Department of Health & Social Care

From Stephen Kinnock MP
Minister of State for Care

39 Victoria Street
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By email to: MPs appointed to the Mental Health Bill Public Bill Committee

4 July 2024

Dear Colleagues,

I am writing to follow up on some of the points raised on Day 2 of the Committee Stage for the Mental Health Bill, on 12th June 2025.

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

Capacity of Legal and Judicial system particularly tribunals (Clause 7)

You asked how the new detention criteria will impact discharge rates in practice, and whether tribunal members will retain discretion to consider individual patient circumstances beyond the statutory criteria. You also asked how this change will be monitored.

Automatic referrals are intended to strengthen, not weaken, the safeguards around discharge, with evidence-based Tribunal scrutiny ensuring appropriate – not prolonged – detention. We therefore believe the reforms have the potential to modestly raise discharge rates. His Majesty's Courts and Tribunals Service (HMCTS) and the Department for Health and Social Care (DHSC) will keep this under review.

To ensure the Tribunal has time to prepare for the anticipated increase in applications the role out for tribunal reforms will be phased in, with changes to automatic referrals planned for 2030/31. We estimate that the additional demand to the Tribunal will require 5000 additional sitting days per year (51% increase from 2023/24 sitting days) once all reforms are implemented.

The Ministry of Justice is working alongside HMCTS and DHSC to model and support the necessary planned recruitment. Over 50 Specialist Members were appointed in April and are due to be trained this summer, with a further campaign expected in 26/27. Recruitment for both salaried and fee-paid judges of the Mental Health Tribunal is also ongoing, with more due to be launched as part of the 25/26 recruitment programme.

The Government will monitor the impacts of these reforms using quarterly management information on referral volumes, listing times, hearing outcomes and subsequent discharge

rates, publishing headline Tribunal figures in HMCTS's *Tribunal Statistics Quarterly*, while overall trends in detentions and community orders will continue to appear in NHS England's annual *Mental Health Act Statistics*.

Second Opinion Appointed Doctor Certificates (Clause 13)

You asked about the potential unintended consequences of the second opinion appointed doctor's certificates being 'combined'. There was some confusion over which part of the Explanatory Note this was in reference to, but we believe this was in relation to paragraph 117, which states:

Where a patient lacks capacity or competence to consent and the compelling reasons test applies within the first two months of medical treatment, to avoid the second opinion appointed doctor's providing two separate certificates (i.e. one to certify the absence of capacity or competence at two months and one to certify treatment under section 57A), the second opinion appointed doctor is able to provide a single combined certificate covering both issues. This may help to streamline responsibilities on the second opinion appointed doctor's service and minimise administrative burden.

The main reason for this approach is that, under s.57A (i.e. the compelling reason test) and under s.58 (where the patient lacks capacity or competence to consent), the second opinion doctor will be assessing a very similar set of things: the patient's capacity to consent, whether the treatment (including the broader treatment plan) constitutes appropriate medical treatment and whether the clinical checklist has been appropriately applied. The only difference is that s.57A also requires the compelling reason test to be applied. Bearing this in mind, it was considered duplicative for a second opinion doctor to certify the patient's treatment under s.57A and soon afterwards conduct the same assessments again and issue another certificate under s.58. Doing so would result in unnecessary burden on the second opinion appointed doctor's service. Therefore, in these particular circumstances (i.e. where a s.57A certificate had been issued in the past 2 months), we decided that the two certificates can effectively be combined. This approach has been developed in consultation with the principal second opinion doctor, who heads up the service, and its members.

Recourse for people who want to challenge their treatment

You inquired about routes of recourse for individuals who wish to challenge compulsory treatment, under the Bill. Of course, our hope is that the compelling reason test, the clinical checklist and other reforms to the Mental Health Act will see that more people receive care and treatment that is in line with their wishes and feelings and that the therapeutic benefit of detention is clear. Therefore, we expect that fewer people will want to raise issues or seek recourse.

Where they do, this should first be done via the patient's care team, potentially with the support of their Independent Mental Health Advocate, Nominated Person or Lasting Power of Attorney. It may also be appropriate to involve a second opinion appointed doctor in particular circumstances, who are appointed by the regulator and play an important role in making sure compulsory treatment decisions are appropriate and that key patient safeguards are in place Under the Bill, second opinion doctors will also need to assess other things such as where the compelling reason test has been met and the clinical checklist has been applied by the treating clinician.

If concerns remain unresolved, patients can request the view of another second opinion doctor. If appropriate, they may also wish to use the complaints process available to all NHS patients and complain to the NHS service provider or commissioner. CQC can investigate complaints relating to the Mental Health Act (usually once local complaints procedures have been exhausted) and the Parliamentary and Health Service Ombudsman (PHSO) can consider any complaints which do not fall within the remit of CQC, including how a complaint made to CQC has been handled. Anyone can complain to CQC including patients, their families, friends and carers, and staff. Where an individual lacks capacity, a representative may raise complaints to the PHSO on their behalf.

Additionally, patients have opportunities to voice concerns during their Tribunal review, with the support of non-means tested legal aid. While the tribunal is not designed to deal with specific treatment decisions, this does not mean that the patient's care and treatment more generally should not form a part of the Tribunal's review. Under the reforms the increased emphasis on the principle of therapeutic benefit within the detention criteria will mean that the patient's care and treatment and whether it is proving effective will play a role in the tribunal's consideration of the patient's case for continued detention under the MHA.

For patients who do not bring an application to the tribunal, they will be automatically referred at the relevant trigger points. This is an important safeguard for patients who lack capacity. Where proceedings are before a MHT and the patient is unrepresented, under tribunal procedure rules the MHT has the power to appoint a legal representative for a patient who lacks capacity.

Judicial review also provides a vital safeguard for challenging decisions under the Mental Health Act, when other mechanisms are unavailable. It is intended as a last resort, with several options available to address concerns before reaching this stage. Legal aid is available for those eligible to pursue Judicial Review, ensuring access to justice for individuals in exceptional circumstances where oversight and fairness are required. Where the patient lacks capacity, then judicial review can be brought by someone who has "sufficient interest", such as the patient's Nominated Person.

These multiple layers of recourse work together to safeguard patients' rights and well-being under the Act.

I hope this letter has provided further clarification on the issues raised in Committee. I am copying this letter to all members of the Committee and will place a copy in the library of the House.

Yours sincerely,

STEPHEN KINNOCK