Lincolnshire COUNTY COUNCIL Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Lincolnshire Health and Care System

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9 March 2021**
Subject:	**Reforming the Mental Health Act White Paper**

Summary:

This report presents a briefing paper which provides a summary of the Reforming the Mental Health Act White Paper and details of the consultation questions.

Actions Required:

The Lincolnshire Health and Wellbeing Board is asked to:

- Note the content of the briefing note and consultation questions in the attached Appendices 1 and 2.
- Note and approve the proposed system response to the consultation in Appendix 3.
- Consider if it has any feedback on the consultation questions that is wishes to be included in the final submission.

1. Background

Issued by the Department of Health and Social Care (DHSC) on 13 January 2021, the White Paper proposes a substantive programme of legislative reform to give people greater control over their treatment, and ensure they are treated with dignity and respect. It includes steps to improve how people with learning disability and autistic people are treated in law and reduce the reliance on specialist inpatient services for this group.
The White Paper responds to recommendations in the report of the Independent Review of the Mental Health Act.

It is arranged around three discrete parts:

- Part 1: proposals for reform of the Mental Health Act and the plans for legislative change.
- Part 2: proposals and ongoing work to reform policy and practice to support implementation of the new Mental Health Act to improve patient experience
- Part 3; the government's response to the recommendations made by the Independent Review of the Mental Health Act.

A summary of the White Paper is provided in the attached Appendix 1. The paper also includes a series of questions on the implementation and impact of the proposed reforms which the government is seeking views on (appendix 2). Feedback from the consultation will be used to inform the final drafting of the revised Mental Health Bill. The consultation period runs for 14 weeks and concludes on 21 April 2021.

As part of our system collaboration, it was agreed that key stakeholders would work together on a system response- as opposed to submitting (potentially conflicting) individual organisational responses. This is seen as an important reflection of how we are operating as an integrated health and care system.

Following a period of engagement led by Lincolnshire Partnership NHS Foundation Trust, Lincolnshire County Council and the NHS Lincolnshire Clinical Commissioning Group a proposed submission has been agreed and is included in Appendix 3. This engagement has had input from East Midlands Ambulance Service, Lincolnshire Police, primary care, third sector, voluntary and wider community services.

The paper being presented to the Health and Wellbeing Board before the close of the consultation period allows a window of opportunity for further input as well as an opportunity for formal approval of the submission.

2. Conclusion

The Mental Health Act white paper is an important and well overdue review of the legislation- with a key focus on improving the patient experience in each part of the pathway. Mental Health is a priority in the Lincolnshire's Joint Health and Wellbeing Strategy and a key area of focus in the NHS Long Term Plan. The proposals resonate with the Lincolnshire vision of integrated care close to home, ill health prevention through person centred care and health equality.

The system has responded swiftly and collegiately to agree a joint consultation response.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Relevant evidence from the JSNA has been used to inform the consultation response.

Mental Health is a priority in the Joint Health and Wellbeing Strategy, and a key area of focus in the NHS Long Term Plan.

4. Consultation

The government is seeking views on the implementation and impact of the proposed reforms to inform the final drafting of the revised Mental Health Bill. The consultation period concludes on 21 April 2021.

The Lincolnshire Health and Wellbeing Board is requested to agree a system response to the consultation arrangements for responding to the consultation and who should be the SRO for the Council.

5. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Briefing Paper
Appendix 2	Consultation Questions
Appendix 3	Proposed Lincolnshire Health and Care System Response – **TO FOLLOW**

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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APPENDIX 1

BRIEFING PAPER
REFORMING THE MENTAL HEALTH ACT WHITE PAPER

INTRODUCTION

This briefing provides a summary of the key proposals outlined in the Reforming the Mental Health White Paper issued by the Department of Health and Social Care (DHSC) on 13 January 2021. The White Paper responds to recommendations in the Independent Review of the Mental Health Act.

The paper includes a series of questions (summarised in Appendix 2) on the implementation and impact of the proposed reforms which the government is seeking views on to inform the final drafting of the revised Mental Health Bill (consultation ends 21 April 2021).

PART 1: PROPOSALS FOR REFORM OF THE MENTAL HEALTH ACT

Part 1 sets out the changes the government plans to make to the MHA to ensure the legislation works better for people.

1. New Guiding Principles

The following principles will be introduced to drive a more person-centred system, in which choices made by patients have weight and influence, where care must have a therapeutic benefit for the patient, and where the powers of the act are only used when absolutely necessary. These principles will apply to all professionals involved in the care of people under the act and will be embedded into future revisions of the Act's Code of Practice.

- *Choice and autonomy* - ensuring service users' views and choices are respected and represented in advance and that they are involved in care and treatment plans and have enhanced opportunities to challenge treatment decisions.

- *Least restriction* – ensuring the Act's powers are used in the least restrictive way by strengthening and clarifying the criteria used to detain and treat an individual. Discharge planning will become a key part of care planning to ensure people are detained for the shortest possible time.

- *Therapeutic benefit* - ensuring patients are supported to get better and discharged as quickly as possible.

- *The person as an individual* – ensuring patients are viewed and treated as individuals with enhanced rights to Independent Mental Health Advocates and improved access, experience and outcomes for people from BAME backgrounds.

2. Clearer, Stronger Detention Criteria

Revisions are proposed to the detention criteria to ensure any detention only takes place when it is absolutely appropriate. The revised criteria is based on:

Therapeutic Benefit - greater emphasis to be given to if detention and interventions would be beneficial to a person's health and recovery as well consideration of the patient's

wishes and preferences. For a person to be detained under section 3 of the Act the following must be demonstrated:

- the purpose of care and treatment is to bring about a therapeutic benefit
- care and treatment cannot be delivered to the individual without their detention
- appropriate care and treatment is available

Discharge decisions should include an assessment about whether the hospital or an alternative community setting provides the most therapeutic package of care with the presumption that care should always be delivered in the least restrictive setting possible.

Substantial likelihood of significant harm - amendments are proposed to sections 2 and 3 of the Act, to stipulate that for someone to be detained the evidence must demonstrate that there is substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. New statutory Care and Treatment Plan will be required with the aim of improving transparency and to help tackle the culture of risk aversion.

3. Giving Patients More Rights to Challenge Detention

A review of the decision to detain a patient under section 3 of the Act should increase to three times within the first year – as opposed to the current two times.

Increased access to the MHT which provides independent scrutiny of detention decisions. For patients detained under:

- Section 2 will have 21 days instead of 14 days to appeal their detention.
- Section 3 will have 3 opportunities to appeal to the MHT in the first 12 months of detention, an increase from the current 2.

New statutory powers will be given to Independent Mental Health Advocates (IMHAs) to apply to the MHT to challenge a patient's detention on their behalf – this is in addition to the nominated person or nearest relative. Automatic referrals to the tribunal are also being considered. The MHT will review applications for discharge against the new detention criteria and new statutory care and treatment plan.

Automatic referral to tribunals when a Community Treatment Order (CTO) is revoked will be removed.

The role of the MHT will be extended to give it power to grant leave, transfer patients and to direct services in the community. New legislation will place an obligation on health and local authorities to take all reasonable steps to follow the MHT's decision. Hospital managers' panels for discharge case hearings will be removed and this function transferred to the MHT.

4. Strengthening the Patient's Right to Choose and Refuse Treatment

Patients will be given greater influence over decisions about their care and treatment – to include:

- *Advance Choice Documents (ACDs*) **-** these will enable people to set out in advance the care and treatment they would prefer, and any treatments they wish to refuse, in the event they are detained under the Act and lack the relevant capacity to express

their views at the time. It will be a legal requirement that ACDs are considered when a patient's care and treatment plan is developed.

- *Care and Treatment Plans* **-** these will set out the patient's care and treatment, including how this takes into consideration the wishes and preferences of the patient, and critically the rationale when a person's wishes have not been followed. Care and treatment plans will be a legal requirement for all patients, and there will be a legal time limit within which plans will need to be in place

- *Revised Part 4* **-** this will provide a new legal framework for consent to and refusal of medical treatment, setting out the process which must be followed to ensure wishes and preferences are taken into consideration, and limiting the circumstances where a patient's views, and treatment refusals, can be overruled.

- *Enhanced role of the MHT* **-** this will give patients a new route to challenge their treatment, where their choices have not been followed, by introducing a new role for the tribunal.

5. Improving the Support for People Who Are Detained

Nominated Person – a new statutory role called a 'Nominated Person' (NP) will replace the current 'Nearest Relative' (NR). They will have the same rights and powers to act in the best interests of the patient as NRs along with the following additional powers:

- have the right to be consulted on statutory care and treatment plans, to ensure they can provide information on the patient's wishes and preferences
- be consulted, rather than just notified, as is the case now, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO
- be able to appeal clinical treatment decisions at the tribunal, if the patient lacks the relevant capacity to do so themselves and the appeal criteria are met
- have the power to object to the use of a CTO if it is in the best interests of the patient

People with the relevant capacity will have the right to opt out and not have a nominated person, if that is their preference. Young People aged 16 or 17 will have the same right to choose a NP as an adult.

The AMHP's power to apply to displace a nearest relative will be replaced by temporary overruling a nominated person's objection to admission. Considerations are being made to place the power to overrule or displace a nominated person with the tribunal rather than the County Court as it currently stands.

Advocacy – the current IMHA role will be expanded to include supporting patients to take part in care planning; helping individuals to prepare ACDs; power to challenge a particular treatment where they have a reason to believe it is not in the patient's best interest and power to appeal to the MHT on the patient's behalf.

Steps to improve the quality of advocacy services will be made through improved training that focuses on the legislation, supporting autistic patients and those with a learning disability and culturally appropriate advocacy for people from BAME backgrounds. Considerations are being made to professionalise the IMHA role.

6. Community Treatment Orders (CTOs)

CTOs will be reformed so that they can only be used where there is a strong justification, they are reviewed more frequently and by more professionals, are time limited, and that people subject to them really need them to receive a genuine therapeutic benefit. A new criteria for using CTOs will demand strong justification for their use, frequent reviews and by more professionals, time limited and that people subject to them really need them to receive a genuine therapeutic benefit.

In addition to the current AMHP and RC having responsibility to make a CTO, the community supervising clinician who will work with the patient in the community will need to be involved in decision making. CTOs will end after a period of 2 years unless the patient relapses or deteriorates during that period.

7. The Interface Between the Mental Health Act and the Mental Capacity Act

Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards - currently, AMHPs may consider detaining individuals that lack capacity under the MHA or make them subject to DoLS. This is being revised to take account of the new Liberty Protection Safeguards (LPS). Where LPS provides a better alternative for the patient, it could streamline the process for example if arrangements for detention are mainly taking place in an NHS hospital, the hospital's Trust will be able to authorise deprivation of liberty under the LPS without any necessary involvement from a local authority. Considerations are being made to include options to consent to informal hospital admissions as part of advanced decisions.

Accident and Emergency (A&E) - the government intends to improve the powers available to health professionals in A&E departments so that individuals in need of urgent mental health care, stay on site, pending a clinical assessment. Currently, the police are used too often in these situations. LPS would enable A&E health professionals to deprive a person of their liberty and use holding powers to provide life-sustaining treatment or to prevent a serious deterioration in their condition only if they lack capacity and are over 16. Considerations are being made to extend holding powers under section 5 of the MHA for this purpose. Extending section 5 would provide hospitals with the power to hold a person with the relevant capacity, who wants to leave A&E.

8. Care for Patients in the Criminal Justice System

Reform to Part 3 of the Act - Part III of the act is guided by the principle that those who have committed a criminal offence should be able to access equivalent medical care and treatment to civil patients. That means that Part III patients will benefit equally from the majority of proposed reforms to the act – the following areas will differ:

- criteria for detention under the Act – where the proposal to apply the reformed criteria to part 3 patients, to ensure changing the threshold does not make it harder for those subject to the criminal justice system to access the care and treatment they need
- a nominated person for a part 3 patient will have limited powers
- tribunal powers, and automatic referrals to the tribunal – will differ
- changes proposed to the detention criteria for individuals with a learning disability and autistic people will not apply to part 3 patients

Secure transfers - to speed up transfer from prison or immigration removal centre (IRC) to mental health inpatient settings, a statutory 28-day time limit will be introduced, split into two sequential, statutory time limits of 14 days each. First from the point of initial referral to the first psychiatric assessment, and then from the first psychiatric assessment until the transfer takes place.

Views are being sought on where a new prison/IRC transfers and remissions co-ordinator role might sit. One option is to expand the remit of AMHPs. The preferred option is to create an entirely new role to sit in NHSEI or across NHSEI and HMPPs. This will be a designed role to manage the process of transferring people from prison/IMC to hospitals when they require inpatient treatment.

Consideration is also being given to the role of the IMHA and how best to provide advocacy support for individuals awaiting transfer.

Prison as a place of safety - viable alternatives are being explored to identify a timely pathway to transfer people directly from court to a healthcare setting where a mental health assessment and treatment can be provided.

Restricted patients – There is currently no effective legislative mechanism to continuously supervise restricted patients while taking care to safely manage the potential risk they may pose (violent, dangerous, or inappropriate sexual behaviour). The introduction of 'supervised discharge' is being proposed which would enable discharge of a restricted patient with conditions amounting to a deprivation of that person's liberty, in order to adequately and appropriately manage the risk they pose. Measures will also be put in place to address concerns that victims of unrestricted patients do not always receive timely, accurate information about key developments in the offender's case.

9. People with a Learning Disability and Autistic People

Reducing inappropriate admissions - the government wants to limit the scope to detain people with a learning disability (LD) or autistic people under the act. Revisions to the MHA will make it clear that for the purposes of the Act autism or a LD are not considered to be mental disorders warranting compulsory treatment under section 3. The changes would allow for the detention of people with LD and autistic people for assessment under section 2 when their behaviour is a substantial risk of significant harm to self or others (as for all detentions) and a probable mental health cause to that behaviour warrants assessment in hospital.

The assessment should seek to identify the driver of this behaviour. Detention under section 2 for assessment on the basis of distressed behaviour should only be considered after all alternatives to de-escalate have been considered.

Care (Education) and Treatment Reviews (CETRs) are expected to be carried out in advance of a detention. A new statutory requirement will be introduced for Responsible Clinicians to consider the findings and recommendations made as part of a CETRs in the patient's care and treatment plan.

Ensuring an adequate supply of community services - views are sought on the creation of new duties on local authorities and Clinical Commissioning Group commissioners to ensure an adequate supply of community services for people with LD and autistic people with the intention of reducing the use of and need for mental health inpatient services.

A new duty will also be placed on commissioners to ensure every local area understands and monitors the risk of crisis at an individual level on people with a LD and autistic people in the local population. The aim would be to enable better planning for provision and to avoid unnecessary admissions to inpatient settings.

Views are also sought on how pooled budgets for services with people with a LD and autistic people under Section 75 of the NHS Act 2006 could also be improved.

10. Children and Young People

The rights of children and young people will be strengthened to ensure they are involved in decisions about their care, can challenge decisions and ensure they are only detained for treatment in hospital when it is absolutely necessary. The proposed reforms to the children and young people service will be delivered through the NSH Long Term Plan:

- A full crisis care service by 2023/24 which will combine crisis assessment, brief response, and intensive home treatment functions. This will be available nationally on a 24/7 basis.
- A new approach to young adult mental health services for people aged 18-25 to support the transition to adulthood.

The legislative changes affecting adults – to have ACDs, care and treatment plans and to choose a NP – will also apply to children and young people detained under the Act. The requirement to have a care and treatment plan will become statutory for all children and young people receiving inpatient care.

The Mental Capacity Act Code of Practice will be improved to provide guidance on how practitioners assess competence. Including how the Mental Health Act can make it clear that the MCA should provide the only test of the capacity of 16- and 17-year olds. 16- and 17-year olds who lack capacity will not be admitted on the basis of parental consent. For under 16s, although the MCA does not apply to children under 16, the MCA's functional test will be used as a formal test to assess 'Gillick competence' to standardise the assessment and have clearer evidence.

11 The Experiences of People from BAME Backgrounds

To address inequalities, an enhanced patient voice, support by advocacy, coupled with a greater reliance on evidence, increased scrutiny of decisions and improved patient's right to challenge, are intended to address the disparity in outcomes, and in turn detentions. The Patient and Carer Race Equality Framework (PCREF) will support NHS mental healthcare providers and local authorities to improve access and engagement in the community. Advocacy will include culturally appropriate advocacy services.

The NHS Long Term Plan outlines the commitment to introduce new mental health transport vehicles to reduce inappropriate ambulance conveyance or conveyance by police. Police conveyance has been established to be associated with many tragic cases involving conveyance of black people.

PART 2: REFORMING POLICY AND PRACTICE AROUND THE NEW ACT TO IMPROVE PATIENT EXPERIENCE

Part 2 describes how the government and the NHS will work with partners to bring about an overall culture change within mental health services.

- ***NHS Long Term Plan (LTP)*** – includes 'radical transformation' of mental health services backed by an additional £2.3bn of new investment a year by 2023/24. A key ambition is to provide integrated models of mental health care across primary, community and secondary care services and to improve therapeutic services. It also seeks to reduce lengths of stay in all adult acute inpatient mental settings to 32 days or fewer by 2023/24.

- ***Quality improvement (QI) programme*** – to be led by NHSEI and HEE, the QI programme will support the system to address issues around quality, patient experience, leadership and culture.

- ***Suicide*** – the NHS LTP outlines how suicide reduction remains a high priority. The Mental Health Safety Improvement Programme will focus on reducing 'absent without leave' episodes, the risk of suicide of staff working within the healthcare system, and suicide in acute general hospitals.

- ***The physical ward environment*** – commitment to eradicate dormitory provision, ensuring every person admitted to a mental health hospital has the dignity and privacy of their own bedroom and en-suite.

- ***Role of the Care Quality Commission*** – over the next year the CQC will be working with services, families, staff and other stakeholders to improve the way they regulate services. This will include a commitment to change the methodology, updating internal guidance and inspection assessment frameworks, and to review how it assesses all wards in mental health and learning disability services. The CQC's monitoring role may also be extended to consider the effectiveness of local joint working by assessing how the Act and Code is working in local areas, rather than looking at services in isolation.

- ***Supporting people in the community*** – the focus will be shifted from reactive care to preventative measures and early intervention in the community The NHS Mental Health Implementation Plan 2019/20 to 2023/24 provides details on the commitment to expand services for people with severe mental illnesses, delivered through new models of integrated primary, secondary and social care, information about how funding will be spent.

- ***Care planning in the community*** – reviewing how existing care plans interlink to understand how any new statutory care plan could work in practice, while also conducting work to explore how we can ensure that quality of care planning is consistently high, with limited variation. This will include exploring what further information, guidance and support we can provide to commissioners on care planning and the practicalities and implications that placing care planning on a statutory footing would have on the workforce.

- ***Section 117 National Guidance*** – the guidance will be improved to provide greater clarity on how budgets and responsibilities should be shared to pay for section 117

aftercare. A clear statement will also be included in the new Code of Practice of the purpose and content of section 117 aftercare.

- ***Supporting people in a mental health crisis*** – emergency mental health services will be available for people when they need them, whether before or during a crisis to prevent detention under the Act. To support the Covid-19 response, NHSEI asked all areas to ensure urgent mental health advice and support is available to people of all ages through open access NHS 24/7 telephone help lines – this was in place by May 2020. The wider objective remains that by 2023 to 2024, the whole country will have crisis care support available at all times of the day and night, for people of all ages, fully accessible via NHS 111.

- ***Use of Police custody* -** Sections 135 and 136 of the Act will be updated to remove police stations as designated places of safety by 2023 to 2024 to ensure that people in a crisis are taken to a clinical environment. Funding is being considered to increase health based places of safety in areas that need them. A national agreement between mental health services, social care and the police will be established to ensure that people detained under section 136 are safely and effectively transferred into health services in a timely way.

- ***Ambulance conveyance*** – the LTP has a commitment to improve the capacity and capability of the ambulance service to meet mental health demand. Mental health professionals will deliver mental health specific initiatives and extra capacity in ambulance services, (integrated urgent care telephone triage control rooms training and education of ambulance staff).

- ***The mental health workforce*** – reviewing the national support requirements, including on training on the changes to the Act, and supporting meaningful co-production and the development of expert-by-experience leadership roles within providers and local systems.

  The level and staff skill mix on acute inpatient mental health wards will be improved through the development of new roles and by increasing access to multi-disciplinary staff groups such as peer support workers, psychologists, social workers, occupational therapists and other allied healthcare professionals. Additional workforce will be required: expanding role of responsible clinician, advocates, Approved Mental Health Professionals, second opinion appointed doctors and expansion of community mental health and crisis services. Training the future mental health workforce is being prioritised.

- **Improving staff morale -** Improving staff morale: additional support around wellbeing to help address the unprecedented challenges faced by professionals including pressures from Covid-19.

- ***Digital*** - The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 in October 2020, which came into force on 1 December 2020, amended legislation to allow for the electronic communication of forms.

Appendix 2

Consultation Questions

We propose embedding the principles in the MHA and the MHA Code of Practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?
We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?
We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person or the safety of any other person. Do you agree or disagree with this change?
Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal? (set out in Appendix B) I. Patients on a section 3 II. Patients on a community treatment order (CTO) III. Patients subject to Part III IV. Patients on a conditional discharge
We want to remove automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?
We want to give the Mental Health Tribunal more power to grant leave, transfers and community services. We propose that health and local authorities should be given 5 weeks to deliver on direction by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount to time?
Do you agree or disagree with the proposal to remove the role of the manager's panel in reviewing a patient's case for discharge from detention or a community treatment order?
Do you have any other suggestions for what should be included in a person's advance choice document?
Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as in the case under the Mental Health Capacity Act?
Do you have any other suggestions for what should be included in a person's care and treatment plans?
Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?
Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?
Do you agree or disagree with the proposed additional powers of the nominated person?
Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?
Do you agree with the proposed additional powers of Independent Mental Health Advocates?
Do you agree or disagree that advocacy services could be improved by: I. Enhanced standards II. Regulation III. Enhanced accreditation IV. None of the above, but by other means
How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be subject to the powers which most appropriately meet their circumstances?
Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the MHA and the MHA code of practice to make clear the availability of this right to individuals?
We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do you think

amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extent section 5 of the MHA?
To speed up the transfer from prison or IRC to mental health inpatient settings, we want to introduce a 28-day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfer?
We want to establish a new designated role for a person to mange the process of transferring people from prison or an IRC to hospital when they require inpatient treatment for their mental health. Which of the following option is the most appropriate to achieve this? I. Expanding the existing approved mental health professional role in the community so they are responsible for managing prison/IRC transfers II. Creating a new role within NHSEI or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison/IRC transfer process III. An alternative approach
Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?
For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty. Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?
We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?
Beyond this, what further safeguards do you think are required?
Do you agree or disagree with the proposed reforms to the way the MHA applies to people with learning disability and autistic people?
Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?
Do you expect that there would be unintended consequences of the proposals to reform the way the MHA applies to people with a learning disability and autistic people?
We think that the proposal to change the way that the MHA applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?
Do you expect that there would be unintended consequences on the criminal justice system as a result of our proposals to reform the way the MHA applies to people with a learning disability and to autistic people?
Do you agree or disagree that the proposal that recommendations of a CTR for a detained adult or of a CETR for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?
We propose to create a new duty on local commissioners to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?
We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?
What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?
How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?
In the impact assessment we have estimated likely costs and benefits of implementing the proposed changes to the Act. We would be grateful for any further data or evidence that you think would assist the departments in improving the methods used and the resulting estimates. We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following: • Different professional groups in particular:

- how the proposals may affect the current workloads for clinical and non-clinical staff, IMHAs, approved mental health professionals, MHTs, SOAD etc
    - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
- Service users, their families and friends, in particular:
    - How the proposal may affect health outcomes
    - Ability to return to work or effects on any other daily activity
    - Whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
    - Any other impacts on the health and social care system and the justice system more broadly.

Proposed Lincolnshire System Response **Appendix 3**

To follow

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