Department
of Health &
Social Care

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

39 Victoria Street
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By email

6 February 2025

Dear Colleagues,

I thank you for the constructive discussion held on the second day of the Committee Stage for the Mental Health Bill, on 20th January 2025.

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

Has Tier 3 training on learning disability and autism been developed and who will hold responsibility for oversight of this?

Baroness Barker spoke on the importance of specialist training on learning disability and autism and asked whether tier three training has been developed and who holds responsibility for its oversight.

By way of background, the Health and Social Care Act 2008 (as amended by the Health and Care Act 2022) requires that all Care Quality Commission (CQC) registered providers ensure their staff receive specific training on learning disability and autism appropriate to their role. This will help to ensure that staff have the right knowledge and skills to provide good care to people with a learning disability and autistic people using their services. This builds on existing requirements in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18. The role of CQC is to assess whether training requirements are being met by providers and it may take action if not.

The Health and Care Act 2008 (as amended) also requires the Secretary of State to issue a Code of Practice to guide providers in meeting the training requirement and this must include information on matters such as training content delivery, monitoring, and evaluation. Consulted on in 2023, a draft code of practice outlined three tiers of capabilities to help providers determine the level of training that their staff require and what that training should contain. These tiers are mapped to the existing Core Capabilities Frameworks, published by Skills for Health, for learning disability and autism for staff working in health and social care.

To support providers, we have been rolling out the Oliver McGowan Mandatory Training on Learning Disability and Autism. Over two million people have completed the e-learning package which is the first part of this training and over 1700 trainers are delivering the interactive second part across the country. An independent, long-term evaluation of this training is underway which will take place over 36 months, looking at how the training is being delivered and what impact it has had on staff, people with a learning disability, autistic people and their family carers.

This is intended to address the requirements of most staff. However, some staff will need training beyond this level. As training required at tier three level will be highly varied, we do not consider there is a standardised package that could be developed to meet all needs. Individual employers have responsibility to provide the appropriate training for their staff.

Other examples of training available for staff in relation to autism and learning disability include the National Autism Trainer Programme, developed by NHS England, which is co-designed, co-produced and co-delivered with experts by experience. In addition, foundation and enhanced autism training is being rolled out to upskill psychiatrists across specialist and mainstream settings with the aim to improve autism assessment and diagnosis times. These are designed at a higher competency level to enhance and complement other training.

Will experts by experience be priortised in guiding research?

Baroness Bennett of Manor Castle raised points about how research on autism in particular can ignore the wants and needs of autistic people and also highlighted the importance of treatment being led by research. Following on from this Baroness Bennett specifically asked how the Government would prioritise experts by experience in guiding research and the type of input there may be.

The National Institute for Health and Care Research (NIHR) is funded by the Department of Health and Social Care to improve the health and wealth of the nation through research. Partnering with the public is a key priority for the NIHR. Public contributors, including patients, carers and individuals with lived experience, improve the relevance and quality of research. People contribute at every stage of the NIHR research pathway, including shaping priorities and research questions, the design of studies, and the evaluation of research proposals through public members on funding committees. Applicants for NIHR funding are also required to set out plans for involving public members in applications assessed by funding committees.

How will the government ensure that inpatient wards for people with a learning disability and autistic people do not undermine the aim of therapeutic benefit?

Baroness Tyler of Enfield asked for clarification on the definition of appropriate medical treatment and whether this would include consideration of the setting in which the treatment takes place being appropriate to the individual.

Environment is part of medical treatment and an appropriate and therapeutic environment will form part of the consideration of whether or not treatment is appropriate.

Appropriate medical treatment could include: treatment that is evidence based to treat the relevant condition but also the particular needs of the patient; available treatment that is wanted and consented to by the patient (other than in exceptional circumstances) and given in a therapeutic environment that is safe; and addresses any particular sensory needs in a way that makes reasonable adjustments.

As mentioned during Committee Day 3 in the debate on treatment, we know that the sensory environments in NHS settings can cause difficulties for people with sensory sensitivities, which could undermine therapeutic benefit. To support NHS services to address sensory aspects of the environment, including mental health inpatient settings, NHS England have published a sensory friendly resource pack. The sensory friendly resource pack outlines 10 principles to improve the sensory environment and signposts to further resources. We are also actively supporting sensory friendly design as part of our capital investment in the mental health estate.

A range of other actions are also happening now to improve the quality of inpatient care and ensure it is appropriate for people with a learning disability and autistic people, who often find these settings distressing. These include NHS England’s Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme to work with people and families, clinicians, providers, systems, and stakeholders to ensure the appropriateness of therapeutic environments. As part of this programme NHS England has commissioned a national Culture Change programme, which includes a specific focus on being autism informed. Every provider of NHS Commissioned inpatient services is part of this programme and is being directly supported with ways to improve the inpatient experience so it better meets the needs of autistic people.

Will the Government will consider the use of mental health nurses, perhaps as a method of introducing more locally available psychiatric prescribing services, or are there too many concerns?

Lord Kamall questioned the role that mental health nursing could play in introducing more locally available psychiatric prescribing services.

Employers determine the skills mix within their teams in order to provide care to the communities that they serve, and they develop specialist roles to meet service need to support this. The Non-Medical Prescriber role is one of those specialist roles.

The Non-Medical Prescribers role, which includes the Mental Health Nursing Workforce, has demonstrated great impact for patient care in terms of access, expertise, and economic benefit. It is seen as a as a key enabler in the planning and delivery of new care models and transforming care. NHSE fund tuition fees to enable nurses to undertake this professional development.

A central part of the 10 Year Health Plan will be our workforce and how we ensure we train and provide the staff, technology and infrastructure the NHS needs to care for patients across our communities. This summer we will publish a refreshed Long Term Workforce Plan to deliver the transformed health service we will build over the next decade, and treat patients on time again. We will ensure the NHS has the right people, with the right skills, including Mental Health nursing, to deliver the care patients need when they need it.

We are also continuing to develop resources to attract more people into mental health nursing. We are collating all activity into a single national mental health nursing plan.

What information does the Government have on the effectiveness of Community Treatment Orders?

We have provided a summary of the data and research on the effectiveness of Community Treatment Orders (CTOs) below. This addresses Lord Kamall's amendment by setting out what we understand about the impact of CTOs on people from different ethnic minority backgrounds, the prevention of readmission to hospital, the therapeutic benefit gained from CTOs, and a rationale for why the use of CTOs should continue.

CTO use among ethnic minorities

We recognise there are significant disparities in the use of CTOs between different ethnic groups. This data is published by NHS England as part of the Annual Mental Health Act Statistics. In 2023/24, the standardised rate of CTO use per 100,000 population was higher for all broad ethnic minority groups than for White people. The starkest disparity in CTO use is among Black people. The standardised rate of CTOs per 100,000 population was 7 times higher for Black or Black British people (48.8 per 100,000 population) than for White people (6.9 per 100,000 population).

We are strengthening decision making in the Bill to account for variation in this and the ways in which the Act are applied which may be contributing to disparities in the use of CTOs (for example, by requiring a community clinician to be involved in all decision making).

However, the evidence on what drives these inequalities and how disproportionate detention rates and CTO use compare to levels of need at point of presentation (in 2023/24 detention rates were over 3 and half times higher for Black people than for White people) is less clear. This is something we will explore with experts including academic researchers to determine whether there are evidence gaps that need to be filled through commissioning further research.

Evidence on readmission rates

Evidence considered by the Independent Review

There have been three randomised controlled trials (RCTs) studies looking at the use of CTOs. The National Institute for Health and Care Research (NIHR) funded a randomised controlled trial in England (Burns *et al.*, 2013[1]), which explored the outcomes of patients with a CTO compared to patients with Section 17 leave. It did not find evidence that CTOs reduced readmission rates over a 12 month period.

A further meta-analysis (Kisely *et al.*, 2017[2]) combined this study with results from two studies in the US, giving a total sample size of 749 people. Similarly, this concluded that compulsory community treatment was no more likely to result in significant differences in readmission, social functioning or symptomatology compared with standard care. However, the American model of compulsory treatment does differ from the UK to some extent, in that it is court-ordered (rather than clinical) and generally a longer period of compulsory treatment. The meta-analysis also expressed some concerns with selection bias in each of the control trials. For example, the UK study has been criticised for only considering patients who would be suited to a relatively short Section 17 leave, which may have excluded patients most suited to CTOs; some of the most unwell patients were excluded.

Further research was commissioned as part of the Review which was funded by NIHR. Barnett *et al.,* 2018 conducted a systematic review and meta-analysis of Compulsory Community Treatment (CCT) to prevent readmission and increase engagement with community care, with 41 studies included set in USA, European countries or Australia, including a sample 190,000 patients. Findings suggest CCT is ineffective at reducing readmissions, however, evidence from pre-post and two-group studies suggests that CCT does act as a mechanism for patients to receive more treatment and support from community mental health services.

Further research since the Independent Review

CTOs exist in more than 75 jurisdictions worldwide. The results from more than 50 non-randomised studies show mixed results. More recent case control and cohort studies have reported that CTOs are associated with reduced hospitalisations, however these primarily take place in Australia (Harris *et al.*, 2019[3]) and New Zealand (Beaglehole *et al.*, 2022; Beaglehole *et al.*, 2022[4]) so are arguably of limited applicability to the UK, given the major differences in healthcare delivery between the UK and other countries.

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[1] Burns, T., Rugkåsa, J., Molodynski, A., Dawson, J., Yeeles, K., Vazquez-Montes, M., ... & Priebe, S. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *The Lancet*, *381*(9878), 1627-1633.

[2] Kisely, S. R., Campbell, L. A., & O'Reilly, R. (2017). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane database of systematic reviews*, (3).

[3] Harris, A., Chen, W., Jones, S., Hulme, M., Burgess, P., & Sara, G. (2019). Community treatment orders increase community care and delay readmission while in force: Results from a large population-based study. *Australian & New Zealand Journal of Psychiatry*, *53*(3), 228-235.

[4] Beaglehole, B., Newton-Howes, G., Porter, R., & Frampton, C. (2022). Impact of diagnosis on outcomes for compulsory treatment orders in New Zealand. *BJPsych open*, *8*(5), e145.

Evidence on therapeutic benefit

Engagement with stakeholders

Whilst there are mixed views, it is notable that clinicians have identified patients who may receive therapeutic benefit from CTOs. The independent review identified that there are a small number of people for whom CTOs represent the least restrictive option, which raised enough concern that repealing CTOs entirely could have a detrimental impact on some service users.

Such patients include those with complex symptoms (for example, psychosis) and comorbidities or other risk factors (such as homelessness) who have insufficient insight into their illness so would be at risk of disengaging once in the community. These patients often require time and supervision to achieve stability of their symptoms which then allows them to engage with treatment on a voluntary basis.

CQC visits report

In 2022, the CQC published a focused visits report looking at how CTOs have been used in nine boroughs across London. They spoke with patients on a CTO, their relatives, carers and professionals. Patients had a mixed view of their CTOs – some found them helpful (particularly that they could be admitted quickly if they became unwell), but most did not like the coercion or having to take depot medication (a slow-release form of medication given via injection which does not need to be taken as often as oral medication) .

Carers viewed CTOs more positively and believed that CTOs helped their loved ones stay out of hospital and that they would otherwise not stick with their medication.

Approved Mental Health Professionals (AMHPs) and Responsible Clinicians tended to view them positively and did think they played a role in preventing readmissions but were unsure how effectively patients could be cared for in the community.

Some patients had been recalled to hospital and this was taken as evidence that the CTO provided speedy access to treatment when their mental state deteriorated. Some hadn't been recalled and that was taken as evidence that the CTO had prevented readmission by ensuring the patient complied with medication in the community.

Rationale for CTOs

The above considerations as well as engagement with people with lived experience presents a mixed picture which nevertheless shows that there are benefits to CTOs for some patients. In line with the Independent Review, we believe that there is not sufficient evidence to abolish CTOs, particularly when it is not clear what alternatives these patients would have for treatment and a least restrictive option may not be available. Our focus is on reviewing the impact of the reforms.

How will we keep CTOs under review?

We already monitor published data on CTO use, but the data on outcomes and patient experience is limited. Officials are working with NHS England and system partners to understand what additional data it would be helpful to collect.

We will continue to monitor racial disparities in the use of CTOs. The patient and carer race equality framework (PCREF) will improve data collection on racial disparities over the coming years. The PCREF will support trusts and providers to work with their local communities, patients and carers to agree and implement concrete actions to reduce racial inequalities within their services and to make decisions with people from diverse ethnic backgrounds, and not for them.

Further research

Through the National Institute for Health and Care Research (NIHR) Policy Research Programme, DHSC has commissioned four new research studies in response to the recommendations from the Independent Review of the MHA published in 2018. These studies have now completed. We expect the findings from all four studies to be published in the coming months. The first two studies were explicitly focussed on understanding and addressing racial inequalities in the application of and/or outcomes under the Mental Health Act.

1. Experience-based investigation and codesign of approaches to prevent and reduce Mental Health Act use (CO-PACT)
    - A study aimed at understanding and addressing the disproportionate use of the MHA among racialised communities in England.

2. Improving the Experiences of Black African Caribbean Men Detained Under the Mental Health Act: A Co-Produced Intervention Using the Silences Framework (ImprovE-ACT)
    - A study aimed at enhancing the experiences of Black African and Caribbean men who have been detained under the Mental Health Act in the UK.

3. One-to-one Peer support for family members and friends of patients treated under the Mental Health Act (OPAL)
    - A study aimed at developing and implementing a peer support program for informal carers—family members, partners, or friends—of individuals detained under the Mental Health Act (MHA) in England.

4. Development, Feasibility Testing and Pilot Trial of a Crisis Planning and Monitoring Intervention to Reduce Compulsory Hospital Readmissions (the FINCH Study):
    - A study aimed at evaluating whether an intervention to prevent compulsory readmission can be developed that is acceptable to people who have recently been compulsorily admitted (including Black and Black British people).

We plan to commission an independent evaluation of the reforms. The evaluation will aim to understand how in practice the reforms established by legislation are implemented and how far they are likely to achieve the intended outcomes for patients. This could look at CTO use, including for people from different ethnic minority backgrounds, CTO and detention length, outcomes following tribunal referrals, decision making around CTOs, and patient experience and outcomes (including readmission and therapeutic benefit).

We plan to supplement evaluation with further investigation into racial inequalities in the application of and/or outcomes under the Mental Health Act. This may involve:

- Synthesising findings of existing research, including analysis of logic models for interventions;
- Conducting a review of recent literature;
- Exploration with experts and academics on whether there are evidence gaps that need filling by commissioning further research

Any independent evaluation and further research would be subject to the availability of funding and to receipt of fundable research application(s). Applications are subject to peer review and judged in open competition, with awards being made on the basis of the importance of the topic to patients and health and care services, value for money and scientific quality.

Point of Clarification

I would like to provide clarification to Lord Scriven, around the Community Treatment Order policy is set out in the Bill:

- Under Clause 6 of the Bill, one of the criteria for placing a patient on a CTO is if appropriate medical treatment is available for the patient. The definition of appropriate medical treatment includes that there is a reasonable prospect of the treatment having therapeutic benefit for the patient.
- The Bill would mean that a responsible clinician cannot extend a community treatment order beyond 6 months unless the amended criteria, including therapeutic benefit, continue to be met.
- The Bill adds the requirement that a second medical professional must be involved in decision making. They must be consulted on decisions regarding the making of a CTO, the conditions to be placed on the CTO, renewing of the CTO, recalling the patient to hospital, revoking the CTO, and discharging the patient. This second

medical professional is the community clinician which is the approved clinician who is responsible for the patient’s care and treatment when they are in the community.

- The Bill also adds the requirement for an approved mental health professional to consult the patient’s nominated person, unless this is not reasonably practicable, or would involve unreasonable delay.
- CTOs must be reviewed after an initial 6-month period, then following a further 6 months, and then subsequent 12-month periods if the person is still on a CTO.
- In the Bill, we are increasing the frequency of automatic referrals to the tribunal to review a CTO so that these would occur at each of these periods. This means that following an initial tribunal referral at 6 months, another referral is required after a further 6 months, followed by a mandatory referral 12 months after that, if the patient has not made an appeal themselves. Currently, automatic referrals are required after the initial 6 months but do not need to occur again until a person has been on a CTO for three years (or 12 months if they are under 18). Under our reforms, a person should not have to wait for more than a year for an automatic referral.

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

All good wishes,

Gillian

BARONESS MERRON