British Psychological Society

Mental Health Bill

House of Commons, Committee Stage

The British Psychological Society (BPS) is the representative body for psychology and psychologists throughout the UK. We are committed to providing and disseminating evidence-based expertise and engaging with decision makers. We believe psychology has a fundamental role in helping to tackle some of the most crucial policy issues we are facing in our communities.

Reform of the Mental Health Act is long over-due to ensure that it is fit for purpose for today, to tackle disparities in the mental health system and to address the unacceptable trend of people with severe mental health difficulties ending up in the criminal justice system.

In preparing this briefing, we have consulted the running list of amendments dated 6 June 2025, that will be put forward at Committee Stage in the House of Commons. The first half of the briefing is focused on amendments, both accepted in the House of Lords and tabled ahead of Committee Stage, that have been made to the Bill. The remainder of this briefing focuses on the areas where we believe further amendments to the Bill are necessary for the government to achieve its aim of ensuring that everyone is treated with dignity throughout treatment.

To support successful implementation of many of the changes proposed by the Mental Health Bill, it is particularly important that the UK and Welsh government invest in ensuring healthcare and community services are appropriately supported and resourced, including having the workforce needed to operate effectively. Without this necessary and continued investment, it will be challenging for this Bill to successfully achieve the changes it intends to achieve in reforming the Mental Health Act.

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Part 1: Amendments to the Bill

1. Definition of psychiatric disorder

The BPS is concerned with the amendments made to Part 2 of the Act, subsection (2), which changes the meaning of mental disorder by including new definitions of 'autism', 'learning disability' and 'psychiatric disorder', and amendment 56, which would insert the new clause – "The Secretary of State may by regulations update the definitions in subsection (2) in response to scientific advancements."

Psychiatric disorder is defined in the draft bill as "mental disorder other than autism or learning disability." The introduction of the term psychiatric disorder raises several issues.

Firstly, this term inaccurately implies the disorder, its assessment and treatment all fall within the purview of psychiatry as a single discipline and professional group. For many mental disorders, including eating disorders and personality disorders. For example, where the Act is frequently deployed, the evidence base is clear that the primary assessment and treatment approaches are psychological not psychiatric. Therefore, one unintended consequence of labelling all conditions (bar learning disability and autism) as psychiatric disorders could include inappropriately qualified clinicians leading on the care of very complex and vulnerable patients who present significant risk to themselves or others.

Secondly, introducing the term psychiatric disorder risks a reversal of the emphasis on multi-professional working brought about by the 2007 amendments to the Act. This was an explicit recognition of equivalent clinical and leadership expertise and unique perspectives of multiple professional groups in a modern mental health service.

We therefore recommend that the term psychiatric disorder is replaced by 'mental health disorder' within the amended Act. This term is not aligned to any single profession, it is less stigmatising and so more compatible with the Act's ambition to prioritise patient experience, and it clearly distinguishes it from learning disability and autism. This change is consistent with the principles set out within Section 118(2B) & (2C).

2. Community treatment order extensions

The BPS is concerned by the amendment made to Clause 6 of the Act, which inserts the following text – "the responsible clinician may extend the duration of a community treatment order beyond 12 months only after— (iii) consulting a General Medical Council registered psychiatrist regarding the conditions of the community treatment order and obtaining their written agreement that an extension is necessary and in accordance with the principles set out in section 118(2B)."

Currently, only an Approved Clinician (AC) acting as the Responsible Clinician (RC) (with an Approved Mental Health Professional's agreement) can make, extend and revoke community treatment orders (CTOs). It would therefore be inappropriate and potentially unsafe for a person who is not an AC to be relied upon in the manner proposed in the renewal process, as they would lack the knowledge and competence to give such an opinion.

If a second opinion is required in this process, then it should be provided by an AC who, by definition, has been approved by a delegated authority as having the required competence to provide such an opinion. As with the proposed use of the term psychiatric disorder in Part 2 subsection (2), this amendment would be a regressive step in terms of the development of a competency-based workforce to support a modern Mental Health Act.

We understand that this issue could be remedied with a technical amendment stating that a 12-month maximum duration for CTOs can only be extended with the written agreement of an AC and an AMHP. Again, this would be consistent with the principles set out within Section 118(2B) & (2C).

3. Adequate community provision for individuals with learning disabilities and autism

The BPS believes that without necessary and additional investment in community-based services, the proposed changes to remove autism and learning disability from section 3 of the Act (admission for treatment), will have substantial and potentially harmful unintended consequences for the individuals these changes are intended to support. This could include: a lack of appropriate care and treatment in the community, a weakening of the protections for people with these conditions, reductions in access to section 117 aftercare funding, and increased use of the criminal justice system.[i]

The BPS therefore supports amendment NC11, which would insert the following new Clause – "Costed plan to ensure community provision for individuals with learning disabilities and autism who are at risk of detention".

4. Racial inequalities

The BPS does not believe that this Bill goes far enough to address the racial inequalities currently entrenched within the application of the Mental Health Act. **The BPS supports amendment NC3, which would insert the following new Clause — "Addressing and reporting on racial disparities and other inequalities in the use of the Mental Health Act 1983."** We further agree that after section 120D of the Mental Health Act 1983, the following proposed amendments should be inserted:

- ***"120E Mental health units and services to have a responsible person:***

  A relevant health organisation that operates a mental health unit or community mental health service for qualifying patients must appoint a responsible person for that unit or service for the purposes of addressing racial disparities and other disparities based on protected characteristics related to functions discharged under the Mental Health Act 1983."

- ***"120F Policy on racial disparities and other disparities based on protected characteristics:***

  - *The responsible person must publish a policy on how the unit plans to reduce racial disparities and other disparities based on protected characteristics in that unit or service*

- *Before publishing a policy under subsection (1), the responsible person must have regard to the (i) views, wishes and feelings of people from ethnic minority communities who have been detained; (ii) the views, wishes and feelings of people with other protected characteristics who have been detained."*

- ***"120G Training in racial disparities and other disparities based on protected characteristics***

  - *The responsible person for each mental health unit or service must provide training for staff that relates to addressing racial disparities and other disparities based on protected characteristics in that unit or service*
  - *Refresher training must be provided at regular intervals whilst a person is a member of staff."*

- ***"120H Annual report by the Secretary of State***

  - *As soon as reasonably practicable after the end of each calendar year, the Secretary of State must conduct a review in consultation with relevant bodies with commissioning functions on the use of treatment and detention measures contained in the Mental Health Act 1983 broken down by race and other demographic information.*
  - *Having conducted this review, the Secretary of State must publish a report on the progress made in reducing inequalities in treatment outcomes and the use of detention measures in the use of this Act on people who have protected characteristics under the Equality Act 2010."*

Part 2: BPS recommendations for further amendments

1. Amending the detention criteria

This Bill amends the criteria for detention under section 2 (admission for assessment) and section 3 (admission for treatment), with the aim of providing greater clarity as to the level of risk that a person must present in order to be detained. The BPS agree that people should only ever be detained under the Mental Health Act where they pose a risk of serious harm to themselves or others. However:

- **The definition of 'appropriate medical treatment' needs further clarification.** This is defined as *"references to medical treatment which, taking into account the nature and degree of the disorder and all other circumstances — (i) has a reasonable prospect of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations, and (ii) is appropriate in the person's case."* The prospect of alleviating or preventing the worsening of one of the symptoms/manifestations of a disorder must be weighed up against the impact the treatment could have on an individual's overall risk. Additionally, what is considered 'appropriate treatment' has a broad scope and this could allow for minimal provision of care, significantly impacting patient outcomes.

2. Strengthening the rights of families and care

The BPS agree with the proposal to replace the 'nearest relative' provisions in the Act with a new role of a 'nominated person'. We feel that this empowers people as it provides them with choice, flexibility, and autonomy. We also welcome for individuals close to the patient to be consulted in the decisions around their care where appropriate and where the patient wishes.

However, it must be ensured that there is no opportunity for coercion or exploitation within the process.

3. Ending the use of police stations as places of safety under section 136 of the Mental Health Act

Police stations are not an appropriate 'place of safety' under the use of the Mental Health Act. People detained in police cells have described them as distressing, unsafe environments - with some feeling as though they were being punished for their mental illness.[ii] Due to the additional distress inflicted in this type of setting, this environment can also result in a worsening of symptoms and reduce a person's chances of recovery. The BPS agree individuals in a mental health crisis should be taken to a health-based place of safety opposed to a police station.

However, an increase in funding for healthcare services and the psychological workforce is required to ensure that patients can access suitable healthcare facilities and appropriate psychological support.

Research has found that where a street triage service was implemented in Sussex, whereby mental health nurses accompanied police officers to incidents where people needed mental health support - the number of people detained in police custody under Section 136 of the Mental Health Act fell by 53%.[iii] This research suggests that street triage could be an effective way of reducing the number of people detained under Section 136 of the Mental Health Act unnecessarily in the first instance. Wider research on street triage services has highlighted that resource pressures can present challenges for successful implementation.[iv] For these services to work effectively, consistent and stable funding is vital to ensure services have an appropriate workforce.

4. Speeding up transfers from prison to hospital

The most recent HM Chief Inspector of Prisons annual report raised many gaps in mental health provision across a number of prison sites.[v] It reported that many prisons do not have an adequate number of clinical staff to deliver mental health support and there is variability in the provision of talking therapies and other psychology services. This report also identified excessive waits for transfers to hospitals under the Mental Health Act, with prisoners waiting far too long to be transferred to a mental health hospital to get the support they need.

Offenders with mental health problems should be able to access the care they need as quickly and early as possible. Early intervention for all mental health problems is important to reduce the risk of problems escalating or worsening.[vi]

The BPS have long been calling for increased investment in the psychological workforce across prisons, so people can access psychological support at the point of need. This increased investment in this workforce is pivotal so mental health difficulties can be supported early on. However, where people need treatment in a mental health hospital, it is also essential that this transfer happens in a timely manner.

The BPS therefore welcomes that this Bill will speed up transfers from prison to hospital by limiting the time it can take to transfer prisoners who need treatment in a mental health hospital to a maximum of 28 days (absent to exceptional circumstances).

However, for this transfer period to successfully work in practice within the timeframes set:

- **This duty needs to be backed up by practical availability of resources within the healthcare system.** Failure to provide adequate resources risks an increase in people being transferred but not receiving the quality of care that they need.

- **Clear lines of accountability are needed in this process.** A current challenge is that prisons can make a referral to a healthcare unit but if space is not available, the healthcare unit can turn the prison down, and the prison service will have to try a different unit. This Bill states the relevant referring body (the prison) and notified authorities are responsible for managing the transfer within a period of 28 days beginning with the date of the initial request (which will be made by a registered medical practitioner).

  Notified authorities include the Secretary of State, the relevant detention authority, NHS England, Integrated Care Boards, National Health Service Trusts, and Local Health Boards. With a number of authorities involved in this process, lines of accountability may be blurred without clear direction of who is responsible for exactly what part of the transfer process.

- **Furthermore, this Bill needs to be amended to clearly define what is classified as an 'exceptional circumstance'.** It states that "the following are not (together or separately) 'exceptional circumstances'— (a) a shortage of hospital accommodation; (b) a shortage of hospital staff; unless occurring as a result of other exceptional circumstances." What is considered an exceptional circumstance must be explicit to avoid any loopholes where a transfer does not take place because of individual judgement.

5. Considerations for those with learning disabilities and autism

The removal of autism and learning disabilities from section 3 means that if a local authority cannot provide adequate community-based services, individuals with autism and learning difficulties risk being detained under spurious diagnoses, given inappropriate treatment in unsuitable environments and being diverted to the criminal justice system which is unable to and is not intended to meet their needs. We are concerned that excluding people with learning disabilities and autism from section 3

could potentially impact the ability of these individuals to access appropriate inpatient services (potentially against their will) where this support would be beneficial.

Therefore, **it is vital the government accepts the recommendation of the Joint Parliamentary Committee, to conduct a review of the Building the Right Support Action plan**.[vii] This action plan was published in 2022 to strengthen community support for people with a learning disability and autism.[viii] We agree there is a need to "identify which milestones in this plan must be met to ensure that people with learning disabilities and autistic people who would have been eligible for detention under section 3 can be supported to live in the community. ***The milestones outlined in this review must be met before commencement of those parts of the bill that remove learning disabilities and autism as a condition for which people can be detained under section 3."***[ix]

Furthermore, the BPS is concerned that if the proposed changes to remove autism and learning disability from section 3 of the Act were to come into effect, that powers under the Mental Capacity Act might potentially be overused – with people with autism and learning disabilities being detained under the Mental Capacity Act under Deprivation of Liberty Safeguards.[x] The UK government must further clarify how the Mental Health Act will interact with the Mental Capacity Act in light of the changes proposed by the Mental Health Bill.

6. Section 12 approval eligibility

The BPS welcomed the 2007 amendments to the Mental Health Act which introduced the roles of approved clinician (AC) and responsible clinician (RC), enabling mental health professionals to carry out duties previously performed by psychiatrists. Psychologists, nurses, social workers and occupational therapists are eligible under the 2007 Act to be approved clinicians and thus act as the responsible clinician with overall legal responsibility for patients subject to the provisions of the 1983 Act. Responsibilities reserved to the responsible clinician include renewing a patient's detention and discharging a patient from detention.[xi]

To be an approved clinician, an applicant must provide evidence to demonstrate to the approving body that they have relevant competencies. This includes the ability to identify the presence and severity a of mental disorder and determine whether the mental disorder is of a kind or degree warranting compulsory detention.[xii]

Applications for detention under civil sections of the 1983 Mental Health Act require at least one recommendation from a registered medical practitioner who is approved under section 12 of the Act. Approved clinicians who are medical practitioners are automatically approved for section 12 purposes, however, other approved clinicians are not. The BPS recommends that this legislation is amended so that all ACs (including psychologists) are eligible for section 12 approval. This seems appropriate as the same criteria is used when making decisions about renewal and discharge from detention, as when making recommendations for initial detention.

This amendment would be equitable, enforce consistency, and most importantly – patients, particularly those with complex bio-psycho-social problems, would benefit from

access to multi-professional approved clinicians being able to make recommendations about initial detention. Further, this change would potentially enable more timely access to section 12 approved professionals to carry out Mental Health Act assessments for initial detention, thus benefitting patients who often spend too long awaiting these assessments.[xiii]

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[i] Taylor J, (2023). England and Wales draft Mental Health Bill: Implications for people with intellectual disabilities. International Journal of Law and Psychiatry.

[ii] Akther S.F, et al (April, 2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. BJPsych Open.

[iii] Heslin M, Callaghan L, Packwood M, et al (2016). Decision analytic model exploring the cost and cost-offset implications of street triage. BMJ Open.

[iv] Horspool, K., Drabble, S.J. & O'Cathain, A (2016). Implementing street triage: a qualitative study of collaboration between police and mental health services. BMC Psychiatry.

[v] HM Inspectorate of Prisons (2024). HM Chief Inspector of Prisons for England and Wales Annual Report 2023–24.

[vi] Colizzi M, Lasalvia A & Ruggeri M (2020). Prevention and early intervention in youth mental health: is it time for a multidisciplinary and trans-diagnostic model for care? International Journal of Mental Health Systems.

[vii] GOV.UK (2024). Government response to the Joint Committee on the draft Mental Health Bill.

[viii] GOV.UK (2022). Building the right support for people with a learning disability and autistic people.

[ix] GOV.UK (2024). Government response to the Joint Committee on the draft Mental Health Bill.

[x] Mental Capacity Act (2005).

[xi] Taylor J, & Burrell C (2024). Extending section 12 approval under the Mental Health Act to professions other than medicine. BJPsych Bulletin.

[xii] GOV.UK (2015). Mental Health Act 1983 - Instructions with respect to the exercise of an approval function in relation to approved clinicians 2015.

[xiii] Department of Health and Social Care (2018). Modernising the Mental Health Act. Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983.