Department
of Health &
Social Care

Mental Health Bill - Implementation Policy Paper

Implementation Context

This government is committed to implementing this legislation so that people detained under the Mental Health Act, or at risk of detention, see real improvements in their care and outcomes as soon as possible.

This paper sets out our current assessment of implementation requirements with indicative timescales as set out in the Impact Assessment accompanying the Bill. More detailed plans will be developed once the legislation has been passed.

We estimate full implementation will take around ten years due to the time needed to expand specialised workforce groups including approved clinicians, second opinion appointed doctors and tribunal judges, along with expanding community infrastructure for people with a learning disability and autistic people. The Pre-Legislative Scrutiny Committee acknowledged that to get this right will require a long-term programme of reform. That does not mean that patients will have to wait ten years to experience the benefits of these reforms or the wider programme of non-legislative activity that is improving care for people with mental health problems. We will phase implementation, so that we can turn on new powers and duties as soon as there are resources in place to do so.

This timeframe necessarily spans multiple spending reviews and multiple parliaments. There are interdependencies with the expected NHS ten-year plan and wider workforce plans. This limits the detail we can give about future spend and timelines. Whilst we cannot pre-empt ongoing and future spending decisions, we are being as clear as we can be on what it will take to make these reforms a reality.

Whilst the government is having to make tough choices about spend, as set out in the NHS planning guidance for 2025/6, we expect ICBs to meet the Mental Health Investment Standard in the coming year.

Timeline and Sequencing of Implementation

In summary, when the Mental Health Bill receives Royal Assent, we will then need to draft and publish a revised Code of Practice, and train staff on the new guidance and the Act. Sections of the Bill would then be commenced as soon as safe to do so, the rate limiting factor being the availability of sufficient workforce and requisite funding to fulfil some of the new duties. Indicative timings subject to workforce capacity and funding are provided in the Impact Assessment.

1. The first priority will be to draft and consult on the **Code of Practice**. We will engage with people with lived experience and their families and carers, staff and professional groups, commissioners, providers and others to do this. The Code will be laid before Parliament before final publication. We are committed to working with both Houses of

Parliament to ensure we get this crucial document right. We expect this process will take at least a year from Royal Assent.

2. Alongside the Code we will develop **secondary legislation**, which will be laid before Parliament, and which will provide further essential operational detail to support the effective delivery of areas like statutory Care and Treatment Plans and Dynamic Support Registers. We are publishing policy papers ahead of Report which set out more information on some of the delegated powers in the Bill and provide an early indication of what regulations might include.
3. We will then need time to **train the existing workforce** on the new Act, regulations and the Code. That will likely be in 2026 and/or 2027 depending on progress made with the Code and subject to the current spending review.
4. Some clauses can be commenced before the Code is published, such as those concerning supervised discharge, but the first set of major reforms are expected to follow that training – as set out in the Impact Assessment, indicatively in 2027/28. These include clauses concerning detention criteria, Nominated Persons and other reforms that change processes and decision making, but do not require significant workforce expansion. They do, however, have cost implications so timings are subject to spending review decisions.
5. We will continue to expand the workforce and improve community support, with the aim of implementing the later reforms such as increasing frequency of Mental Health Tribunals when we have sufficient workforce in place. The long lead-in time for these later reforms is necessary because of the time needed to train sufficient approved clinicians and Tribunal panels to cope with the increased case load from more frequent Mental Health Tribunals. The training of this new workforce will continue in parallel to the Bill implementation programme.

<u>Learning Disability and Autism reforms</u>

As with wider implementation of the Bill, we will prioritise the development of the **Code of Practice, statutory guidance and secondary legislation** necessary to commence the learning disability and autism provisions, such as the statutory Care (Education) and Treatment Reviews and Dynamic Support Registers.

Regarding the proposed changes to the section 3 detention criteria, we know that the right community support must be in place to improve care, reduce reliance on inpatient settings and ensure the reforms have their intended effect. For this reason, the proposed section 3 reforms will not be commenced until there are sufficiently **strong community services in place.**

Local systems do not need to wait for the legislation to come into force to begin putting in place the necessary community services, and there are already areas delivering strong

community services with examples of good practice that we would like to see across all local areas. However, we also recognise that a significant programme of work alongside investment is required to fully implement the reforms.

Funding and Spending Reviews

The indicative costs of these reforms are set out in the Impact Assessment. This will require investment, decisions on which are subject to the forthcoming spending review. The implementation timeframe necessarily spans multiple spending reviews and multiple parliaments, and we are unable to pre-judge the outcome of the current or future spending reviews. We will continue to iterate our plans based on the final form of the legislation, the final drafting of the Code, and the funding available.

Code of Practice

The code was last updated in 2015. **We will take this opportunity to fully revise the Code**. Our changes will include:

1. **Guidance on the new legislation** contained in the Mental Health Bill and subsequent secondary legislation.
2. Fully updating the code to **embed the Principles** based on the Independent Review, which are now set out in section 118 of the Bill.
3. **Other non-legislative reforms** (e.g. tackling racial disparities)
4. **Updating previous guidance that is now out of date** (for example, updating references to the Care Programme Approach, which is no longer used in NHS community services, and other changes to reflect case law since it was last updated)
5. We would like to include more **case studies and examples of how to apply the Act in practice**, with particular regard to reducing racial disparities, to make the guidance more practical for professionals and service users.

We will co-produce the Code with a wide group of partners, including NHSE, CQC, LGA, ADASS, MoJ, HMCTS and others. We will engage and consult widely on the new Code, including:

- A reference group of patients and carers
- A reference group of professionals who use the Act
- Specialist subgroups on themes such as racial disparities, children and young people, public protection and learning disability and autism

- We will also engage with interested parliamentarians to ensure we have fairly reflected those changes we have agreed should be made in the Code rather than in primary legislation.

The draft Code will be laid before Parliament before it is published as the new statutory guidance.

We will require at least a year to train staff on the new Act and draft Code prior to commencing first phase of reforms.

Programme Oversight and Governance

DHSC will play the leading role in providing oversight and guidance of the implementation programme and leading funding bids at future Spending Reviews.

We commit to establishing a **quarterly implementation board** with key bodies for oversight and to identify and unblock issues.

We will update Parliament throughout the implementation period.

At the same time, we plan to commission an independent evaluation of the reforms. This will be a long term, staged exercise given the long period over which different reforms are expected to be sequentially commenced following initial primary legislation.

An 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. It will be important to assess whether new safeguards and support mechanisms are being equitably accessed, considering race, disabilities, age, gender and socioeconomic factors.

We can use existing data sets to give us some of this information. The Mental Health Services Dataset (MHSDS), provides patient-level data for patients who are in contact with a wide range of mental health services, and the Assuring Transformation dataset holds information about people with a learning disability and autistic people who are receiving treatment or care as inpatients in a mental health hospital. We can use this to monitor changes in detention rates, racial disparities and other key metrics.

There are also various metrics in the Adult Social Care Outcomes Framework that can provide general insight into aspects of quality of life, independence, safety, and continuity and quality of care. These aggregate metrics could be supported by qualitative studies for people discharged.

The CQC carry out a range of monitoring activities, including but not limited to their inspections programme. They produce an annual ‘Monitoring the Mental Health Act report which includes data on mental health tribunal activity, the work of the SOAD service, and thematic reviews of patient care.

The Ministry of Justice publish data on tribunals, other relevant courts activity in the for mental health provision, and the Home Office publish statistics on police use of s135 and s136 of the MHA.

As the Bill is introduced, we will proactively seek new opportunities for additional monitoring data to enhance the metrics captured for monitoring and evaluation.

The ongoing data and feedback from independent evaluations will allow us to keep Parliament updated on progress throughout the implementation period.

Wider context

Finally, it should be noted that the Mental Health Bill reforms will be taking place in a wider context on new and ongoing programmes to improve inpatient and community care.

1. The National Inpatient Commissioning Framework requires Commissioners to localise all inpatient care commissioned by Integrated Care Boards. Every Integrated Care Board is implementing a plan to deliver this by 2026/27.
2. There is an ongoing Culture Change Improvement programme to improve patient experience, a reduction in restrictive practice, and improved staff experience, because we know that achieving a positive workplace culture has benefits for employee engagement and performance, staff retention and patient outcomes.
3. We are testing neighbourhood mental health centres for people aged 18 and over with serious mental illness, offering 24/7 open access care closer to home, with an integrated service including healthcare providers, Local Authorities and the voluntary sector. These pilots build on international evidence that show that similar models have led to a reduction in hospitalisation and waiting times and support our efforts to move more care into the community.
4. Planning Guidance includes a commitment to improving access to services for children and young people, combined with productivity and reducing local inequalities in access, so we can reach those in most need of support. We will also continue the rollout of mental health support teams (MHSTs) in schools in line with our manifesto commitment.
5. The planning guidance also includes a focus on improving mental health and learning disability care and contains the objective to deliver a minimum 10% reduction in the use of mental health inpatient care for people with a learning disability and autistic people in 2025/26.

All of this wider work will support and enable the implementation of the Mental Health Bill reforms.