifying patients who would be eligible for a C(E)TR

7. In line with the proposed policy change, we have used admissions data to account for all CYP and adults with a learning disability and autistic people receiving a C(E)TR. Using the 'Patient admissions within the month, by admission status and Care, (Education) and Treatment Review on admission' data, from the Assuring Transformation database[188], we determined that an estimated 86% of all admissions currently receive a C(E)TR. To note, NHS England colleagues have advised that their policy is that patients should also have C(E)TRs whilst they are in hospital. As such, the frequency of C(E)TRs may be different for different groups of patients.
8. Under the proposed policy change, we assume that 100% of admissions of people with a learning disability and autistic people will be required to receive a C(E)TR, meaning an additional 14% of C(E)TRs will be required to take place following the introduction of the policy change in order to meet the required standard. However, we were advised by NHS England to adjust this percentage to account for a small proportion of individuals who are expected to not consent to a C(E)TR. They estimated this to represent 5% of eligible individuals, which means that we expect C(E)TRs to take place for an additional 9% of people following the proposed reforms. We applied the additional 9% percentage to our adult and CYP admissions data, in order to determine an estimated number of additional C(E)TRs that will be required to take place. The percentages and subsequently calculated estimate numbers for this are displayed below in Table D.2.

Table D.2. Summary of current use of C(E)TR, additional use of C(E)TRs required following the proposed policy change, forecast admission data, and estimated number of additional C(E)TRs required following the proposed policy change, in 2025/26[189].

Group	Current % receiving C(E)TR	Additional % C(E)TRs required following policy change	Forecasted admissions data (2025/26)	Estimated number of additional C(E)TRs required following policy change (2025/26)
Adults	86%	9%	1210	**109**
CYP	86%	9%	499	**45**
Total	86%	9%	1709	**154**

[188] Learning disability services monthly statistics from Assuring Transformation dataset: Data tables - NHS England Digital
[189] Estimates of the number of additional C(E)TRs required following the policy change are based on the % of current patients receiving a CETR. This includes all patients who have ever had a CETR recorded (not necessarily related to their current admission). The current % receiving a C(E)TR (86%) therefore overestimates the % of patients being admitted who receive a C(E)TR close to admission and so should be treated with caution.

Step 2: Working out total costs

Estimating workforce costs for C(E)TRs

9. The main costs associated with C(E)TRs are workforce costs, as integrated care boards (ICBs) will need to recruit and pay staff to provide this service. Each C(E)TR panel comprises a chairperson, an independent clinical expert, an independent expert by experience, and an administrator. If the review is for a CYP, a children's social care or education professional on the panel is also included[190]. NHS England has also advised that we include an additional cost for clinical staff, to represent workforce already involved in administering care to the individual receiving the C(E)TR.

10. Guidance for supporting C(E)TR panel members and their requirements[191], published in January 2023, has indicated that experts by experience and clinical experts are paid a minimum rate of pay for their involvement in a C(E)TR. However, pay estimates for the remaining panel members are not publicly available, and so desk-based research was conducted to estimate the annual salaries of the panel members using data published by the NHS on their pay bands[192] and via job adverts[193,194].

11. Salary information has been taken from the 2024/25 financial year wherever possible. We have adjusted for inflation[195] to bring the rate of pay for experts by experience and clinical experts to bring these figures in line with 2024/25 salary data. Where multiple professions with differing annual salaries were eligible to hold a panel position, an average of their salaries was taken and used as an estimate for the position. Given the overall uncertainty in the cost of the workforce, we have used the highest salary estimates available when a range has been provided for a particular profession or role.

Assumptions & uplifts applied to our estimates

12. Once we had determined estimate annual salaries for the panel positions whose pay per C(E)TR was not publicly available, we applied a series of assumptions provided by NHS England[196] to calculate an estimate for the number of working hours we would expect an individual to work per year. This included accommodating for annual leave, bank holidays, performance management, continuous personal development (CPD) and sick leave. We were then able to determine an estimate hourly rate for each panel position, by dividing annual salary estimates by the assumed working hours per year. For each estimated hourly rate, we then applied a 48% uplift as advised by NHSE Strategic Finance partners, to allow for the additional cost of expenses and overhead fees.

13. A C(E)TR is estimated to take a full working day to complete[197]. As such, we have used 8-hours as an estimate for required workforce hours for our calculations. As advised by NHS England, six or seven additional clinical staff representatives may also be involved for one hour each. To reflect this, we have taken a mid-point and used 6.5 staff to represent their time in our analysis.

14. In order to estimate the cost of the C(E)TR, the estimated salary per hour for the panel positions whose pay per C(E)TR was not publicised was summed, and multiplied by the estimated number of hours taken to complete a C(E)TR. We then added the rate of pay for the 6.5 additional clinical staff representatives, and then added the rate of pay for experts by experience and clinical

[190] Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf (england.nhs.uk)

[191] Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf (england.nhs.uk)

[192] Agenda for change - pay rates | Health Careers

[193] Education-Welfare-Officer | Explore careers | National Careers Service

[194] Social-Worker | Explore careers | National Careers Service

[195] GDP deflators at market prices, and money GDP June 2024 (Quarterly National Accounts) - GOV.UK (www.gov.uk)

[196] Working for the NHS in England | Health Careers

[197] CETR Information for young people and families NA updated March 2023.pdf (icb.nhs.uk)

experts to generate a total cost per C(E)TR. We calculated adult and CYP costs separately to account for the additional panel members required to conduct the C(E)TR when a CYP is present. The estimated workforce salaries used in this analysis are summarised below, in Table D.3.

Table D.3. Summary of estimated workforce day rate salaries, and total costs for CTRs & CETRs, set in 2024/25 prices.

	Workforce	Estimated day rate (£), in 2024/25 prices
Adults & CYP panel	Chairperson	£535.40
	Administrator	£208.97
	Clinical expert	£414.40
	Expert by experience	£296.00
	Clinical staff representatives	£360.88
CYP only	Educational representative	£353.96
Total costs		
Adults	Total cost per **CTR** in 2024/25	£1,815.65
CYP	Total cost per **CETR** in 2024/25	£2,169.61

Estimating the total annual C(E)TRs costs

15. Lastly, we multiplied the estimated cost per C(E)TR by the forecasted number of admissions to calculate the estimated total costs for the additional required C(E)TRs each financial year, starting from 2025/26. Table D.4 below illustrates the estimated total costs for conducting the additionally required C(E)TRs, split by sub-group.

Table D.4. Estimated total costs forecast for appraisal period in £million, set in 2024/25 prices.

Group		2025/26 (£)	2026/27 (£)	2027/28 (£)	2028/29 (£)	2029/30 (£)	2030/31 (£)	2031/32 (£)	2032/33 (£)
Adults	Total costs for additional **CTRs** each year	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
CYP	Total costs for additional **CETRs** each year	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total	Total costs for additional **C(E)TRS** each year	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.2

Group		2033/34 (£)	2034/35 (£)	2035/36 (£)	2036/37 (£)	2037/38 (£)	2038/39 (£)	2039/40 (£)	2040/41 (£)
Adults	Total costs for additional **CTRs** each year	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
CYP	Total costs for additional **CETRs** each year	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total	Total costs for additional **C(E)TRS** each year	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2

Group		2041/42 (£)	2042/43 (£)	2043/44 (£)
Adults	Total costs for additional **CTRs** each year	0.2	0.2	0.2
CYP	Total costs for additional **CETRs** each year	0.1	0.1	0.1
Total	Total costs for additional **C(E)TRS** each year	0.2	0.2	0.2

DIII: Estimating the impact of requiring ICBs to establish and monitor Dynamic Support Registers (DSRs)

Background and proposed policy change

1. A Dynamic Support Register (DSR) is a 'live' mechanism for local systems to identify children, young people (CYP) and adults (with consent) who are at risk of admission to mental health inpatient services without access to timely dynamic support. They provide the mechanism to:
   - use risk stratification to identify people at risk of admission to a mental health hospital.
   - work together to review the needs of each person registered on the DSR.
   - mobilise the right support (for example, a Care (Education) and Treatment Review (C(E)TR), referral to a keyworker service for CYP, or extra support at home) to help prevent the person being admitted to a mental health hospital.

2. The DSR enables systems to identify adults, children and young people with increasing and/or complex health and care needs who may require extra support, care and treatment in the community as a safe and effective alternative to admission to a mental health hospital. Additionally, they play a role in ensuring that people's needs are included in commissioning plans, financial plans, service delivery and development.

3. The current NHS England policy requires all people at risk of admission, and all inpatients, to be on or added to a DSR. Under the proposed reforms, it will become a statutory requirement for all Integrated Care Boards (ICB) to establish and maintain a local 'at-risk' register. This will allow them to understand, monitor and respond to the risk of admission for people with a learning disability and autistic people in their population.

4. There will be duties on both ICBs and Local Authorities to have regard to risk registers and the needs of the local 'at risk' population when carrying out their commissioning functions, to ensure adequate community services are available for people with a learning disability and autistic people who are at risk of admission under Part II of the MHA.

5. By having these duties, we consider that this would increase the likelihood of effective joint action being taken locally and would enable commissioners to better understand the needs of people with a learning disability and autistic people in their population. The intention behind these changes is to enable better planning for the provision of appropriate community-based services and to avoid unnecessary admissions into inpatient settings.

Methodology

Step 1: Identifying patients who would be eligible for being added to a DSR

Identifying the current number of admissions per year & current percentage of DSRs

6. In line with the proposed policy change, we have used forecasted admissions data to ensure that all CYP and adult inpatients with a learning disability and autistic inpatients are recorded on a DSR. However, we note that the estimate population who would be eligible for this proposal could be higher than what admission data would indicate, as the proposed reforms would mean that any individual who is deemed 'at risk' of admission should be registered on a DSR. As such, this analysis represents a minimum projected cost, and sensitivity analysis has been applied to our figures to accommodate this risk.

7. Secondly, the unit cost of DSRs is regarded as highly uncertain, due to assumptions made on the time involved and workforce costs. We also understand that some portion of the DSR costs may be fixed and therefore would be unaffected by population size. As such, we have presented a range of costs to reflect this uncertainty.

8. We were advised by NHS England that 53% of all admissions are currently recorded on a DSR. Under the proposed policy change, 100% of admissions of people with a learning disability and autistic people should be recorded on a DSR, meaning that an additional 47% of patients will

be required to be recorded on a DSR following the introduction of the policy change in order to meet the required standard.

Identifying the additional people to be added to a DSR that will need to happen post-reform

9. We applied the additional 47% percentage to our adult and CYP admissions data, in order to determine an estimated number of additional people that would need to be added to an ICB's DSR that will be required to take place. The percentages and subsequently calculated estimate numbers for this are displayed below in Table D.5.

Table D.5. Summary of current use of DSR, additional use of DSRs required following the proposed policy change, forecast admission data, and estimated number of additional DSRs required following the proposed policy change, in 2025/26.

	Current % registered on a DSR	Additional % required to be on a DSR following policy change	Forecasted admissions data (2025/26)	Estimated number of additional people on a DSR required following policy change (2025/26)
Adults	53%	47%	1210	569
CYP	53%	47%	499	234
Total	53%	47%	1709	803

Step 2: Working out total costs

Estimating workforce costs for DSRs

10. All ICBs should already have a DSR established, and so there are no expected costs associated with this element of the statutory requirement. The main costs associated with DSRs are workforce costs for 'monitoring' the DSR, as ICBs will need to recruit and pay staff to provide this service. Everyone on the DSR should have a care plan, and so when we refer to monitoring of the DSR, this refers to developing and reviewing the care plans by a multi-disciplinary team.

11. There is limited information available about the precise workforce involved in a DSR, however, we have been advised by NHS England regarding the typical workforce involved in monitoring a DSR and have used this advice to inform our analysis. It is important to note that the precise workforce involved is expected to vary significantly, and so the following analysis is based on an indicative example, as advised by NHS England.

12. For the purpose of this analysis, reviewing a DSR care plan is expected to involve a commissioning manager, a learning disability & autism executive lead, a social care service manager, and an administrator[198]. If the DSR review is for a CYP, we would also expect a senior education, health and care plan co-ordinator[199] to be present.

13. As advised by NHS England, we also expect there to be specialist keyworkers for CYP on the DSR who are rated as red or amber, whereby red indicates an immediate risk of admission, and amber indicates urgent intervention being required to prevent a patient becoming at 'immediate risk of admission'. Assuring Transformation data[200] currently indicates that 26% of CYP admissions who are recorded on the DSR are categorised as red or amber, and therefore would require additional keyworker support. Case load is expected to vary significantly for these specialist keyworkers, affecting the estimated number of hours we might expect for their involvement. As such, we have used high, low and mid-point estimates for their time, as advised by NHS England.

14. Pay estimates for this workforce are not publicly available, therefore desk-based research was conducted to estimate the annual salaries of the panel members using data published by the

[198] Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf (england.nhs.uk)

[199] The DSR (Dynamic Support Register) and CETRs (Care Education and Treatment Reviews) - City of London Family Information Service

[200] Learning disability services monthly statistics from Assuring Transformation dataset: Data tables - NHS England Digital

NHS on their pay bands[201], national careers service data[202] and via job adverts[203]. All salary information has been taken from the 2024/25 financial year.

15. Where multiple professions with differing annual salaries were eligible to hold a panel position, an average of their salaries was taken and used as an estimate for the position. Given the overall uncertainty in the cost of the workforce, we have used the highest salary estimates available when a range has been provided for a particular profession or role.

Assumptions & uplifts applied to our estimates

16. Once we had determined estimate annual salaries for each staff member, we applied a series of assumptions provided by NHS England[204] to calculate an estimate for the number of working hours we would expect an individual to work per year. This included accommodating for annual leave, bank holidays, performance management, continuous personal development (CPD) and sick leave.

17. We were then able to determine an estimate hourly rate for each staff member, by dividing annual salary estimates by the assumed working hours per year. For each estimated hourly rate, we then applied a 48% uplift as advised by NHSE Strategic Finance partners, to allow for the additional cost of expenses and overhead fees. The estimated workforce salaries are summarised below, in Table D.6.

Table D.6. Summary of estimated workforce hourly rate salaries, set in 2024/25 prices.

	Workforce	Estimated hourly rate (£), in 2024/25 prices
Adults & CYP	Commissioning manager	£66.93
	Learning disability and autism executive lead	£123.30
	Social care services manager	£71.90
	Administrator	£26.12
CYP only	Senior education health and care plan co-ordinator	£60.03
	Keyworker support, for red/amber CYP only	£44.25

18. There is limited guidance available online to suggest how long it takes to review a DSR care plan. As a result, we used a higher, lower and central estimate of time taken in hours for each element. We have tested our proposed approach with commissioning representatives from an ICB with an established DSR, who confirmed that our time estimations are sound. We then calculated an estimated yearly number of hours for reviewing a DSR care plan, following guidance which suggests that a DSR is conducted monthly at a minimum[205]. This data is displayed in Table D.7 below.

Table D.7. Estimated length of time required to review a DSR care plan, in hours.

	Higher estimate (hours)	Lower estimate (hours)	Central estimate (hours)
Length of time for a DSR care plan review	2.00	0.17	1.08
Length of time for a DSR care plan review (hours/year)	24.00	2.00	13.00

Estimating the total annual DSRs costs

19. Lastly, we multiplied the estimated cost per DSR care plan review per year by the forecasted number of admissions, to calculate the estimated total costs for the additional required DSR care plan reviews each financial year, starting from 2025/26. Adults, CYP and red/amber CYP

[201] Agenda for change - pay rates | Health Careers

[202] Clinical-Psychologist | Explore careers | National Careers Service

[203] Job Advert (jobs.nhs.uk)

[204] Working for the NHS in England | Health Careers

[205] Dynamic Support Register (DSR) - West Sussex County Council

estimated costs were calculated separately, to account for the differences in their associated workforce costs, and then summed to give overall figures.

Annex E. Estimation approach for Justice system impacts.

E.I Types of costs modelled.

Main costs

1. There are two primary costs modelled: Legal Aid costs and Sitting Day Costs. In order to calculate the cost impact associated with the recommendations, any changes in the volume of referrals, applications, or cancellations for hearings at the Mental Health Tribunal (MHT) were modelled based on assumptions agreed between analytical and policy colleagues at MoJ. Below is a summary of the methodology of how the two main costs were estimated, followed by a brief description of how the volumes were modelled to estimate the costs.

2. Mental Health Tribunal (MHT) receipts are beginning to recover from the dip in recent years due to COVID-19. In the future, we are adjusting based on the detention trends as more people receiving detentions leads to more people being eligible to apply to the MHT.

3. Estimates were made using a forecast of the number of receipts/hearings (see methodology below) and a hearing days per sitting day ratio of 1.38, multiplied by the average sitting day costs for an MHT. The average sitting day cost of the MHT used in this IA was £2,561 in 2024/25 prices – this cost consists of staff costs, judicial salaries, estate costs and any other associated costs. The average sitting day cost is assumed to increase in line with the OBR's Average Weekly Earnings (AWE) projection (March 2024) throughout the appraisal period. This is because the vast majority of the cost of a sitting day is from judicial and non-judicial staffing costs, which have historically more closely tracked with increases in AWE than the GDP deflator.

Legal Aid costs

4. Legal Aid costs include the cost to provide legal aid services to those who have cases before the MHT (or other courts if required). We have not included costs to the Legal Aid Agency (LAA) to administer any additional demand for legal aid. The administrative costs are likely to be small compared to the impact on the legal aid fund. The modelling is based on the average payment for claims of legal aid work in 2023/24 prices. Prices were isolated based on particular 'matter codes' used when filing legal aid claim forms.

5. The following assumptions were used in the modelling:
   - Costs were mostly calculated based on the number of receipts of cases, rather than hearings. This is because preparatory work for cases can be claimed, and may extend across financial years. This preparatory work can also be claimed even if cases do not proceed.
   - The estimated average cost of Legal Aid payments is fixed in nominal prices over the Impact Assessment's time horizon as legal aid fees do not routinely rise with inflation, instead rising in cash terms irregularly.
   - That all those eligible for Legal Aid will take up the representation.
   - Legal aid provider capacity has not been considered but it is assumed there will be sufficient capacity at the time of implementation.

6. The Option 1 (BAU) scenario will not match the published claim value for legal aid for various reasons. The estimated total legal aid costs to reimburse legal aid providers reflects an upper bound of public sector costs and a fairer estimate of the overall economic cost. The BAU scenario

is modelled for each proposal individually using an approximate average cost for the patient group and receipt volumes, which are estimations of the actual work completed by legal aid providers.

7. Legal aid impacts have been calculated using a similar approach to other justice cost impacts, however the cost impacts have been calculated using projected receipt volumes, instead of hearings, as preparation costs can be claimed by providers even if cases do not proceed to a hearing. It was not possible to accurately consider the potential cost impact of additional preparation resulting from some recommendations. The average cost of providing legal aid for specific hearing types was calculated based on data provided by the Legal Aid Agency.

Sitting Day costs

8. Sitting day costs constitute the cost of facilitating hearings, including the fees paid to judicial and non-judicial members of the MHT. They are based on an assumption of maintaining the current average number of hearings per day, based on MoJ analysis of MHT data. The cost of a sitting day is extrapolated over the time period using the OBR's AWE projection.

E.II. Justice system estimates for automatic referrals

9. The Government proposals related to automatic referrals are one of the 4 themes of recommendations considered in the Justice system's impacts of the IA and the largest aspect of our costs.
10. Since civil patients can be discharged at any point by the Responsible Clinician (RC), the MHT's purpose is to offer a safeguard against unnecessary detention. Around a third of the Section 3 cases (those admitted for treatment) disposed of annually involve the patient being discharged by their RC shortly before the MHT hearing. We used MHT hearing volumes instead of receipt volumes in most of the analysis for the potential MHT costs. This avoided overestimating MHT activity in light of discharges by an individual's RC that often occur prior to the hearings taking place.

11. The Government's proposal is to accept recommendations on automatic referral policies to reduce the initial maximum detention criteria and ensure there is an automatic referral to the tribunal at specified time periods (3 months after the detention started then at 12 months and annually after that). This is expected to shorten the application and referral periods for people detained under Section 3 of the MHA. The proposals to allow patients to apply to the MHT in the first 3 months of their detention and to implement a first automatic referral point at 3 months rather than 6 months would have the consequence that 100% of all patients will have the opportunity to apply or instead be automatically referred to the MHT in the first 3 months of their MHA detention.

12. Given the data limitations around determining what proportion of patients currently go to the MHT in the first 3 months, an alternative methodology was devised. The proposal meaning patients are able to apply 3 times in their first year of detention as opposed to twice would be an approximate 50% increase. Across 3 years, patients would have an increase from 4 to 5 chances to apply, which is a 25% increase. These ranges were averaged to create the central scenario of a 37% increase. Using assumptions on the proportion of Section 3 detentions that last longer than 1 year from the Length of Stay data provided by NHS Digital (NHSD), an increase in the volume of actual Section 3 applications annually was estimated.

13. It was assumed that the move from 6 to 3-month mandatory referrals would induce a 'bring forward' effect only on the volume of Section 3 MHT receipts and subsequent hearings. Thus, the main impact would be the move from referrals every 3 years to annual referrals, which has been captured as a 100% increase on the volume of these hearings annually – under Section 68(6).

14. The Government has accepted a recommendation that 100% of patients detained under part III of the MHA will have the opportunity to apply or instead be automatically referred to the MHT in the first 12 months of their detention. We know the volume of restricted patients detained under part III of the MHA and the volume of applications to the MHT by each section of the MHA, but not the volume of non-restricted part III patients. The two data sets above were used, with assumptions including that the proportion of restricted part III patients and non-restricted patients who apply to the MHT would be the same, to arrive at a high and low scenario to estimate the expected annual increase in MHT receipts. This methodology also assumes that the proportion of direct applicants remains constant, and that the volume of patients detained under part III of the MHA is steady.

15. The Government proposes to introduce a completely new right for discharged patients ("There should be an automatic referral for people on conditional discharge to the tribunal after 12 months and at regular intervals after that for patients who have not applied directly"). Currently, such patients are eligible to apply to the MHT once in the first 12-24-month period and then every 2 years, but there is no automatic referral process.

16. Because this would be a completely new right under the MHA for patients, the counterfactual annual volume and cost of the status quo is zero here. There is also no available information on what proportion of receipts might follow through into hearings. Therefore, receipt volumes were used, rather than hearings.

17. The estimation approach uses data on the length of time that previous patients were on conditional discharge before being given an absolute discharge on the grounds that the profile of these previous patients is representative of the current sample. Length of detention is not a direct indicator for suitability for absolute discharge as this will depend on individual circumstances. However, it gives an indication of the volume of current conditional discharge patients that could be suitable for immediate absolute discharge.

18. The analysis then estimates the number of people who have another automatic referral 4 years after the first. A steady influx of patients being given a conditional discharge and a stable proportion of direct applications to the MHT is assumed. The current success rate of applications to the MHT under Section 75(2) is around a quarter. However, it is felt by operational colleagues that it is very unlikely the majority of patients would meet the criteria for absolute discharge after 2 years – the mean duration of conditional discharge before absolute discharge is 6 years 8 months. Success rates are likely to be higher at the second automatic referral, so differing success rates are used depending on the duration spent on conditional discharge at the time of the tribunal. At the 2 year point the success rate varies between 3% and 7%, with the central scenario using 5%. At the second automatic referral (the 6-year point) the success rate varies between 30% and 36%, with the central scenario using 33.3%.

19. The Government has accepted proposals regarding the rights of patients released on a CTO to appeal to the MHT. Patients are currently automatically referred after the first 6 months and at 3-year intervals after that. The Independent Review suggests changing this 3-year referral period to an annual one, much like with Section 3 referrals.

20. The estimation approach involved trend analysis, utilising the known volumes of referrals under Sections 68(2) and 68(6) currently. It is worth noting that greater scrutiny of CTOs as part of the Bill reforms is expected to reduce the use of CTOs over the appraisal period. Therefore, while the individual proposals considered in this section have the impact of increasing potential receipts to the MHT, they do so within the context of an overall reduction in CTO volumes.

21. The cross-cutting assumption used for this analysis was a central scenario of a 20% reduction in CTOs over our appraisal period due to the impact of the reforms. This policy is expected to start

from 2031/32, with the impact being a gradual decline (4 percentage point reduction each year) until it reaches a total 20% reduction in CTOs in 2035/36. As the implementation period for this policy starts in 2030/31 it appears as though there is a sharp decline in CTOs from the start, when it is more gradual.

E.III. Justice system cost estimates for treatment choice

Background and proposed policy change

1. The Government proposes to allow the MHT to review the patient's CTP where concerns have been expressed.

Main assumptions for Option 1 (BAU)

2. BAU assumes no reviewing of CTPs by the MHT.
3. Therefore, there is no additional time required for hearings.

Main assumptions for Option 2 (Policy On)

4. In the central scenario, it is assumed that reviewing the CTP will require an additional 40 minutes per hearing.
5. It is assumed the average sitting day is 5 hours.
6. The hearing volumes for each policy scenario uses the expected hearing volumes from the automatic referrals recommendations as an input. The costs for each policy scenario thus reflect the additional costs from the increase in sitting days resulting from a lower hearings per sitting day ratio, for the same volume of hearings. The original hearings per sitting day ratio is 1.38 but with an additional 40 minutes per hearing this lowers the hearings per sitting day to 1.17 under the central scenario.

Output

7. The total number of relevant hearings for this policy is calculated and the time taken for each hearing is increased.
8. The number of additional sitting days required is then calculated followed by the associated cost.

E.IV. Justice system cost estimates for expanded powers

Background and proposed policy change

1. The Government proposes to expand the powers of the MHT through three reforms for which costs have been estimated. The Government proposes that:
    - The MHT should have the power, during an application for discharge of non-restricted patients, to recommend that the relevant aftercare bodies make plans for the provision of aftercare services for the patient where this is necessary to facilitate discharge at a future date.
    - The MHT should have the power to review the conditions attached to the CTO and recommend that the RC reconsider the conditions specified in a CTO.
    - For a very distinct group of restricted patients the MHT should have the power to discharge with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

Main assumptions for Option 1 (BAU)

2. BAU assumes no extension of the MHT's current powers.

3. Therefore, no additional time for hearings.

Main assumptions for Option 2 (Policy On)

4. For the tribunal having the power to grant leave from hospital and direct transfer to a different hospital, it is assumed this will only affect 10 cases per year and require 2 additional hours for each case.

5. When refusing to discharge from a CTO, the MHT will also be able to order changes to the conditions attached to the CTO. This additional duty is assumed to add an additional hour to considerations of CTO discharges.

6. For the tribunal having the power to discharge patients with conditions, it is assumed that the supervision reviews will be held every 2 years.

Output

7. For the expanded power to grant leave from hospital and direct transfer to a different hospital, and the power to order changes to the conditions of the CTO, the cases and additional time per case are used to calculate the total additional hours per year and therefore the total additional number of sitting days. This can then be multiplied by cost per sitting day to calculate the total cost of the policies.

8. For the supervision reviews, it is estimated that the number of those supervised will increase over time as not many patients' status will change during the period. The cost is expected to result predominantly from the new additional sitting days required, as well as the legal aid cost of providing representation.

E.V. Justice system cost saving estimates for detention criteria

Background and proposed policy change

1. The Government proposes that section 3 patients should be certified as continuing to meet the criteria for detention 10 days in advance of a hearing at the MHT.

Main assumptions for Option 1 (BAU)

2. BAU assumes patients don't need to certify that they continue to meet the criteria.

3. Therefore, the number of cancellations will stay the same.

Main assumptions for Option 2 (Policy On)

4. 50% of cancellations can be avoided by giving 10 days' notice.

5. Section 3 cancellation fees make up 37% of total cancellation fees. The reasons for late cancellations are commonly (but not limited to) that the patient has been discharged within 48 hours of the hearing; there has been a change in a patient's circumstance; or that there has been late notification of discharge or a change in circumstances. For these reasons, in conjunction with the fact that not all cancelled panel members can find a suitable alternative 45 panel to sit on, even with 10 days' notice of cancellation, the proportion of all cancelled panels that can be reallocated with 10 days' notice of cancellation was assumed to be 50%.

6. We assume a physical examination can be conducted as close to 10 days of the hearing as possible, with a maximum of 17 days prior to the hearing, and certification itself is provided to the MHT 10 days prior to the hearing.

Output

7. The costs of the BAU scenario are calculated by multiplying section 3 claim volumes (37% of total cancellation volumes) by fees.

8. The Policy On scenario costs are calculated by multiplying BAU costs by 50% as 50% of panel members can be reallocated.

9. The difference between these two is then calculated to give the cost of the policy.

Annex F. Methodology behind breakeven analysis for non-monetised benefits

Patient health benefits

1. The cost per QALY "at the margin" in the NHS (£15,000):
    - The NHS budget is limited, in any given time period. This means that there are potential activities, or beneficial uses of funds that would generate QALYs, but which cannot be undertaken because the budget is fully employed. If additional funds were given to the NHS, additional QALYs would be generated by funding these activities. Similarly, if funds were taken from the NHS, QALYs would be lost - as some activity "at the margin" could no longer be funded and would necessarily be discontinued.
    - The cost per QALY "at the margin" is an expression of how many QALYs are gained (or lost) if funds are added to (or taken from) the NHS budget. It has been estimated by a team led by York University, and funded by the Medical Research Council, to be £12,981.[206] Expressed in 2016, and adjusted to give an appropriate level of precision, DHSC interprets this estimate as a cost per QALY at the margin of £15,000.
    - This implies that every £15,000 re-allocated from some other use in the NHS is estimated to correspond with a loss of 1 QALY. Conversely, any policy that releases cost savings would be deemed to provide 1 QALY for every £15,000 of savings released.
2. The social value of a QALY is now estimated by DHSC at £70,000.[207] This is based on inflating previous estimates of the social value of a QALY (£60k estimate in 2014 prices) and appropriately rounding.
3. Society values health, as individuals would prefer to be healthy and to avoid death. This value can be expressed as a monetary "willingness to pay" for a QALY – the unit of health. The value society places on a QALY is also, in principle, a matter of empirical fact that may be observed. DHSC currently estimates this value to be £70,000, based on analysis by the Department for Transport of individuals' willingness to pay to avoid mortality risks. Note that the estimated social value of a QALY significantly exceeds the estimated cost of providing a QALY at the margin in the NHS. This implies that the value to society of NHS spending, at the margin, significantly exceeds its cost. Adding £15,000 to the NHS budget would provide 1 QALY, valued at £70,000, according to these estimates.
4. To estimate the health benefits following from the policy intervention completely offsetting the costs of the policy in each year, we divided the additional overall cost of the policy in each year by £70,000 to work out the number of QALYs this would be equivalent to. This was then divided by the estimated number of people detailed in each year to work out the health gains that would need to be gained per detention.

Example of an increase in health benefits

[206] Methods for the Estimation of the NICE Cost Effectiveness Threshold (nihr.ac.uk); DH Title (dhsc.gov.uk)

[207] Franklin150331Monetary-Valuation-of-a-QALY-2014-prices.pdf (dhsc.gov.uk); DH Title (dhsc.gov.uk)

5. Based on the calculated NPV over the 20-year appraisal period for option 2, the time profile of overall annual discounted net cost of the policy in that year is divided by the social value of a QALY at £70,000 (discounted) to give the estimated number of QALYs needed to offset net cost in each year;
6. Dividing this number of QALYs by the estimated number of detentions under BAU for each year produces an estimate of a health gain per detention from 2025/26 required.
7. Based on the discounted net cost of Option 2, we estimate that the in-year patient health gains per detention projected across the period would need to be equivalent to 0.003 QALYs in the 'policy on' scenario in order to produce discounted benefits commensurate with the monetised NPV.
8. This is equivalent to helping someone live for an extra 0.9 days in perfect health (i.e. health-related quality of life (HRQoL) of 1), or, live for an extra 1.9 days in a state of perfect health rather than in moderate health (if that were equivalent to a HRQoL of 0.5).
9. One of the most widely used preference-based instruments for the assessment of Health-Related Quality of Life (HRQoL) that can be used to generate QALYs is the EQ-5D. We can illustrate using the EQ-5D-5L to measure the health state of a patient.
    - For example, a health state of 23245 (slight mobility, moderate self-care, slight usual activities, severe pain/ discomfort, extreme anxiety/ depression) is equivalent to an EQ5D score of 0.247. If a patient moves to a slightly improved health state of 23234 (slight mobility, moderate self-care, slight usual activities, severe pain/ discomfort, severe anxiety/ depression), with the difference being from extreme to severe anxiety / depression, the EQ5D score equates to 0.251.[208] Therefore, over a year this patient has gained the equivalent of 0.004 QALYs ((0.251-0.247) x 1 year). This is a hypothetical example to show the extent of patients' health gains which would equate to similar (bigger) QALY impacts needed to offset the net monetised impacts of the policy.

Reduction in length of stay

10. We first estimate the national average unit cost per bed day using NHS Reference costs)[209]. Using the real discounted cost of a mental health day, we estimate the number of bed day reductions to offset net costs of the policy from 2025/26 required. Dividing this by the number of detentions in that year results in a 0.33-day reduction per detention across the appraisal period.
11. For reference, the median length of a detention is estimated to be around 26 days (for part II patients).

Wellbeing

12. Wellbeing outcomes are captured for an individual dependent on wellbeing, health, relationships, environment, living, finances, economy, governance, education, and work. Health is a subset of what is captured within wellbeing.
13. The idea of a WELLBY is about length of life and quality of life. The quality 'weight' is how satisfied people themselves say they are with their life.
14. Personal wellbeing is measured by the ONS through subjective reports of satisfaction, purpose, happiness, and anxiety. The Office for National Statistics (ONS) uses four survey questions to measure personal wellbeing. These are known as the ONS4.[210]The questions are:
    - *"Overall, how satisfied are you with your life nowadays?"*
    - *"Overall, to what extent do you feel the things you do in your life are worthwhile?"*

[208] Valuing health-related quality of life: An EQ-5D-5L value set for England (euroqol.org)

[209] NHS England » National Cost Collection for the NHS

[210] Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf

- *"Overall, how happy did you feel yesterday?"*
- *"Overall, how anxious did you feel yesterday?"*

People are asked to respond to the questions on a scale from 0 to 10 where 0 is "not at all" and 10 is "completely".

15. 1 WELLBY is one unit of life-satisfaction on a 0-10 scale for one person for one year. A normal level for someone who is very healthy is roughly an 8. The WELLBY captures (almost) everything that is important to people.[211] The WELLBY is broader and more encompassing than the QALY. The adoption of the WELLBY reduces the importance of physical health for policy, elevating the importance of mental health and social relations. Physical health thus captures about 40% of the quality of life.
16. Therefore, we have used WELLBYs to quantify the wellbeing of patients. This patient wellbeing is non-monetised (further detail in the non-monetised section) but we can illustrate the improvement in patient wellbeing needed to offset the NPV of the policy.
17. The standard value of one wellbeing adjusted life year on a WELLBYs is estimated to be £13,000.[212] To estimate the wellbeing benefits following from the policy intervention completely offsetting the costs of the policy in each year, the time profile of overall annual discounted net cost of the policy in that year is divided by the social value of a WELLBY at £13,000 (inflated to today's value and discounted for each year), gives the estimated number of WELLBYs needed per detention from 2025/26 required.
18. **We estimate that in order to offset the NPV of the policy and 'breakeven', an improvement in wellbeing of 0.012 points of life satisfaction (on a 0-10 scale) is required per detained patient over the appraisal period. This is equivalent to a 0.16-point (i.e. moving from 5.00 to 5.16 on a 1 to 10 scale) improvement in life satisfaction if delivered over a 26 day period (26 days being the median detention length for Part II patients in 2023/24).**
19. To contextualise, the effect of employment to unemployment is estimated as -0.46 WELLBYs in the UK[213]; improvement from moderate loneliness to mild loneliness is estimated as +0.7 WELLBYs[214][215].

Annex G – Estimation approach for Wales

1. In this Impact Assessment, we have modelled the impacts for the majority of the reforms on Wales, excluding advocacy, Statutory CTPs, C(E)TRs and DSRs. These reforms have been excluded when modelling the impacts on Wales as the policies either apply to England only or are already in place in Wales.

2. To account for the impact of the reforms on Wales, we have used a scaling approach where costs and cost savings that have been estimated for England have then been scaled up impacts depending on the processes that the reforms are linked to. As an example, ACD reforms are linked to Mental Health Act detention numbers. We have estimated the proportion of detentions occurring in Wales compared to England and have consequently uplifted costs/cost savings of ACDs by the same proportion to estimate impacts on Wales. The latest data shows ~2,200 people were detained under the MHA[216] in Wales in 2021/22 compared to over 53,300 people in England in 2021/22[217], equating to 4%. Hence, the costs/cost savings of ACDs in England have been uplifted

[211] WELLBY & TOOLS — State of life

[212] Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf (publishing.service.gov.uk)

[213] Slides - Paul Frijters and Christian Krekel - Treasury Guest Lecture: Wellbeing Report seminar series: WELLBY cost-benefit analyses, principles and examples - 9 June 2022

[214] loneLINESS MONETISATION REPORT

[215] from 3 - "occasionally" lonely - to 2 - "hardly ever" lonely - on a 1 to 5 self-reported scale,

[216] Admission of patients to mental health facilities: April 2021 to March 2022 [HTML] | GOV.WALES

[217] Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital

by 4% to estimate the impacts to Wales. The table below shows the metrics that have been used to scale the impacts of the reforms on Wales.

Table G.1. Metrics and uplift % applied to estimate costs/cost savings for Wales, by policy reform

Policy	Metric used to scale costs/savings	Data for Wales	Data for England	Wales as a proportion of England
Nominated Persons	Total Detentions	2,231 (2021/22)[218]	53,337 (2021/22*)[219]	4%
Opt-Out Advocacy	N.A	N.A	N.A	N.A
Informal Advocacy	N.A	N.A	N.A	N.A
ACDs	Total Detentions	2,231 (2021/22)	53,337 (2021/22*)	4%
Changes to SOAD visits	Total SOAD Visits	694 (2022/23)[220]	11,492 (2022/23)[221]	6%
Changes to CTOs	Recorded CTOs (For Wales, assumed the equivalent is Supervised Community Treatments)	137 (2021/22)[222]	5,552 (2021/22)[223]	2%
Statutory CTPs	N.A	N.A	N.A	N.A
Additional Tribunals	Tribunal Hearings	1,943 (2022/23)[224]	21,471 (2022/23)[225]	9%
Increased S3 Renewals	Total Detentions	2,231 (2021/22)	53,337 (2021/22*)	4%
C(E)TRs	N.A	N.A	N.A	N.A
DSRs	N.A	N.A	N.A	N.A
Familiarisation & backfill costs	Total Detentions	2,231 (2021/22)	53,337 (2021/22*)	4%
Training Costs	Total Detentions	As Above	As Above	As Above
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	Total Detentions	As Above	As Above	As Above
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	Number of inpatients with a learning disability and autistic inpatients	256 (2019)[226]	2,270 (2019)[227]	11%
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	Number of inpatients with a learning disability and autistic inpatients	256 (2019)	2,270 (2019)	11%
Housing capital cost	Number of inpatients with a learning disability and autistic inpatients	256 (2019)	2,270 (2019)	11%
Housing revenue cost	Number of inpatients with a learning disability and autistic inpatients	256 (2019)	2,270 (2019)	11%
Community Infrastructure cost	Number of inpatients with a learning disability and autistic inpatients	256 (2019)	2,270 (2019)	11%
Automatic Referrals	Tribunal Hearings	1,943 (2022/23)[228]	21,471 (2022/23)[229]	9%
Increased treatment choices on the Mental Health Tribunal	Tribunal Hearings	As Above	As Above	As Above
Expanded Powers on the Mental Health Tribunal	Tribunal Hearings	As Above	As Above	As Above
New detention criteria on the Mental Health Tribunal	Tribunal Hearings	As Above	As Above	As Above

218 Admission of patients to mental health facilities: April 2021 to March 2022 [HTML] | GOV.WALES Table 1a J12

219 MHA Statistics Annual Figures 23-24

220 Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 22-23

221 Our activity - Care Quality Commission (cqc.org.uk)

222 Admission of patients to mental health facilities: April 2021 to March 2022 [HTML] | GOV.WALES

223 MHA Statistics Annual Figures 23-24

224 Mental Health Review Tribunal for Wales 2022-2023 (gov.wales)

225 Data provided by MoJ

226 nccu.nhs.wales/qais/national-reviews/learning-disabilities-hospital-inpatient-provision/ncrld-documents/improving-care-improving-lives/

227 Ibid.

228 Mental Health Review Tribunal for Wales 2022-2023 (gov.wales)

229 Data provided by MoJ

*2021/22 data is the most recent data for Wales (as of Oct-24), hence data from the same year has been used for England, despite more recent 23/24 data being available for England.

3. The tables below show the estimated total process costs (inclusive of process cost savings) and estimated benefits for the Health and Social Care and Justice systems in Wales:

Table G.2. Total process costs for the Health and Social Care system by policy or process, Wales only (£m, 2024/25 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Nominated Persons	0	0	0	0	0	0	0	0	0	0
Opt-Out Advocacy										
Informal Advocacy										
ACDs	0	0	0	0	0	1	1	1	1	1
Changes to SOAD visits	0	0	0	0	0	0	1	1	1	1
Changes to CTOs	0	0	0	0	0	0	0	0	0	0
Statutory CTPs										
Additional Tribunals	0	0	0	0	0	0	1	1	1	1
Increased S3 Renewals	0	0	0	0	0	0	0	0	0	0
C(E)TRs										
DSRs										
Familiarisation & backfill costs	0	0	0	0	0	0	0	0	0	0
Training Costs	0	0	0	0	0	0	0	0	0	0
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	0	0	0	0	0	0	0	0	0	0
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	0	0	39	15	0	0	0	0	0	0
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	0	0	0	5	5	5	5	5	5	5
Housing capital cost	0	0	1	7	7	7	7	7	7	7
Housing revenue cost	0	0	2	4	3	3	3	3	3	3
Community Infrastructure cost	0	0	4	4	4	4	4	4	4	4
Total	**0**	**0**	**46**	**34**	**18**	**20**	**21**	**21**	**22**	**22**

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Nominated Persons	0	0	0	0	0	0	0	0	0	0	**2**
Opt-Out Advocacy											
Informal Advocacy											
ACDs	1	1	1	1	1	1	1	1	1	1	**11**
Changes to SOAD visits	1	1	1	1	1	1	1	1	1	1	**9**
Changes to CTOs	0	0	0	0	0	0	0	0	0	0	**-1**

Statutory CTPs											
Additional Tribunals	1	1	1	1	1	1	1	1	1	1	**9**
Increased S3 Renewals	0	0	0	0	0	0	0	0	0	0	**4**
C(E)TRs											
DSRs											
Familiarisation & backfill costs	0	0	0	0	0	0	0	0	0	0	**1**
Training Costs	0	0	0	0	0	0	0	0	0	0	**6**
NHS Community Care Services (transfer of activity) (excl. people with a learning disability and autistic people)	0	0	0	0	0	0	0	0	0	0	**4**
NHS Community Care Services (transfer of activity) (people with a learning disability and autistic people) - excl. Housing Costs	0	0	0	0	0	0	0	0	0	0	**53**
Social Care Services (transfer of activity) (people with a learning disability and autistic people)	5	5	5	5	5	5	5	5	5	5	**86**
Housing capital cost	7	7	7	7	7	7	7	7	7	7	**115**
Housing revenue cost	3	3	3	3	3	3	3	3	3	3	**57**
Community Infrastructure cost	4	4	4	4	4	4	4	4	4	4	**68**
Total	**22**	**22**	**22**	**22**	**22**	**22**	**22**	**22**	**22**	**23**	**425**

Table G3. Total process costs for the Justice system by policy, Wales only (£m, 2024/25 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Automatic Referrals	0	0	0	0	0	0	2	1	1	1
Treatment choice	0	0	0	0	0	0	0	0	0	0
Expanded Powers	0	0	0	0	0	0	0	0	0	0
Detention criteria	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**2**	**2**	**2**

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Automatic Referrals	2	1	1	1	1	1	1	1	1	1	**20**
Treatment choice	0	0	0	0	0	0	0	0	0	0	**5**
Expanded Powers	0	0	0	0	0	0	0	0	0	0	**1**
Detention criteria	0	0	0	0	0	0	0	0	0	0	**0**
Total	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**26**