Mental Health Bill Second Reading
Briefing for Peers

The British Association of Social Workers

Social workers and the Mental Health Bill

Social workers are uniquely well positioned to comment on the Mental Health Bill.

'*AMHPs (Approved Mental Health Professionals) are responsible for setting up and coordinating assessments under the Mental Health Act, and, if necessary, making applications to detain ('section') people in hospital for assessment and treatment of their mental health needs*.'[i]

Although a range of professionals can be accredited as AMHPs, 95% of all AMPHs are social workers[ii].

Social workers in other roles (for example, working in child safeguarding or adult care assessment and review) also come across those with severe enough mental health issues to impact on a range of other statutory responsibilities.

About BASW

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.

Summary of Key Points

BASW broadly welcomes the Bill. However, it can be strengthened in a number of areas.

1. A key aspect that is missing is a power around prevention. Given the cost of statutory inpatient admissions under the mental health legislation and the stated intention of Secretary of State for Health and Social Care to reduce hospitalisation through prevention this is a surprising omission. We propose a simple amendment that would empower relevant authorities while being realistic about current financial realities.

2. We welcome the removal of police station cells and prisons as 'places of safety'. However, these settings are used inappropriately precisely because there are insufficient hospital beds enabling a speedy admission. Resources will have to be committed to make this legislative imperative a reality.

3. Community Treatment Orders. Without significant investment in the provision of social services and community support (NHS and non-NHS) and investment in workforce recruitment and retention, we fear that the intention of the Bill with regard to CTOs will fail.

4. Mental health and mental capacity. Delays on the replacement of DOLs with LPS and introducing a new Code of Practice under the mental capacity legislation is both problematic in itself and may impede effective implementation of the new Mental Health Act.

5. Inequalities. Greater emphasis needs to be placed on the impact of inequalities on both the causes and treatment of mental health.

6. Autistic people and people with a learning difficulty. The clarification around definitions and scope in the Bill is welcome.

7. Securing a sufficient number of AMHPs is an increasing challenge. Without addressing this shortfall, people with severe mental health problems are unlikely to receive appropriate timely intervention.

8. BASW supports the broad shift to nominated person and advance choice documents, however, further practical consideration is needed.

Introduction

BASW welcomes the intent to reform the Mental Health Act and believes that this is overdue. We especially welcome the move towards an approach based upon principles relating to least restrictive intervention, patient involvement and therapeutic benefit.

We welcome the pace with which the legislation has been introduced and Second Reading scheduled. This document therefore reflects our initial responses.

A power to promote mental health

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 perspectives are equally valuable.

Consequently, the prevention of mental health problems, or the maintenance of an acceptable level of mental health, can be as much around social and societal issues, as any clinical intervention. For example, there is considerable evidence to suggest that physical exercise, undertaken in green space, can reduce or prevent mental health issues[iii]. 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.

The Secretary of State for Health and Social Care has stated:

As the Prime Minister said last week, radical surgery is required. We will publish a 10-year plan early next year that will set out how we deliver 3 big shifts in the focus of the NHS:

- *from analogue to digital*

- *hospital to community*
- *sickness to prevention*[iv]

While there will always need to be a basis for statutory intervention for those who represent a severe risk to themselves and/or others it is nonetheless surprising that in this journey from 'hospital to community' and 'sickness to prevention' that there is no explicit mention of the promotion of good mental health within the Bill.

This can be remedied. We propose an additional clause 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. We are deliberately choosing the word 'power' rather than 'duty'. The term 'duty' raises both questions of 'which duty' and 'how should this duty be funded'? Instead, being explicit that relevant bodies have a power encourages those already undertaking work in this field while giving permission to those bodies who wish to undertake this work.

Police cells and prisons: an issue of resources.

We welcome the removal of police station cells and prisons as 'places of safety' (Section 46). However, these settings are used inappropriately precisely because there are insufficient hospital beds enabling a speedy admission. Resources will have to be committed to make this legislative imperative a reality.

Community Treatment Orders

We recognise the Government's intention to drive down rates of detention and the use of Community Treatment Orders (CTOs) under the MHA to ensure restriction of liberty is used as a last resort for those most in need. However, without significant investment in the provision of social services and community support (NHS and non-NHS) and investment in workforce recruitment and retention, we fear that the intention of the Bill will fail. Investment in preventative services is essential to reduce the rate of hospital admissions under the MHA.

It is clear that CTOs have been used more widely than anticipated – and disproportionately on individuals from particular ethnic backgrounds, notably those who are Black or Black British. The impact of these measures must be monitored to ensure they tackle this disproportionately in use, not just reduce the overall number of CTOs.

A greater focus on alternatives to admission and therapeutic treatment in the community is required. Improvement in the range and accessibility of services is needed to reduce hospital admission. Yet many of the proposed changes in the Bill focus on what happens post-admission. Embracing the purpose of the principles means focusing on better non-hospital options. This requires non-hospital options to be available. Decision-making is driven by the availability of services. Nothing will change if services are not available due to lack of resource. Higher levels of acute mental illness in the community can only be managed effectively with greater investment in social services and NHS and non-NHS community provision.

The Mental Health Bill and the Mental Capacity Act

The relationship between reform to the Mental Health Act and the Mental Capacity Act 2005 (MCA) and Mental Capacity (Amendment) Act 2019 remains unclear. We are concerned that the UK government does not appear to have undertaken any action with regard to updating the mental capacity Code of Practice or taken a decision on replacing Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS). Currently, application and use of the MHA and MCA frameworks varies for a number of reasons. There remains uncertainty as to which legal framework applies and in what circumstances and depending on the decision to be made. High quality training is required for all health and social services staff involved to deliver consistency and enable practitioners to assess the most appropriate choice of framework.

Greater consistency in this respect can help to minimise any risk of either framework being used inappropriately, for example attempts to use the MHA framework to tackle the backlog of best interests' assessments under the MCA.

Inequalities

It cannot be assumed that attempts to improve the general operation of the MHA in practice will serve to address the particular needs for these population groups who are subject to structural and social-economic disadvantage. Just as poverty and disadvantage impact on physical health outcomes, they also impact on mental health outcomes. There is also the challenge of facing conscious and unconscious bias in decision-making throughout the mental health system.

The largely medically focused approach of the reforms is not well placed to tackle issues such as the impact of experiencing racism, of growing up in a deprived neighbourhood and having fewer educational and job opportunities, or not feeling able to trust the very services that are supposed to be there to help and support. Social circumstances are fundamental to health and wellbeing and too overt a focus on a medical approach can fail to take these into account.

There also needs to be consideration of practical communication barriers such as where individuals do not speak fluent English or are Deaf and how this may negatively impact the outcome of an assessment if a professional interpreter is not provided.[vvi]

Autistic people and people with learning disabilities

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

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' (ATU).

BASW's Homes not Hospitals campaign group advocate ways of working to avoid admission and to support, advocate and challenge on behalf of those currently in

ATUs or other restrictive settings. The campaign group calls for stronger legal levers to require public bodies to provide alternative care in the community and hold them accountable for delivery. Homes not Hospitals would support a dedicated review looking at how mental health and/or capacity legislation can strength discharge mechanisms for people with LD/A who are at risk of detention in ATUs, to address restrictive practices, and prohibit or prevent admission or longer-term detention in ATUs altogether. Such a review much include people with LD/A themselves and organisations that are led by people with LD/A.

Impact on the workforce

From the perspective of the social work workforce, there are already insufficient staff to deal with current challenges in the form of both increasing demand and the existing backlog of work which has been aggravated by the effects of the pandemic.

Existing data suggests up to one third of the current AMHP workforce are approaching retirement age[vii]. Approximately 95% of AMHPs are social workers. Whilst the option to qualify as an AMHP is open to other relevant professions, there has been little uptake. The reasons for this limited uptake require consideration.

Even before the Covid-19 pandemic, the training of social workers to become AMHPs was under pressure. Local authorities were unable to send groups of social workers for AMHP training because they were (and are) unable to backfill their roles within the service. This prevents the necessary number of social workers undertaking AMHP training because the broader issues of social worker recruitment and retention remain unaddressed, including years of cuts to local authority budgets and the highly demanding nature of the profession in increasingly difficult circumstances.

Nominated persons

The hierarchy of the 'nearest relative' approach was outdated and required revision. We support changes to introduce the Nominated Person (NP) (Section 23 onwards) as this empowers an individual's choice and better reflects the range of diverse living and family arrangements. There are some practical issues which are best addressed post Second Reading.

Advance Choice Documents

The Bill says that NHS England and each integrated care board must make such arrangements as it considers appropriate for making information about advance choice documents available to people for whom it is responsible and helping those people as it considered appropriate to create advance choice documents (Section 42).

There are practical considerations that need to be made about Advance Choice Documents such as where they would be stored, how they can be retrieved, and how to be sure that a person had capacity to make such a document.

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20th Nov 2024

[i] p 4. DHSC/Skills for Care/Workforce Intelligence (May 2024) *The AMHP Workforce in the Social Care Sector*. London: DHSC.

[ii] p 6. DHSC/Skills for Care/Workforce Intelligence (May 2024) *The AMHP Workforce in the Social Care Sector*. London: DHSC.

[iii] 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.

[iv] Secretary of State for Health and Social Care (18 Sept 2024) Secretary of State for Health and Social Care Address to IPPR. https://www.gov.uk/government/speeches/secretary-of-state-for-health-and-social-cares-address-to-ippr Accessed 17 Nov 2024.

[v] INforMHA: https://sites.manchester.ac.uk/informhaa/context-of-the-study-mental-health-act-assessments/overview-of-the-project/

[vi] Young, A., Vicary, S., Tipton, R., Rodríguez Vicente, N., Napier, J., Hulme, C., & Espinoza, F. (2024). Mental health professionals' (AMHPs) perspectives on interpreter-mediated mental health act assessments. *Journal of Social Work*, *24*(2), 219-239. https://journals.sagepub.com/doi/10.1177/14680173231197987

[vii] Skills for Care/Workforce Intelligence: The Approved Mental Health Professional workforce in the adult social care sector (2021): p8