Department of Health & Social Care

From Stephen Kinnock MP
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To: MPs appointed to the Mental Health Bill Public Bill Committee

6th June 2025

Dear Colleagues,

MENTAL HEALTH BILL: COMMONS COMMITTEE

I would like to thank colleagues for the constructive Second Reading debate and for engagement on the Mental Health Bill during its passage to date. I look forward to continuing these important discussions with you all at Committee stage from the 10th of June.

I am writing to provide you with key information on the Mental Health Bill and its proposed reforms in advance of Committee Stage. **Annex A** sets out the timeline for reform, including the role played by the Independent Review in shaping the Bill. **Annex B** offers an overview of the Bill's key provisions, while **Annex C** contains a fact sheet with recent data on relevant areas such as the number of detentions and the use of Community Treatment Orders under the Mental Health Act.

I am also writing to provide further details of the amendments the Government has tabled which relate to certain issues we have discussed over the Bill's passage. At Lords Report Stage, my colleague Baroness Merron committed the Government to bringing forward amendments at Commons Committee Stage relating to Advance Choice Documents (ACDs) and the Human Rights Act. I referenced these commitments in my letter marking the transfer of the Bill to this House. I am now pleased to confirm that these amendments are being brought forward, and I have outlined further details of their content below.

- **Advance Choice Documents:** This amendment seeks to strengthen and increase the specificity of duties on health commissioners around ACD's. This includes requiring that commissioners make arrangements to, 1) proactively bring the availability of information and help to the attention of the appropriate people, rather than solely making it 'available', 2) inform and support individuals where appropriate through discussion with a suitably qualified person 3) encourage commissioners to have regard to the benefits of the person making an ACD within 12 months of their discharge. This last amendment is in line with the approach taken in recent research pilots.
- **Human Rights Act:** This amendment seeks to address unequal application of the Human Rights Act to patients receiving care and treatment from private care and treatment providers. This issue follows from the Sammut case from 2024, which

highlighted concerns that private care providers are not considered to be public authorities where care and treatment is funded and/or arranged by the NHS or Local Authority under section 117 of the Mental Health Act.

The Government will also seek to overturn certain amendments made to the Bill at Lords Report. I have provided further details on the amendments we are seeking to overturn in **Annex D**, and the rationale for seeking to do this.

I hope colleagues feel able to support these amendments and I look forward to further constructive debates at Committee.

Yours sincerely,

STEPHEN KINNOCK

Annex A: The Timeline to Reform of the Mental Health Act

The Mental Health Act 2007

The 1983 Act was amended by the Mental Health Act 2007 after a lengthy reform process. Several changes were made, including:

- widening the admission criteria by broadening the definition of mental disorder
- introducing independent mental health advocacy to support some detained patients
- expanding the range of professional roles involved in the detention process
- bringing in Community Treatment Orders (CTOs) - new provisions for supervised treatment in the community on discharge from hospital.

Independent review of the Mental Health Act (2018)

In 2017, the government announced an independent review of the Mental Health Act 1983, in response to concerns about the use of the act. The terms of reference of the independent review set out that the review should consider:

- the rising rates of detention under the act
- the disproportionate numbers of people from Black and minority ethnic groups in the detained population
- concerns that some processes in the act are out of step with a modern mental health system

The independent review team, led by Professor Sir Simon Wessely, published its final report in December 2018.

The review made over 150 recommendations, including changes to the law to make it easier for patients to participate in decisions about their care, to restore their dignity and recognise the importance of human rights in mental health care. The government accepted most of the recommendations and incorporated them in a subsequent white paper.

White Paper on Reforming the Mental Health Act (2021)

The previous government published its white paper, Reforming the Mental Health Act, in January 2021. Proposals in the white paper included tightening admission criteria and raising the threshold for compulsory detention. There were also proposals designed to reduce the use of the act for persons with a learning disability and autistic people. The government consulted on the white paper proposals from January to April 2021 and published its response to the consultation in August 2021. Respondents were broadly supportive of the proposals. The government said it would continue to work with stakeholders to refine the proposals, to make final policy decisions and develop the draft bill.

Draft Mental Health Bill (2022) and pre-legislative scrutiny

In June 2022, the previous government published a draft Mental Health Bill. It contained proposed amendments to the Mental Health Act 1983, including:

- redefining “mental disorder” so autistic people and people with a learning disability could not be detained for treatment under section 3 of the act without a coexisting psychiatric disorder
- clarifying the threshold for detention and increasing the frequency of detention reviews

- replacing the nearest relative with a nominated person, chosen by the patient
- introducing a clinical checklist to ensure patient's wishes and preferences are considered as part of treatment decisions
- placing care and treatment plans on a statutory footing for detained patients
- expanding access to advocacy services
- removing prisons and police cells as places of safety
- introducing a statutory 28-day time limit for transfer from prison to hospital

A joint select committee scrutinised the draft bill from July to December 2022 and published its report in January 2023. The committee said it supported reforming the act, but the government should strengthen the bill to address rising detention rates and racial inequalities.

Examples of recommendations made by the committee included introducing a new statutory Mental Health Commissioner role, abolishing Community Treatment Orders (CTOs) for most patients and explicitly referencing Advance Choice Documents (ACDs) within the reformed Act.

Government response to scrutiny of the draft Mental Health Bill

The previous government published its response to the joint committee's report on 21 March 2024. It said it would consider some of the committee's recommendations in preparing the bill but did not agree with all of the recommendations. For example, the government did not agree with creating a Mental Health Commissioner role.

A mental health bill was not introduced by the previous government before the General Election 2024.

Annex B: Key provisions in the Mental Health Bill

The Bill will:

Improve patient experience by

- Including the wording of the guiding principles identified by the Independent Review within the Act's requirements for the statutory Code of Practice.
- Introducing statutory care and treatment plans for patients detained under the Act, (and on community treatment orders (CTOs) or subject to guardianship), excluding those subject to extremely short detention periods, such as those lasting a matter of days. This is to ensure that patients have a clear and up to date plan in place outlining what treatment and support they need to progress towards recovery and a safe and effective discharge.
- Strengthening and clarifying the detention criteria. The revised criteria will make it explicit that individuals may only be detained if they pose a significant risk of serious harm to themselves or others. Additionally, for detention under Section 3 and CTOs, there must be a reasonable prospect that the individual will benefit from the proposed treatment.
- Reforming the use of CTOs to reflect the revised detention criteria, to increase oversight and scrutiny of decision making, and to create new powers to empower the Nominated Person to object when appropriate (see below).
- Improving Mental Health Tribunal (MHT) oversight of a patient's detention by increasing the frequency that patients can appeal their detention and ensuring that those who do not appeal are referred automatically more frequently. It will also provide the MHT with a power to recommend that a plan for the provision of community aftercare services is made to facilitate patient discharge.

Improve patient choice and autonomy by

- Introducing a new clinical checklist requiring clinicians to, among other things, support the patient to take part in decision making about their care, to consider their wishes and feelings (including those stated in advance) and not to make unjustified assumptions about the patient e.g. based on their ethnicity.
- Introducing duties on health commissioners that aim to facilitate people at risk of detention to make an Advance Choice Document (ACD), containing a record of their decisions, wishes and feelings, at a time when they are well. This can be used by mental health professionals if the individual later loses the relevant capacity or competence, allowing the individual to still inform decision making around their admission, care and treatment.
- Strengthening treatment safeguards, so that when someone is given compulsory treatment, which is against their expressed wishes and preferences, it is only where there is good reason to do so and that this decision receives additional scrutiny.
- Allowing patients to choose someone to be their 'Nominated Person' to look out for them and their interests, increasing their powers compared to those of the Nearest Relative, so for example they can be consulted about a patient's future care. In response to a Joint Committee recommendation, removing the requirement for the Approved Mental Health Professional (AMHP) to see the Nominated Person in person.
- Expanding access to Independent Mental Health Advocates to voluntary patients and making access opt out for detained patients.

Limit the detention of people with a learning disability and autistic people (without a qualifying co-occurring mental health condition) by

- Restricting the use of Part II the Act for people with a learning disability and autistic people. It will no longer be possible to detain a person with a learning disability or autistic person under Part II, section 3 unless they have a co-occurring mental disorder that warrants hospital treatment and detention will provide a reasonable prospect of therapeutic benefit. Detention under Part II, section 2 will still be possible for a maximum of 28 days for assessment. This change will affect civil patients only. Hospital will remain an option for those patients in contact with the criminal justice system where the only alternative to detention in hospital is prison.
- Placing Care (Education) and Treatment Reviews on a statutory footing so that an NHS commissioning body must take steps to ensure reviews are held when a patient with a learning disability or an autistic patient is detained in hospital. And placing a duty on certain bodies to have regard to the review recommendations.
- Creating a duty on Integrated Care Boards to establish and maintain a register of people with a learning disability and autistic people who are at risk of detention. Placing a duty on that body and on local authorities to have regard to any information obtained for, or contained in, the register or shared under the provisions and seek to ensure the needs of these people can be met without detaining them.

Improve access to mental health care and treatment for people in the criminal justice system by

- Ending the use of prisons as 'places of safety' under the Act. The use of police cells as a place of safety will also be ended for civil patients where the police exercise their powers under section 135 and 136 of the Act.
- Ending the use of remand for own protection under the Bail Act where the Court's sole concern is the defendant's mental health.
- Introducing a statutory 28-day time-limit for transfers from prison and other places of detention to hospital when a person requires treatment under the Act.
- Introducing a sub-set of Conditional Discharge, 'Supervised Discharge', to provide for a small number of restricted patients that are no longer benefitting from being in hospital.
- Introducing new powers to enable patients remanded by the Crown Dependencies' courts to transfer to suitably secure hospitals in England and Wales for treatment and assessment.

Ensure patient and public protection by

- Strengthening clinical decision making across the detention pathway and allowing for greater scrutiny of decisions. This includes the decision to discharge, where going forward the Responsible Clinician will be required to consult with another professional before they can discharge an individual from section. We will build on this further in secondary legislation and in statutory guidance – including that patients must receive a personalised plan for ensuring their safety before and after discharge and managing any risk that they may pose, as part of the new statutory care and treatment plan.
- Responding to a recommendation by the Joint Committee, by removing the draft Bill's proposed requirement for clinicians to consider 'how soon' harm may occur from the detention criteria to avoid the suggestion that harms must be imminent and to ensure we do not dissuade clinicians from making beneficial early interventions.

Annex C: Mental Health Bill Fact Sheet

What is the Mental Health Act?

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. Powers for compulsory admission for assessment and treatment are set out in Part II and Part III of the Act.

Part II of the MHA deals with patients who are detained in hospital and have no criminal proceedings against them. These are generally referred to as civil patients. 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.

Facts and figures

- In 2023/24 there were around 52,500 new recorded detentions under the Mental Health Act in England. This is an estimated 2.5 per cent increase in detentions from 2022/23[1], following a 7.7 per cent fall in detentions from 2021/22.[2]
- The majority of people are detained under Part II of the Act. Over two-thirds (70.8%) of all people detained in hospital on 31st March 2024 were detained under Part II of the Act, while nearly a third (29.2%) were detained under Part III of the Act.[3]
- A total of 1,741 restricted patients were admitted to hospital for treatment under the Mental Health Act in 2024 in England and Wales, a 0.3 per cent decrease from 2023.[4] As of 31 December 2024, there were 7,921 restricted patients, of which 4,644 were detained in hospital and 3,277 conditionally discharged. Restricted patients are offenders subject to special controls by the Secretary of State for Justice, for example after a court sentence or transfer from prison.
- In 2023/24, 963 detentions were recorded for children and young people aged 17 and under - over two-thirds (689) of these were aged 16 or 17[5].
- In 2023/24, black people were three and a half times more likely than white people to be detained under the Mental Health Act, and seven times more likely to be placed on a Community Treatment Order (CTO).[6]
- The number of inpatients with a learning disability and/or autistic inpatients subject to the Mental Health Act has fallen from 2,500 in March 2015 to 1,860 in April 2025. However, a larger proportion of inpatients with a learning disability and/or autistic inpatients are now subject to the Mental Health Act than previously – 92 per cent in April 2025 compared to 86 per cent in March 2015.[7]

Annex D: The amendments made following the will of the House at Lords Report, and the rationale for seeking to overturn these.

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[1] NHS Digital (12 September 2024). Mental Health Act Statistics, Annual Figures, 2023-24. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures. Trend comparisons are affected by changes in data quality. NHS England estimate based on the providers that submitted good quality detentions data..
[2] NHS Digital (25 January 2024). Mental Health Act Statistics, Annual Figures, 2022-23. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2022-23-annual-figures. Trend comparisons are affected by changes in data quality. NHS England estimate based on the providers that submitted good quality detentions data.
[3] NHS Digital (12 September 2024). Mental Health Act Statistics, Annual Figures, 2023-24, People subject to the Act at year-end. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures/people-subject-to-the-act-at-year-end#people-subject-to-the-act-at-year-end-by-parts-of-the-act
[4] Ministry of Justice. Restricted Patients Statistics, 2024, England and Wales. Accessed at: https://www.gov.uk/government/statistics/restricted-patients-statistics-england-and-wales-2024
[5] NHS Digital (12 September 2024). Mental Health Act Statistics, Annual Figures, 2023-24. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures
[6] As above.
[7] NHS Digital (17 October 2024). Learning Disability Services Monthly Statistics, AT: April 2025, MHSDS: March 2025. Table 2.3. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-april-2025-mhsds-march-2025

Extension of Police Powers of Detention to other specified healthcare professionals under section 135/136:

This amendment sought to introduce a new category of “authorised person” who can use powers under section 135/136 of the Mental Health Act. S135 gives police powers to enter any premises, including private homes (with a warrant) to remove someone from their home, with a view to making an application under the Act or for other arrangements for treatment or care. S136 gives the police powers, in a place that is not a home or associated space, to remove someone to, or keep them at, a place of safety so that an assessment under the MHA can be carried out. This can be exercised if a police constable believes that someone appears to have a mental disorder, and they are in need of immediate care or control. Under the amendment made at Lords Report, authorised persons would include medical practitioners, approved mental health professionals, mental health nurses or doctors and further health care and social care professionals' to be defined in regulations. The amendments also extend the powers of detention under sections 2,3 and 5 to the police where they currently have no powers to intervene.

Rationale for seeking to overturn the amendment:

Extending the legal powers currently held by police to other professionals would represent a major shift in roles and responsibilities for health and care professionals, placing significant additional pressure on the NHS and social care providers. Giving health and social care staff statutory powers to use reasonable force could risk safety issues for staff, patients, and the public**.** In addition, we do not support extending police powers to section 2, 3 and 5, and we understand the police do not support an extension either.

The Appropriate Mental Health Professional Leads Network Co-Chair has said extending police powers in this way would have ‘disastrous unintended consequences for both individuals in crisis and those responding to mental health emergencies.’ In a joint statement signed by nine leading health and social care organisations including The Royal College of Psychiatrists, the Association of Ambulance Chief Executives and the Royal College of Emergency Medicine, they describe the proposed extension of police powers as “a radical proposal with a number of serious and potentially dangerous consequences” and advised that “delegating police powers to professionals without consulting them, or patients would be a very damaging way to make policy”. Senior leads in NHS England have raised similar concerns for the mental health and paramedic workforce.

We do of course recognise the pressures police are facing. Still, it is important to state that the majority of assessments under the Mental Health Act already happen without police involvement and action is already underway to reduce this further in situations where there is no risk. Almost all police forces in England and Wales are implementing the Right Care Right Person approach, a police-led initiative to reduce inappropriate police involvement in cases where people have health or social care needs. There has already been a 10% decrease in section 136 detentions in the year ending March 2024.

Community Treatment Orders:

This amendment sought to introduce a 12-month maximum duration for community treatment orders (CTOs), which could only be extended if a second registered psychiatrist gives their written agreement.

Rationale for seeking to overturn the amendment:

Setting a 12-month maximum on CTOs fails to account for individual needs and may withdraw support from patients who benefit from longer durations, such as those with eating disorders. The Act already permits CTO renewals after an initial six months, again at twelve months, and then annually. The Bill allows renewal only if there is a risk of serious harm and a reasonable prospect of therapeutic benefit. The amendment mandates more frequent renewals after 12 months (every six months).

The Bill increases professional oversight by requiring the community clinician to be involved in all decision making relating to CTOs. This aligns with Lord Scriven's amendment, but an Approved Clinician is more appropriate than a GMC-registered psychiatrist, as they have specialised Mental Health Act training and the authority to make decisions under it.

Tribunal reviews will now occur automatically at renewal periods, alongside a new tribunal power to recommend reassessment of CTO conditions by the responsible clinician, which this amendment duplicates. This amendment replicates some provisions in the Bill, and conflicts with existing renewal periods. Where differences exist, the current provisions—such as requiring a community clinician in all decision-making—are more appropriate.

Nominated Person:

This amendment sought to create a hierarchy for the appointment of a Nominated Person by an Approved Mental Health Professional (AMHP) for those aged under 16, who lack competence to choose their own. The AMHP would be required to appoint (in order) a local authority if the child is subject to a care order, a special guardian, a person named in a child arrangements order or a person with parental responsibility. Where two people could be appointed preference would be given based on age.

Rationale for seeking to overturn the amendment:

It is our policy to give preference to a local authority followed by any other person who has parental responsibility. We will set out the remaining hierarchy in the Code of Practice, following consultation with an expert taskforce. This will provide guidance for professionals involved in the Nominated Person appointment process for children and young people. Using a prescriptive list in primary legislation for whom an Approved Mental Health Professional must appoint for an under 16-year-old is unnecessary and would prohibit an Approved Mental Health Professional from appointing any other person with parental responsibility, even if they are not a risk to the child. We agree that in the vast majority of cases we would expect a special guardian or person named in a child arrangements order to be appointed and will set this out in the Code.

The Approved Mental Health Professional must take into account the patient's past and present wishes and feelings so far as reasonably ascertainable when deciding who to appoint. We do not believe that the eldest person should be given preference as this represents an outdated assignment of responsibility.

Debriefing Patients:

This amendment sought to require that Independent Mental Health Advocates offer to consult people after discharge from the Mental Health Act on their hospital treatment and requiring that findings are reported to the responsible hospital, which must then respond on an annual basis.

Rationale for seeking to overturn the amendment:

Recent engagement with advocates indicates that this amendment would be problematic for a number of reasons. In particular, it would result in a significant shift from what advocates currently do, potentially undermining the efficacy of their role in relation to patients and would impact on the services capacity to deliver their core functions.

Advocates agree that service user feedback mechanisms could be improved. We are making improvements to current service user feedback mechanisms. Dr. Dash’s review of the patient oversight and safety landscape is currently evaluating the role of Healthwatch England (and local branches), among five other arm's length bodies of DHSC. It is expected that this will make recommendations as to how Healthwatch, whose primary role is to collect service user feedback and use it to inform services, should be improved.