Department of Health & Social Care

From Baroness Merron
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

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By email

01 February 2025

Dear Colleagues,

I am writing to thank you all for your insightful contributions on the first day of the Committee Stage of the Mental Health Bill, on 14th January 2025. It was a useful and constructive debate, in keeping with the tone that has been set since the Bill's introduction.

I am pleased to follow up on the points I said I would address in writing following the debate.

How does the Code of Practice afford legal protection?

Baroness Barker and Lord Scriven both questioned where it would be appropriate to depart from a principle and why, therefore, the principles should be in the Code of Practice, and whether the Code of Practice, provides adequate protection for individuals if it can be ignored.

The complexity arises in applying a new set of principles to a longstanding existing legal framework, rather than building a new legal framework around a set of principles from the outset.

We would need to consider how the principles apply to each section of the Act, as they would apply differently in different scenarios, depending on the decision being taken and who it is being taken by. There are circumstances where the principles may not apply to specific provisions or need to be balanced against each other. For example, in considering the patient's choice and autonomy, a treatment that takes longer to take effect may be given to a patient, which may result in the patient being detained for longer.

To set out the principles in the legislation and apply them to the Act as a whole would not provide the flexibility nor allow for clinical discretion to apply the principles as is most appropriate in specific circumstances. It would be difficult for practitioners to understand how to apply them or what their legal obligations are in relation to them.

By placing the principles in the Code of Practice we will be able to provide more detailed guidance on how the principles should be interpreted and applied most appropriately in specific circumstances – which we would be unable to do within the Act. For example, the least restriction principle may need to be applied differently to Part 2 and Part 3 patients.

The Act provides that certain people must have regard to the Code. Any person who must have regard to the Code of Practice must also have regard to the statement of principles when carrying out specified functions under the Act. This includes clinicians, managers and staff of hospitals and approved mental health professionals in relation to the admission of

patents to hospital, under guardianship or community patients. It also includes members of other professions in relation to the medical treatment of patients suffering from mental disorder. The Bill extends this application to IMHAs, nominated persons, the regulatory authority, NHS England and ICBs in relation to specified functions.

The fact that the Code is not legally binding does not mean that the Code is the wrong vehicle for ensuring best practice. Using the Code will often be the right approach: there will be areas where applying a rigid, less flexible set of legal rules will be incompatible with, for example, the need to treat each patient as an individual. The courts have held that those who have regard to the Code must have cogent reasons for departing from it. This means it cannot just be ignored. Where departure from the Code is proposed, it must be justified, strongly, by the individual facts of each case.

We are putting the principles on the face of the Act, so that they govern the content of the Code of Practice and will not be able to be changed except by Parliament. The Pre-Legislative Scrutiny Committee recommended that the Government amends section 118 of the Act to include the revised principles, and this is the approach we have taken.

Potential unintended consequences of Amendments 5, 38 and 40

Baroness Browning and Baroness Barker both spoke about the interactions between the Mental Health Act (MHA) and the Mental Capacity Act (MCA), and the need for greater clarity about which legislation is being used to detain a person and why. I set out below some examples how these amendments could have unintended consequences.

Amendment 5 would amend the MCA so that a person with a learning disability or an autistic person who could not be detained under section 3 due to the reforms introduced by the Bill, could also not be detained in hospital under the Deprivation of Liberty Safeguards or a Court of Protection Order if they object to admission or to treatment, or if someone else objects on their behalf.

Amendments 38 and 40, tabled by Lord Scriven, would amend the MHA to prevent use of the MCA to deprive people of their liberty who lack capacity and who do not meet the detention criteria under Part 2, section 3 of the MHA. This includes anyone who needs to be deprived of their liberty for physical treatment in a general hospital, in a care home, or in the community.

Our policy intent is to stop people with a learning disability and autistic people being detained for long periods of time in restrictive and unsuitable hospital environments and help ensure they are supported in the community. We do not intend for people with a learning disability or autistic people to be detained in hospital in an equivalent way under the MCA. However, we think there are some limited circumstances where it may be appropriate to use the powers under the MCA in a defined and time-limited way in the interests of the person.

Where a person lacks capacity and does not have a psychiatric disorder that requires hospital treatment under the MHA, there may be elements of that person's care plan and arrangements that require the Deprivation of Liberty Safeguards (DoLS) to ensure they can access the

community safely and maintain a safe home environment. We would consider this to be an appropriate use of DoLS where these are authorised.

Where someone is subject to DoLS as part of their care plan, there may be circumstances where use of the DoLS could be used to detain someone in a hospital setting in a way that is compliant with their care plan. For example, in the case where there is a rapid breakdown in the person's community arrangements and alternative arrangements are being made. There may be circumstances where it may be most appropriate for DoLS to be used to enable a short-term hospital stay, as a transitionary arrangement, while alternative community care and support is being organised. This would need to be a tightly defined arrangement to ensure there is a place for the individual between community care packages and would need to be articulated thoroughly in the Code of Practice.

Additionally, as mentioned during the debate, we are aware that some specialist community services are provided by organisations who also operate hospital services on the same site. We would have concerns that the amendment could remove such provision as a viable alternative to inpatient care.

What safeguards and oversight mechanisms will be in place to ensure equal application of the Bill to Wales, as in England?

Health is a devolved matter, so it is the responsibility of the Welsh Government to oversee the implementation of these reforms in Wales. We work collaboratively with the Devolved Governments to drive forward our objective of supporting people to lead more independent, healthier lives for longer. DHSC holds some reserved functions and working together across the UK on health and social care is ingrained in the values of our NHS and social care sector.

The UK government will continue to work closely with the Welsh authorities to ensure we are aligned in how the Bill is implemented. We already work closely on a number of matters, for example Welsh colleagues sit on the National Reference Group for the section 12 / Approved Clinician approval panels so that we are aligned on standards and processes for the approval of Approved Clinicians and Section 12 doctors.

In my response to Baroness Berridge, I said "Under our proposed reforms, people with a learning disability and autistic people, as I said, can be diverted from hospital to prison." I confirm that this should have been "from prison to hospital".

I hope this letter has provided clarification on the points raised in Committee. I am copying this letter to all the Peers who spoke during the debate and placing a copy in the library of the House.

All good wishes,

BARONESS MERRON