Written evidence submitted by the British Association of Social Workers (BASW) and The Association of Directors of Adult Social Services (ADASS) (MHB02)

Mental Health Bill: Committee Stage

Submission of Evidence - May 2025

Summary

1. At the heart of the Mental Health Bill are human rights. Article 5 of the Human Rights Act protects individuals' freedom from unreasonable detention without good reason.

2. There are occasions where the severity of mental ill-health requires detention and treatment in a healthcare setting. However, unnecessary or overlong detentions are a human rights and resourcing issue.[i] People become isolated from friends and family, loose skills and self-confidence. Inpatient stays are also costly, and long inpatient stays are more costly still – 29.2% of mental health inpatients were inpatients for at least six months.[ii]

3. Appropriate 'checks and balances' are therefore necessary to prevent unnecessary admission, to keep admissions as short as possible and to provide appropriate after care to prevent readmission. This involves two steps: a formal commitment in the Mental Health Act to prevention and an attention to the granular attention to the details of how the proposed legislation will work.

4. A key check and balance are Approved Mental Health Professionals (AMHPs). The vast majority of AMPHs are social workers - and they decide whether to apply for detention based on the recommendations of doctors - providing a valuable counterbalance to a risk of clinical health perspectives.

5. There are 3800 Approved Mental Health Professionals (AMHPs) in England[iii] and 355 AMHPs in Wales[iv] who work with clinicians to ensure the best outcomes for patients in mental health settings. They ensure the voice of the person is heard and their rights are promoted and protected. Although a range of professionals can be accredited as AMHPs, 95% of all AMHPs are social workers.

6. Our evidence proposes how the Bill could be strengthened to prevent the risk of people reaching a crisis point where formal detention under the MHA is needed, and to ensure that those who do need to be admitted to hospital are only detained for the length of time necessary. This will better safeguard the rights of patients, provide greater support to professionals and reduce costs.

About BASW

7. BASW – the British Association of Social Workers – represents over 21,000 social workers across the UK. This briefing reflects both specialist expertise from our members who are AMHPs as well as consultation with our wider membership.

About ADASS

8. The Directors of Adult Social Services represent the local authority employers of social work AMHPs. Our members are current and former members are Directors of adult care or social services and their senior staff, including principal social workers. Our objectives include:

- Furthering comprehensive, equitable, social policies and plans which reflect and shape the economic and social environment of the time
- Furthering the interests of those who need social care services, regardless of their backgrounds and status, and
- Promoting high standards of social care services.

9. The collaboration of both the professional association of social workers and the employers in this area speaks of a shared commitment to robust safeguards but also appropriate realism in how services can be best delivered.

Power to promote mental health

10. The causes of mental health issues are complex and can be as much around social and societal issues (e.g. unemployment, housing, poverty) as clinical issues. This is recognised in the AMHP role which recognises that while a clinical perspective is appropriate other social perspectives are equally valuable.

11. Consequently, the prevention of mental health problems, or the maintenance of an acceptable level of mental health, requires a holistic approach that considers those wider socio-economic factors. For example, there is considerable evidence to suggest that physical exercise, undertaken in green space, can reduce or prevent mental health issues.[v] Promotion of good mental health can thus cover a wide spectrum of interventions (e.g. public information promoting exercise in the outdoors) some of which can be relatively modest in cost and can have an additional benefit of promoting community connections and cohesiveness.

12. The Health and Social Care Secretary has spoken about the importance of a shift from hospital to community, and from sickness to prevention, but unfortunately, we do not see this reflected in the Bill. This can be remedied. We propose an additional clause (see below) that would give ‘relevant bodies’

(for example, ICBs, Public Health bodies and Local Health Boards (Wales)) the power to undertake the promotion of good mental health.

13. New Clause – Power to promote mental health prevention

To move the following Clause –

Powers to promote mental health prevention

1. Relevant local and health authorities will have the power to undertake the promotion of mental health prevention, specific to the needs of the local community that those authorities serve.

Members explanatory statement: This new clause would give 'relevant bodies' (for example, ICBs, Public Health bodies and Local Health Boards (Wales) the power to undertake the promotion of good mental health. This would make it explicit that relevant bodies have a power to support those already undertaking work in this field while giving permission to those bodies who wish to undertake this work.

Including AMHPs in S3 Renewals

14. Section 3 allows for a person to be admitted to hospital for treatment. Under a Section 3 an individual can currently be detained for up to six months in the first instance (this will be amended to 3 months, followed by a second period of 3 months). This could be renewed for a further six months and then for periods of one year at a time.

15. Under s20(5A) of the current Mental Health Act, the Responsible Clinician (RC) is required to get the written agreement of someone from another profession who is involved with the patient's care before the renewal.

16. Our contention is that this is insufficiently independent, and in a system where medical power and control is significant, it would be a challenge for the second professional to stand up and provide an opinion different from the RC. In most cases, the other professional will be likely to be junior to the RC.

17. In contrast, where someone has been moved onto a Community Treatment Order and an AMHP is involved in the decision we have data (2017 ADASS & NHS digital benchmarking report) that shows that 10% of requests to extend are refused. AMHPs bring a social perspective, knowledge of community alternatives and a more holistic approach to decision-making that make them well placed to carry out independent and objective assessments on a case-by-case basis to ensure the patient gets the best outcome that meets their needs.

18. We also know the percentage of black/non white men detained increases with the tariff (i.e. black men are disproportionately detained longer than their white

counterparts). This discrimination could be addressed by involving AMHPs in the process of decision making for these people. We propose the following amendment:

19. Clause 28, page 37, after line 31 insert –

‘(aa) in subsection (5A) omit paragraphs (a) and (b) and insert “who is an approved mental health professional states in writing that he has interviewed the patient in a suitable manner, consulted the patient’s nominated person (unless it appeared to the professional that in the circumstances such consultation was not reasonably practicable or would involve unreasonable delay) and agrees that the conditions set out in subsection (4) above are satisfied.” ’

Members explanatory statement: This amendment would mean that those put on s3 have access to an independent enough check, the AMHP in addition to the Responsible Clinician, to decide whether their situation warrants extending their s3.

Delays in DoLS Assessments

20. Careful attention needs to be given to the interplay between the proposed legislation and the mental capacity legislation (Mental Capacity Act 2005 and Mental Capacity Amendment Act 2019). Individuals with *prima facie* capacity issues (e.g. people with a learning disability, people with dementia, people with severe autism) need to be given special attention to ensure that any detention under the MHA is both necessary and appropriate.

21. DoLS is the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005. There have been concerns about the DoLS system for many years. This led to the development of its replacement the Liberty Protection Safeguards (LPS) which passed through Parliament in 2019. Its implementation was initially delayed by Covid before being delayed again in 2022 and 2023. It is concerning that no further action to implement LPS has been taken by the current government. Were the LPS implemented, not only would more people be protected, but further savings could be made by local authorities not needing to take community DoLS cases to the Court of Protection for authorization.

22. Backlogs for processing DoLS applications remain high. 123,790 people were waiting for an authorisation as at March 2024 and in 2023/24, only 19% of standard applications were completed within the statutory timeframe. Numbers increased from 13,000 applications in 2013/14 to 332,455 applications in 2023/24 - an increase of 2,557%. Numbers of assessments continue to rise by between 11 and 9% yearly.[vi]

23. When assessments are delayed, staff face the challenge of keeping people safe while protecting their rights. People are being deprived of their liberty for longer than they should, or where less restrictive options could have been identified sooner. Delays in implementing LPS also means that some of the

changes that would have reduced unnecessary duplication of assessment (for example, always needing to use a doctor to confirm a person has a mental disorder where there is no chance of a change in capacity to make decisions, as is the case for those with advanced dementia or a profound learning disability) also result in higher expenditure due to the extra staff and resources needed. This prevents the allocation of resources to other important areas within the public sector. **ADASS estimates that were these amendments implemented, local authorities in England could save up to £50 million in the first 12 months.** Information on these calculations is available from ADASS upon request.

24. The amendments we're proposing below will make the current system more workable and proportionate while the government decide whether and when to implement LPS.[vii]

25. (a) Mental Capacity Act – Schedule 1A (supported by BASW and ADASS)

Part 1 - Application of the Act

Delete the current section 1(2)

1. (1) This part applies if the following conditions are met.

(2) The first condition is that the person (P) is detained in a care home or hospital - for the purposes of being given care or treatment- in circumstances that amount to a deprivation of Liberty.

In Section 1(2) of Schedule 1A of the Mental Capacity Act, the above s2

and replace with:

(2) The first condition is that the person (P) is <u>detained anywhere except a psychiatric hospital</u> - for the purposes of being given care or treatment- in circumstances that amount to a deprivation of Liberty.

Members explanatory statement: This change would mean local authorities and trusts would no longer need to go to the Court of Protection for non-contentious Community cases. This would save Court time and the local authority money.

26. Length of orders (supported by BASW and ADASS)

Amend Paragraph 42 (2) under MCA Best Interest subsection 2(b) to read '3 years maximum' as below:

42.

(1) The assessor must state in the assessment the maximum authorisation period.

(2) The maximum authorisation period is the shorter of these periods—

(a)the period which, in the assessor's opinion, would be the appropriate maximum period for the relevant person to be a detained resident under the standard authorisation that has been requested;

(b)3 years, or such shorter period as may be prescribed in regulations.

Members Explanation: *this amendment is intended to ensure assessments are repeated with a regularity that best suits the needs of the individual. This would mean that in settled circumstances the deprivation of liberty review (which would happen in addition to other reviews) need only occur every 3yrs.*

27. Equivalent assessments (supported by BASW and ADASS)

Amend Paragraph 49 (4) (5) as follows
(4) The third condition is that the existing assessment was carried out within the previous 12 months for a first request for a further authorisation; but this condition need not be met for all future requests for a further authorisation or if the required assessment is an age assessment.;

(5) The fourth condition is that the supervisory body are satisfied that

I. the existing assessment continues to be accurate.
II. that the authorisation requirements continue to be met, and
III. that it is unlikely that there will be any significant change in the detained person's condition during the renewal period which would affect whether those requirements are met

Members Explanation: *This amendment is intended to make it possible to use some assessments more widely, if no other circumstances have changed- particularly in relation to whether a person has a mental disorder such as a learning disability or dementia.*

Also amend
The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 UK Statutory Instruments 2008 No. 1858

Reverse the extension of S135/136 powers

28. An amendment was passed in the House of Lords introducing a new category of ‘authorised persons’ who can remove a person from their home or a public place to a place of safety to have a mental health assessment. Currently, only the police have these powers.

29. We have serious concerns about this change, which has not been properly tested with the professionals named as potential authorised persons, which includes AMHPs. It risks damaging therapeutic relationships clinicians have with patients, impacting on their ability to build rapport and trust, conduct a thorough mental health assessment, and explore the least restrictive options to provide the necessary support to those in crisis.

30. It also risks placing health and social care staff in unsafe situations that they are neither trained nor equipped to handle. Mental health crises in the community are becoming increasingly acute and almost never occur without

some level of risk. While we recognise the high pressures the police are under, their expertise, skills and equipment remain essential for safely reaching individuals in crisis – especially where they may be in immediate danger to themselves, pose a risk to others, or face a threat from others. We ask MPs to seek assurances from the government that they will withdraw this amendment in the Commons.

Extend S5 to A&E Locations

31. Section 5 of the Mental Health Act allows doctors and nurses to detain hospital inpatients for a short time (up to 72 hours for doctors and 6 hours for nurses of prescribed class) for an assessment to be arranged. This ensures their immediate safety whilst the assessment is arranged.

32. Currently, section 5 does not cover A&E locations or other places of safety because they are not considered inpatients. Therefore, if someone presents to A&E or other health-based places of safety, which is not unreasonable given they are requiring emergency help, it is illegal to hold them there whilst they wait for beds to be available to which they can be detained. In such cases, a police officer would need to be present to use s136 powers to detain the person concerned.

33. Extending section 5 so that it also applies to A&E locations or other places of safety will make it easier for clinicians, and other health professionals, to care legally for individuals in crisis who have presented in A&E or other places of safety without requiring the police to try and resolve the situation by using s136 powers. We propose the following amendment:

34. Clause 5, page 11, after line 38 insert –

“5A Admission for assessment in cases of emergency of persons attending hospital Accident and Emergency departments or other places of safety

(1) Where it appears to a registered medical practitioner who is on duty in a hospital or any other place of safety that a person who is present in that place and has attended there for assessment or treatment and is exhibiting behaviour which causes the registered medical practitioner to believe that the person might be suffering from mental disorder to such a degree that it is necessary for the person’s health or safety or for the protection of others for the person to be immediately restrained from leaving that place and that calling a constable to attend the scene to exercise police powers under section 136 of this Act would involve undesirable delay, the registered medical practitioner may record those facts in writing; and in that event the person may be detained in that place, or removed to another place of safety under section 135 of this Act, for assessment for a period of up to 24 hours from the time when that fact is so recorded.

(2) A nurse of the prescribed class may exercise the powers of a registered medical practitioner in subsection (1) above where it appears to the nurse that it is not practicable to secure the immediate attendance of a registered medical practitioner."

Autistic people and people with learning disabilities

35. BASW welcomes the clarification around mental health, autism and learning disability in the Bill (Section 3, Section 4).

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

37. We welcome the commitment from the government to amend the Bill to ensure providers of after-care under S117 of the MHA have direct legal duties to uphold people's human rights and hope to see this change made at committee.

Nominated Persons

38. We were pleased to see the House of Lords pass an amendment that created a clearer and more consistent process for AMHPs to follow when appointing a nominated person for 16- and 17-year-olds, ensuring the necessary safeguards are in place to reduce risks to children and young people.

39. A nominated person is in a position of considerable power and so it is of the upmost importance that AMPHs have clear guidance and a process to follow for how they should choose between differing people with parental responsibility. We would therefore urge the government to retain this change made to the Bill.

40. We also support the AMHP Leads Network (ALN) in calling for Clause 25 - allowing AMHPs to overrule a Nominated Person's objection to an application for admission for treatment or for guardianship – to be removed. We agree with ALN that this power risks "undermining the relationship between AMHP and NP, on which the operation of an effective protection for the patient depends".[viii]

Wednesday, 28 May 2025

---

[i] According to data from NHS England, in 2023 to 2024 there were around 52,500 new recorded detentions under the 1983 Mental Health Act (MHA) in England. This is an estimated 2.5% increase from 2022 to 2023. 29.2% of these detentions were under part 3 of the MHA, meaning they were detained for up to six months with the possibility of further renewals. Mental Health Bill 2025: fact sheet - GOV.UK

According to data from the Welsh Government, in 2021-22, there were 7,428 admissions to mental health facilities in Wales, with 30% being formal, involuntary admissions, an increase of 3% on the previous year. Admission of patients to mental health facilities: April 2021 to March 2022 [HTML] | GOV.WALES

Research from ADASS shows that the referral rate for Mental Health Act admissions in 2024 (extrapolated) was estimated to be 222.9 per 100,000 population across England. Of those 65% were assessed, 48% resulted in detention under s2 or 3, 6% resulted in the use (or extension of) a CTO, and 4% were admitted informally. The average detention rate for England (according to National Statistics) was approximately 91per hundred thousand.

[ii] https://www.gov.uk/government/publications/mental-health-bill-2025-fact-sheet/mental-health-bill-2025-fact-sheet

[iii] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/AMHPs-Briefing-2024.pdf

[iv] https://heiw.nhs.wales/files/mental-health-conference-technical-document/

[v] See, for example: Singh et al (2023) *Effectiveness of physical activity interventions for improving depression, anxiety and distress: an overview of systematic reviews*. British Journal of Sports Med 2023: 57 1203-1209, and Coventry et al (2021) *Nature based outdoor activities for mental and physical health: systematic review and meta-analysis*. SSM-Population Health 16 (2021). We are grateful to Brett Smith, University of Durham, for sourcing these resources.

[vi] Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2023-24 - NHS England Digital

[vii] Recent work undertaken by ADASS to understand the potential costs and savings that could be achieved were our amendments accepted suggests that the average assessment costs per referral could drop from £440 to £175. According to NHS digital, 332,455 assessment requests were made in 2023-24 of which 145,945 were fully complete, meaning 186,510 assessments were not completed. Based on above figures, the costs of assessments could have been as much as £64,215,800. With amendments, this could drop to £25,540,375 allowing up to £39 million to be redirected to ensuring all referrals are actioned in a timelier manner.

[viii] Briefing for MPs from the Approved Mental Health Professional Leads Network (ALN) https://acrobat.adobe.com/id/urn:aaid:sc:EU:f8b41f78-bbcb-4086-9940-49d2b21b191e