Title: Reforming the Mental Health Act - Government Response to Consultation
IA No: 9573

RPC Reference No: N/A

Lead department or agency: Department of Health & Social Care

Other departments or agencies: Ministry of Justice

Impact Assessment (IA)

Date: 15 July 2021

Stage: Final

Source of intervention: Domestic

Type of measure: Other

Contact for enquiries:
MHAconsultation2021@dhsc.gov.uk

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option (in 2020/21 prices)			
Total Net Present Social Value	**Business Net Present Value**	**Net cost to business per year**	**Business Impact Target Status** Non Qualifying provision
-£1,450 million	-£10 million	£1 million	

What is the problem under consideration? Why is government action or intervention necessary?

The Mental Health Act 1983 (MHA) provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others. The current MHA is considered out of step with a modern-day mental health service and in significant need of reform to make it work better for everyone. This is an update of the consultation Impact Assessment (IA) and accompanies the government proposed reforms, based on a public consultation and on the recommendations of the 2018 Independent Review of the MHA.

What are the policy objectives of the action or intervention and the intended effects?

The main policy objectives of the Government reforms are:

- modernise mental health legislation and ensure care and treatment is of the highest quality and promotes recovery;
- enable patients to access safeguards earlier and more often, such as the Mental Health Tribunal (MHT), and ensure that they are empowered and supported to exercise their right to challenge their detention and treatment;
- improve patient's choice and experience and their participation in decisions concerning their treatment;
- reduce racial disparities under the MHA and promote equality. We hope that this will reduce or shorten detentions, but patient experience and outcomes is also a critical concern.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: Business As Usual (BAU) with no changes to the MHA. Note that improvements in mental health community care and crisis care, planned under the NHS Long Term Plan, are included in BAU.
Option 2: Implement the proposals outlined in the government response to the consultation on the MHA reforms. The IA's main focus is on those regarding improvement of safeguards both in the Health and Social Care system and in the Justice system.

Option 2 is the preferred option.

Will the policy be reviewed? It will not be reviewed. **If applicable, set review date:** N/A

Does implementation go beyond minimum EU requirements?		N/A		
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	**Micro** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:** N/A	**Non-traded:** N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: S. Dunn Date: 15/07/2021

Summary: Analysis & Evidence

Policy Option 1

Description: Business as usual

FULL ECONOMIC ASSESSMENT

Price Base Year 20/21	PV Base Year 20/21	Time Period Years 12	Net Benefit (Present Value (PV)) (£m)		
			Low:	**High:**	**Best Estimate:**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0		0	**0**
High	0		0	**0**
Best Estimate	0		0	**0**

Description and scale of key monetised costs by 'main affected groups'

This option pertains to the counterfactual, that is, the status-quo with no new national policies implemented. Therefore, we assume that there are no additional costs and benefits to the baseline associated with the Business As Usual option and impacts are assessed as marginal changes against the Business As Usual baseline.

Other key non-monetised costs by 'main affected groups'

N/A

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		0	**0**
High	0		0	**0**
Best Estimate	0		0	**0**

Description and scale of key monetised benefits by 'main affected groups'

This option pertains to the counterfactual, that is, the status-quo with no new national policies implemented. Therefore, there are no additional costs and benefits to the baseline associated with the Business As Usual option and impacts are assessed as marginal changes against the Business As Usual baseline.

Other key non-monetised benefits by 'main affected groups'

N/A

Key assumptions/sensitivities/risks	Discount rate	N/A

N/A

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: 0	**Benefits:** 0	**Net:** 0	

Summary: Analysis & Evidence

Policy Option 2

Description: Implementation of the Government proposed MHA reforms

FULL ECONOMIC ASSESSMENT

Price Base Year 20/21	PV Base Year 20/21	Time Period Years 12	Net Benefit (Present Value (PV)) (£m) (not including unquantified benefits)		
			Low: -£2,210 million	**High: -£880 million**	**Best Estimate: -£1,450 million**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£6 million	2	£140 million	**£1,410 million**
High	£6 million		£230 million	**£2,310 million**
Best Estimate	£6 million		£180 million	**£1,790 million**

Description and scale of key monetised costs by 'main affected groups'

Costs of the proposed reforms (total cost and average cost per year) in the Health and Social Care system:

- Independent Mental Health Advocates (total cost £120 million; £12 million per year)
- Approved Mental Health Professionals (total cost £40 million; £4 million per year)
- Second Opinion Appointed Doctors (total cost £120 million; £12 million per year)
- Clinical teams (total cost £1,370 million; £137 million per year)
- Quality Improvement programme (total cost £2 million)

For the Justice system, costs of changes in Mental Health Tribunal activity (inc. Legal Aid) are £130 million (£13 million per year). Due to rounding in these total costs, they will not add up to the total cost in the box above.

Other key non-monetised costs by 'main affected groups'

The key non-monetised costs for the Health and Social Care system pertain to familiarisation costs and transition costs. For the Justice system, the non-monetised costs pertain to expanded tribunal powers, the prison system and transfer from prisons and immigration removal centres.

BENEFITS (£m)	Total Transition (Constant Price)	2 Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		£10 million	**£100 million**
High	0		£50 million	**£530 million**
Best Estimate	0		£30 million	**£340 million**

Description and scale of key monetised benefits by 'main affected groups'

We only present quantified benefits associated with reduced detentions following Advanced Choice Documents (ACDs) and with the reduction in hearings cancellation fees for Section 3 patients. Due to the absence of quantitative evidence on the other interventions, we use a breakeven analysis to illustrate the amount of benefits per patient detained required to offset the costs of the policy. Three potential benefits are a reduction in the average length of stay per patient, a reduction in the number of repeat detentions and also direct health benefits resulting from improved treatments. We estimate that it would take either a reduction of 2.3 days in the average length of a detention, a reduction from 15.4% to 10.5% in the number of people with repeated detentions or a QALY increase of 0.03 for each detainee each year for the costs of the policy to be offset by these savings.

Other key non-monetised benefits by 'main affected groups'

The key non-monetised benefits pertain to the improved health outcomes experienced by patients under the improved safeguards, potential reduction in length of detentions, benefits associated with timeliness of prison transfers and stopping prison being used as a place of safety on the grounds of mental health, and wider economic benefits such as increased participation in the labour market.

Key assumptions/sensitivities/risks **Discount rate (%)**	1.5% NHS costs and benefits, 3.5% other costs and benefits

The key overall assumption concerns the rate at which detentions under the MHA will change throughout the policy period. This forecast has been sensitised to best (lowest cost) and worst (highest cost) case scenarios. Key assumptions have also been identified in each of the cost models and sensitised to approximate low and high estimates of the additional costs of the policy option.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: 0	**Benefits:** 0	**Net:** 0	N/A

Evidence Base

Problem under consideration

1. The Mental Health Act 1983 (MHA)[1,2] is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. It provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others. Powers for compulsory admission under the MHA are set out in Part II and Part III. Part II of the MHA deals with patients who are detained in hospital and have no criminal proceedings against them. These are generally referred to as civil patients. Part III of the MHA is concerned with patients who have been involved in criminal proceedings or are under sentence.

2. The current MHA is considered out of step with a modern-day mental health service and in significant need of reform to make it work better for everyone. Following the Independent Review conducted by Simon Wessely and published in December 2018[3], the government published a White Paper in January 2021[4], which accepted the vast majority of the Review's recommendations and consulted on the impact and implementation of these recommendations. This White Paper was accompanied by a consultation IA. Following the publication of the White Paper, the Government also consulted widely to understand the views of service users, clinicians, carers, and people with lived experience of treatment under the Act in regard to key principles, technical changes, and specific measures to improve the experiences of service users.

3. The Government response to the consultation is now published and is accompanied by this IA, which updates the IA published alongside the White Paper. The IA focusses on analysing the costs and benefits associated with delivering many of the headline changes that government proposes to take forward either through legislative reform, or changes to policy and practice.

4. The current MHA applies to both England and Wales. However, health policy is devolved to the Welsh Government and Senedd, whereas the UK Government and Parliament determine justice policy for all of England and Wales. In this document the Government's proposed reforms for health policy cover England, and the same applies to the justice policy recommendations. This means that the Government proposals only refer to the Mental Health Tribunal in England and not the Mental Health Review Tribunal for Wales (MHRTW)[5]. The Welsh Government and other partners are deciding whether it is feasible and desirable to take a similar approach in Wales.

Rationale for intervention

5. The White Paper conducted a public consultation for 14 weeks on proposed changes to the MHA using an online consultation and an easy read version, and a number of online consultation events involving organisations from a wide range of sectors e.g., service users and carers; people with learning difficulties and autism; detained patients; service users and carers from ethnic minorities.

6. In terms of the benefits for these changes, and using the work done by the Independent Review, we would expect that *"patients and service users should experience improved choice, less coercion and*

[1] A list of the acronyms used in this IA can be found in Annex A.

[2] http://www.legislation.gov.uk/ukpga/1983/20/contents

[3] Department of Health and Social Care. (December 2018). Modernising the Mental Health Act - Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Accessed at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

[4] Department of Health and Social Care. (13 January 2021). Reforming the Mental Health Act. (Closed consultation). Accessed at: Reforming the Mental Health Act - GOV.UK (www.gov.uk)

[5] Justice system costs are estimated in this Impact Assessment for England only (except costs relating to recommendation 133).

restriction of their liberties, care that is more consistently respectful, and meets their individual needs" (p. 228)[6]. That is, patients would be more likely to feel more engaged with their care and, within the context of compulsory treatment, feel that they have a voice regarding treatment decisions. These outcomes are difficult to monetise, but evidence indicates that they are highly valued by patients, improving health outcomes and quality of life, and that they are associated with the delivery of more appropriate and cost effective services, including reducing length of stay[7,8].

7. IA assess the value for money of policy options by estimating the potential costs and benefits plus understanding the associated risks. In the case of this IA, there is not sufficient quantitative evidence about its potential benefits (e.g., improved health outcomes, potential in reducing the length of a detention, potential for patients and carers to return to work or other meaningful activities). Additionally, since improved patient experience due to increased participation in decisions regarding care and being treated with dignity and respect are not easily monetised, they should rather be understood in qualitative terms. These have been investigated by the Independent Review and we use their words to summarise this point:

> *"We believe that improving patients' and service users' ability to make decisions about their own care and treatment is essential to upholding dignity. This theme runs throughout the report from start to finish. It underlies our recommendations, for example, on the importance of advance choices, and how these can become more common and more powerful. It is part of our recommendations on the right to advocacy, for those who find it difficult to make their wishes and preferences known and how these are particularly relevant for those at greater risk of discrimination, such as those from a minority ethnicity background. (…)*
> *These recommendations are essential if we are to achieve a real shift in the balance of power between the patient and the professional, and make it easier for patients and service users to participate in decisions about their care. (…). Much of this merely reflects current best practice but, sadly, we are in little doubt that this is far from standard, and that without our recommendations bad practice will continue."* (pp 18-19)

Policy objective

8. In response to the Independent Review of the MHA published in December 2018[2],the government published a White Paper in January 2018 seeking views on the MHA reforms accompanied by a consultation IA[1]. The Government is now publishing a response to the public consultation and the main policy objectives of the Government reforms to the MHA are:
   - To modernise mental health legislation and ensure care and treatment is of the highest quality and promotes recovery;
   - To enable patients to access safeguards earlier and more often, such as the Mental Health Tribunal (MHT), and ensure that they are empowered and supported to exercise their right to challenge their detention and treatment;
   - To improve patient's choice and experience, and their participation in decisions concerning their treatment; to reduce racial disparities under the MHA and promote equality.

[6] Department of Health and Social Care. (December 2018). Modernising the Mental Health Act - Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Accessed at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review
[7] Vahdat, S., Hamzehgardeshi, L., Hessam, S., & Hamzehgardeshi, Z. (2014). Patient involvement in health care decision making: a review. Iranian Red Crescent medical journal, 16(1), e12454. doi:10.5812/ircmj.12454 (also accessed at: https://pubmed.ncbi.nlm.nih.gov/24719703/)
[8] Doyle, C., Lennox, L., & Bell, D. (2012) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013; 3(1). Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549241/

Description of policy options

Option 1: Business As Usual

9. The Business As Usual option (BAU) assumes that there are no changes to the MHA and that none of the Government proposals are implemented. This is the counterfactual used in this IA, which reflects the status quo considering only current national policies in England. Therefore, there are no additional costs and benefits to the baseline associated with the BAU option.

10. The NHS Long Term Plan[9] (LTP) presents plans for improvements in mental health community care and crisis care in England, which should lead to a decrease in detentions (see Annex B). These policies are planned to be implemented independently of the Government proposals for the MHA and the effects are therefore considered under the BAU. A decrease in detentions is one of the most important expectations from the Independent Review recommendations and would have been considered under a policy option instead of under BAU if no improvements in care were planned in the NHS LTP.

Option 2: Implementation of proposals set out in the White Paper

11. The Government proposals to reform the MHA collectively represent Option 2 of this IA. The main changes are summarised in table 1 below.

Table 1. Summary of the Government key proposals

Strengthening the patient voice in treatment choices and the right to refuse
Advance Choice Documents (ACDs)
The Government proposed to introduce Advance Choice Documents as a means of providing people with the opportunity 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. The ACD should adhere to a standard format and approach and there should be a legal requirement on clinicians to account for advance refusals of treatment and show how broader wishes and preferences have informed the patient's care and treatment.
Care and Treatment Plans (CTPs)
The Government proposed statutory care and treatment plans for all patients detained under the Act. The Plan must meet certain requirements when it comes to the contents, the time by which it should be completed, and who oversees it. This aims to ensure that the new legislation facilitates a culture of high quality, co-produced care and treatment planning for all patients detained under the Act.
The right to an early challenge to compulsory treatment
At present, if a patient is not consenting to treatment, either because they lack the relevant capacity to consent or are refusing, then after a period of 3 months, a Second Opinion Appointed Doctor (SOAD) must certify the treatment before it can continue to be administered. The Government proposed earlier access to the SOAD. This will mean that, where someone lacks capacity to consent, the SOAD should be required to check and certify treatment after a period of 2 months. Where someone is refusing treatment with capacity, they should get access to a SOAD from day 14 of detention.
Rights to challenge detentions in tribunal
The White Paper proposed that patients will have increased access to the MHT and should be able to appeal to the Tribunal regarding treatment decisions. At the same time, there may be improvements to the system by, for example, requiring the clinical team to confirm they believe the patient still meets the detention criteria 10 days in advance of a hearing. Responses to the consultation have identified concerns in relation to the proposed role of the tribunal in making treatment decisions, in particular regarding the power to stop a patient's treatment sitting with a single judge acting alone who may lack clinical expertise. The Government will continue to work closely with stakeholders to develop this policy and identify potential means of mitigating the concerns raised by stakeholders.
New detention criteria
The Government proposed to amend the detention criteria of section 3 of the MHA and elsewhere so that detention for treatment is only undertaken when it is clear that this will be therapeutically beneficial for the individual. The Government is also proposing to amend the detention criteria for sections 2 and 3 of the Act, and elsewhere, so that, for someone to be detained, it must be demonstrated that there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person.

[9] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

Table 1. (cont.)

People with a learning disability and autistic people
Changes to the scope of the Act
The Government proposed that people with a learning disability and autistic people could be detained under section 2 of the Act when their behaviour is so distressed that there is considered to be a significant risk of harm to self or others and there is a probable mental health condition. The assessment process under section 2 should seek to find the driver of this distressed behaviour and if a mental health condition is identified as the driver then the patient may follow a treatment pathway for the mental health condition under section 3 of the Act. They should only be detained after all alternatives have been considered. A Care (Education) and Treatment Review (CETR) is also expected to be conducted before a detention to provide evidence as part of any decision made. If, however, if no mental health condition is identified then the individual could no longer be detained under the Act and detention should cease. The Government proposed that these changes will only be made for civil patients to ensure that accused people and offenders who may currently be diverted to an inpatient setting are not forced into the Criminal Justice System which cannot cater for their needs.
Improving the support for people who are detained
Nominated Person
The Government proposed to take forward legislative changes to replace the Nearest Relative role with the Nominated Person role (a new statutory role) so that individuals can choose who represents them and exercise certain rights on their behalf. It will also provide additional support and guidance for those involved in the person's care to address stakeholder concerns, introduce safeguards, and clarify how these new powers interact with existing legal rights, including those of parental responsibility.
Right to Advocacy
Independent Mental Health Advocates (IMHAs) are specialist advocates who are trained specifically to work within the framework of the MHA, and support people who are detained so that they understand their rights and can exercise them appropriately. The statutory right to an advocate will be extended to all mental health inpatients, including informal patients, and to people preparing their advance choice documents (ACDs) that refer to detention under the MHA and the Government is also considering the requirements needed for an opt out service. The advocacy role will also cover additional safeguards (e.g., care planning).
Community Treatment Orders
The Government proposed to reform CTOs so that they can only be used where there is a strong justification and when it is clear that the individual will benefit therapeutically from the framework provided by a CTO. The Government also proposed that CTOs are reviewed more frequently and by more professionals, and that they are time limited. The Government recognises that CTOs are used too often and committed in the White Paper to further review and update Government policy on the use of CTOs in line with the emerging evidence
Caring for patients in the Criminal Justice System
Part III of the MHA relates specifically to offenders, or those involved in criminal proceedings. The Government proposed to improve the process of transfer from prison or Immigration Removal Centres (IRCs) to mental health inpatient settings, through the introduction of an independent role to manage this process, and a time limit for transfers to take place. The Government is also proposing to introduce a new power of "Supervised Discharge" which would enable a small group of restricted patients who are no longer therapeutically benefitting from treatment in hospital, but continue to pose a risk that could not be safely managed in the community without constant supervision, to be discharged from hospital with conditions amounting to a deprivation of liberty.
People from black and minority ethnic backgrounds
The Government supports the introduction of a new Race Equality Framework – the Patient and Carer Race Equality Framework (PCREF). The aim of the PCREF is to identify core competencies for culturally-aware services and opportunities to advance them, so that services can better engage with minority ethnic backgrounds. The PCREF is being taken forward as part of NHSE/I's Advancing Mental Health Equalities Strategy. To address the evidence gap on the uses of the MHA, as identified by the Independent Review, the National Institute for Health has now funded research on how to tackle the rising rates of detention, particularly for people from black African and Caribbean backgrounds, and understanding the experiences of people from minority ethnic backgrounds and family and friends of people who have been detained. The Government has committed to piloting culturally appropriate advocacy services, which will provide valuable insights into how advocates can better work with people from ethnic minority backgrounds so that their rights and needs may be better supported.

Cost Benefit Analysis

12. We have updated the models used in the consultation IA to estimate the various impacts on the Health and Social Care system and on the Justice system and developed a new model to estimate costs and benefits associated with ACDs. We present their assumptions throughout the following section and, where necessary, have highlighted the level of uncertainty involved and the associated risks.

13. We are grateful for all the responses and comments to the Government consultation question asking for evidence for the cost benefit analysis. A common view is that the reforms will impact on workload for different professional groups and we tried to capture those impacts here, while being aware that not all of them can be quantified at this stage. For example, we have monetised administrative costs associated with SOADs and with delivering ACDs, but still need a better understanding about how the reforms will be implemented to assess further administrative impacts. Many comments are also about the impact on specific groups (e.g., unpaid carers, people with ADHD, people with Adverse Childhood Experiences) – this IA presents analysis on the impacts for all people detained rather than focus on specific groups as that would require assumptions about how these groups overlap in order to produce an overall appraisal of the policies.

14. We have provided estimates of costs and benefits (monetised and non-monetised) for those policies for which we have a fair understanding of how they would be implemented in practice. There are a number of other changes for which quantified costs have not been provided because further work to specify the policy is required before any monetary estimates can be provided, or which are already being considered as part of other Government reform programmes e.g., Her Majesty's Courts and Tribunals service (HMCTS) Reform.

15. It is important that Government proposals relating to access to MHTs are not seen in isolation from clinical care. The MHA operates in a complex and dynamic system, where changes to the balance of safeguards can have profound impacts on patient care. We have tried to account for this interaction when feasible e.g., MHT hearing volumes generated from the model estimating the impact of the Justice System proposals inform the Clinical Teams model estimating the impacts on the Health and Social Care system.

16. The first costs incurred under Option 2 start in 2021/22 and pertain to funding to scope the Quality Improvement (QI) Programme[10]. The economic appraisal is over a 12 year period, from 2021/22 to 2032/33, with the legislative changes necessary for policy changes currently assumed to be in place by 2023/24. Option 1 (BAU i.e., not intervening) is the counterfactual, so the impacts of Option 2 are assessed against this benchmark.

17. **Presentation of costs**. The tables for each policy set out rounded[11] figures in constant 2020/21 prices using the March 2021 UK GDP deflator published by HM Treasury [12]. Figures in tables may not sum exactly due to this rounding. All monetary values exclude VAT.

18. The summary tables for all monetised costs present discounted costs using a discount rate of 1.5% for NHS related costs and 3.5% for all other costs (see HM Treasury Green Book[13]).

26. Impact of the COVID-19 pandemic. The assumptions used in all the Health & Social Care models and underlying the respective cost estimates were set up before the COVID-19 pandemic and do not

[10] Note that in the Consultation IA, costs for research in 2020/21 were included. These are now in the past and, according to The Green Book – Central Government Guidance on Appraisal and Evaluation, these are sunk costs as they refer to expenditure already incurred and should be excluded from the appraisal.
[11] These figures are rounded to the nearest appropriate multiple based on the order of magnitude or degree of uncertainty, unless otherwise stated.
[12] HM Treasury (31 March 2021) GDP deflators at market prices, and money GDP March 2021 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2021-quarterly-national-accounts
[13] HM Treasury (2020). The Green Book: appraisal and evaluation in central government. Accessed at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

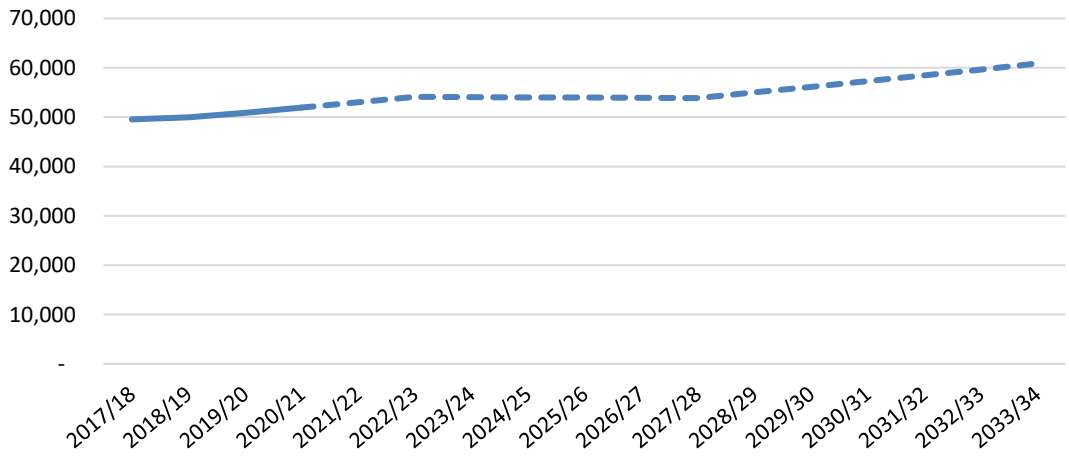
account for potential impacts on mental health and services. We do not currently have the data to reliably estimate the impacts of COVID-19 on people with severe mental illness and numbers of detention under the MHA and whether these impacts will persist during the period appraised in this IA. The total numbers of MHT receipts and hearings in 2020/21 were comparable to previous years, so these volumes have been used as a baseline where relevant. Similarly, there was no discernible effect on the average cost of employing Full-Time Equivalents (FTEs) by different grades in Her Majesty's Prison and Probation Service (HMPPS) over the course of 2020/21. However, 2019/20 average legal aid payments and average costs per sitting day in HMCTS have been used because the pandemic appears to have distorted them during 2020/21.

Option 1: Business As Usual

19. **Detentions.** From an analytical perspective, estimating the number of detentions under Option 1 (BAU) is crucial as it informs on estimates for the Health and Social Care workforce requirements for the additional recommended safeguards and for the volume of MHT activity.

20. The BAU approach for detentions under the MHA assumes that:
    - detentions under the MHA would increase by 2.05% per year (based on the adjusted average percentage change of NHSD estimates) if no policy improvements took place (see Annex B.I);
    - we then assume in our central scenario that this trajectory will decrease by 10%, following improvements in mental health community care services and crisis services proposed within the NHS LTP[14]; this reduction is in line with the expectations in the Independent Review of the MHA (see Annex B.I);
    - this reduction is assumed as a phased decrease over 5 years from 2023/24 to 2027/28, after which the number of detentions will continue to increase by 2.05% annually – see Fig. 1.

Fig 1. Number of detentions - BAU Forecast



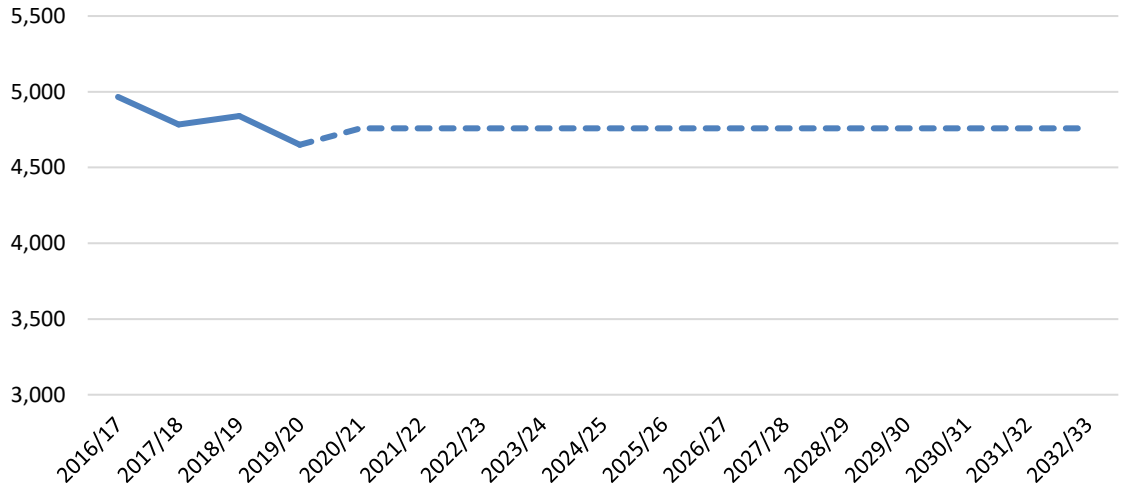
21. We also consider a best case and a worst case scenario in the sensitivity analysis, where the historical growth rate ranges from 1.64% to 2.46% (2.05% being the central scenario) and the reduction in detentions following NHS LTP improvements range from 8% to 12% (10% being the central scenario) (see Risks and assumptions section).

22. **Community Treatment Orders (CTOs).** The annual number of CTOs oscillate in the last 3 years (2017/18 to 2019/20), and it is not possible yet to assess whether the total number of CTOs is either

[14] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

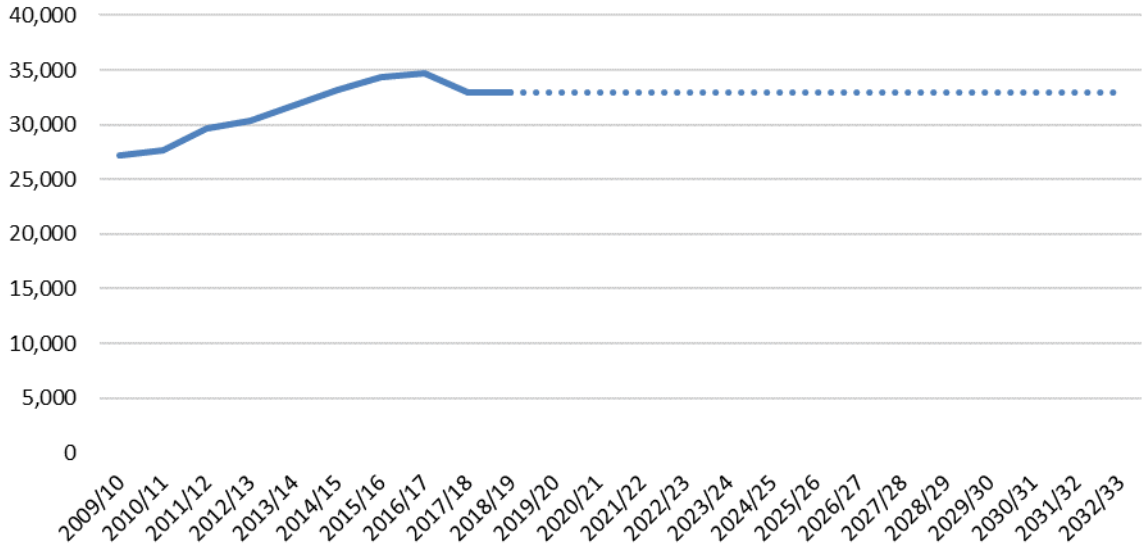
decreasing or stable. As a cautionary approach, we are assuming that CTO numbers stay stable in a BAU scenario – see Fig. 2 (and Annex B.II).

Fig 2. Number of CTOs - BAU forecast



23. **Mental Health Tribunal hearings.** We assume that the volume of MHT receipts will remain flat at 2018/19 levels in future years as seen in Fig. 3. This is because receipts have remained relatively steady since 2015/16 (at around 34,000 per year on average) despite the increase in detention rates.

Fig 3. Number of Mental Health Tribunal receipts (applications and referrals) - BAU Forecast



24. **Health and Social Care workforce requirements.** We also assume that all professional/workforce groups (Independent Mental Health Advocates, Approved Mental Health Professionals, Second Opinion Appointed Doctors, Clinical teams) will keep their current roles and responsibilities when supporting the detentions processes.

Option 2: Implementation of accepted recommendations set out in the White Paper

Monetised Costs

25. Estimating costs for the accepted Government proposals will focus on costs associated with improving the safeguards for those individuals who are detained under the MHA. We present estimated costs for:
    - Professional groups in the Health and Social Care System working together with patients to ensure patients have access to these safeguards - clinical teams, Approved Mental Health Professionals (AMHPs), Independent Mental Health Advocates (IMHAs) and Second Opinion Appointed Doctors (SOADs);
    - MHT activity in the Justice system.

26. As already stated, we consider that the implementation period for the improvements under the Health and Social System will start in 2023/24 after the legislative changes necessary for policy changes are potentially in place. We also assume that the implementation period for all areas under the Justice system, excluding those recommendations on automatic referrals, is 2023/24. The automatic referral recommendations are phased in no earlier than 2025/26, given that the sequencing and implementation of these policies is under consultation.

Monetised costs – Health and Social Care System

Independent Mental Health Advocates (IMHAs)

27. An IMHA is an independent advocate who is trained to work within the framework of the MHA to support people understanding their rights under the Act and participating in decisions about their care and treatment. IMHAs are not employed by the NHS or any private healthcare provider; they are commissioned via local authorities in England[15].

28. Under the current MHA, independent mental health advocacy is available to the following groups: those detained with a length of stay greater than 72 hours, those on CTOs, those subject to guardianship, those under consideration for serious mental health treatment, informal patients aged under 18 years being considered for Electro-Convulsive Therapy (ECT), and conditionally discharged restricted patients[16].

29. Following the consultation on the MHA reforms, the Government proposes to extend the statutory right to an IMHA to all mental health inpatients, including informal/voluntary patients; as is already the case in Wales.

30. The Government also proposes implementation of safeguards, which, despite not specifically aimed at the IMHA service, will result in additional responsibilities for IMHAs. Following conversations with IMHAs professionals, we assume that these will be: setting up the CTP and reviewing it (this applies to section 3 patients who have been admitted for treatment), appealing treatment on behalf of the patient with the SOAD service to SOAD and the MHT (this applies to patients under section 2, i.e., those admitted for assessment and treatment, and section 3), and an one-on-one consultation session with the patient and support setting up their ACD. We estimate that this will result in IMHAs

[15] POhWER. Independent Mental Health Advocacy (IMHA). Accessed at: https://www.pohwer.net/independent-mental-health-advocacy-imha

[16] Social Care Institute for Excellence (October 2014). Understanding Independent Mental Health Advocacy (IMHA) for mental health staff – SCIE At a glance 67. Accessed at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/understanding/

workload increasing by around 18 hours per section 3 detention, 12 hours per section 2 detention, by 12 hours per CTO and 2 hours for ACDs (see Annex B.III for further details of the modelling).

31. Table 2 illustrates the spend for a central scenario over the ten year period from 2023/24 to 2032/33, showing an overall estimated additional cost of £147 million. The additional spend each year is highest in 2023/24 at £15 million, this then drops and becomes fairly stable at around £15-14 million in the later appraisal years. Table 3 shows the estimated additional number of FTE IMHAs required each year.

32. In more detail, in both Options 1 and 2, annual costs associated with IMHAs cover estimated salary (including oncosts and overheads) of £51,977 (2020/21 prices). For Option 1. BAU total costs were calculated by multiplying the estimated FTEs in each year by the estimated annual cost per IMHA. For Option 2. Policy the same methodology was applied, but with the addition of training costs for the required expansion to the workforce. The training cost per IMHA was estimated to be £1,606 (in 2020/21 prices). For further details see Annex B.III.

Table 2. Estimated monetised costs for Independent Mental Health Advocates (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option1.BAU	14	14	14	14	14	15	15	15	15	16	**148**
Option2.Policy	30	29	29	29	29	29	29	30	30	30	**295**
Additional cost	15	15	15	15	15	15	15	14	14	14	**147**

Table 3. Estimated number of Independent Mental Health Advocates (FTEs)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33
Option 1. BAU	250	250	240	240	240	250	250	260	260	270
Option 2. Policy	530	530	520	520	520	530	530	530	530	540
Additional FTEs	280	280	280	280	280	280	280	270	270	270

Approved Mental Health Professionals

33. Approved Mental Health Professionals (AMHPs), who are commissioned by local authorities, are responsible for organising and undertaking assessments under the MHA and, where statutory criteria are met, authorising detention under the Act. Their work covers a wide range of activities, including, but not limited to, ensuring service users are interviewed in an appropriate manner, that they know what their rights are if they are detained, and that detainees are treated in the most humane and dignified way[17].

34. Under Option 2, it is expected that the workload for AMHPs will increase as there will be new duties relating to:
    - ACDs – We assume that the AMHP in a community-based mental health team will be involved in the tasks assigned to the care coordinator role. Overall, AMHPs additional workload could increase on average by around 1 hour per ACD (see Annex B.IV for further details).
    - CTOs – We assume that there will be new duties relating to CTOs: additional assessments and one additional meeting with the patient, NP and the community team before the CTO is finalised.

[17] Lancashire Care NHS Foundation Trust (2018). What is an Approved Mental Health Professional. Accessed at (12/09/19): https://www.lancashirecare.nhs.uk/Approved-Mental-Health-Professional

Overall, AMHPs additional workload could increase by around 30 hours per CTO (see Annex B.IV for further details).

35. Costs on AMHPs covering the proposed new statutory role in prisons and Immigration Removal Centres (IRCs) (recommendation 131) are not included in this IA, as more work is required to scope who will take the role and what the responsibilities should be.

36. To estimate staff costs for additional CTOs and ACDs under Option 2, we multiplied the number of estimated CTOs or ACDs by the estimated additional time required for each CTO or ACD and obtained the number of additional FTEs required; then multiplied these by the estimated staff cost for AMHPs (including salary, oncosts and overhead).

37. For the additional training cost, we calculate how many new FTEs are needed in relation to the previous year by comparing the number of FTEs in one year to the previous year. These additional FTEs for the year is then converted into headcount (at a rate of 1.4 and considering the proportion with single or combined AMHP roles) and multiplied by the estimated training cost for AMHPs (including tuition fee and backfill costs). For further details see Annex B.IV.

38. Over the ten year period from 2023/24 to 2032/33 additional total costs are estimated to be £48 million (undiscounted). The additional cost is expected to be at its highest in the first year under Option 2 due to training costs for additional AMHPs in the first year. In 2023/24 (year 1) the additional cost is £10 million (includes initial training), decreasing to £4 million by 2032/33 in line with the forecast decrease in CTOs over the period – see table below.

Table 4. Estimated monetised costs for Approved Mental Health Professionals (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1.BAU	68	68	68	68	68	68	68	68	68	68	**677**
Option 2.Policy	78	73	72	72	72	72	72	72	72	72	**724**
Additional cost	10	5	5	4	4	4	4	4	4	4	**48**

39. Estimated additional staff required (see table 5 below) and corresponding training costs are placed in year 1 of Option 2 but training new staff may in practice spread over a longer period due to staff availability.

Table 5. Estimated number of Approved Mental Health Professionals (FTEs)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33
Option 1. BAU	980	980	980	980	980	980	980	980	980	980
Option 2. Policy	1,050	1,040	1,040	1,030	1,030	1,030	1,030	1,030	1,030	1,030
Additional FTEs	70	60	60	50	50	50	50	50	50	50

Second Opinion Appointed Doctors

40. The Second Opinion Appointed Doctor (SOAD) service is managed by the Care Quality Commission (CQC) and safeguards the rights of patients detained under the MHA who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.

41. Current SOAD provision, under Section 58 of the MHA, directs that, except in an emergency, after three months from first administration, medicines for mental disorder cannot be given without either capable consent of the patient or, in the absence of such consent, the authorisation of a SOAD. That is, currently, these treatments can be administered for a period of three months without the need for consent, even if the patient has the relevant capacity to refuse treatment. The Government proposes new safeguards for those receiving the majority of medical treatments (category 3 in the White Paper, which excludes invasive treatments):
    - the SOAD's review of the patient's treatment will move from 3 months to as early as day 14 of detention if the patient is refusing with capacity or they have a valid ACD in which they refuse treatment;
    - if the patient is not consenting because they are unable to consent, then the SOAD will be required to certify the patient's treatment at 2 months instead of 3 months (after treatment began).

42. A bespoke NHS Digital (NHSD) dataset on detainee length of stay for 2016/17[18] is used to estimate proportions of Section 3 patients captured by the proposals. The dataset does not provide the full profile of length of stay for a detainee as there is some movement between providers and this limited data only provide length of stay within the same provider. Data from the CQC show that there is 2 weeks between notification to the CQC and a SOAD visit. Combining this information suggests that 50% of Section 3 detainees would be captured from the move to SOAD eligibility from 14 days for refusals, and, 11% from the move to 2 months for those lacking capacity.

43. Management information on the SOAD service provided by the CQC was used to calculate rates of SOADs visits per detainee. The CQC also provided national costs of SOAD provision which included SOAD fees, training and appraisal costs, management and support, travel and subsistence, and overheads. This provided an average unit cost per SOAD visit of around £403 (2020/21 prices), which has been applied to the forecast number of SOAD visits – see Annex B.V for further detail.

44. The additional total costs (undiscounted) are summarised in Table 6 below. Over the ten year period from 2023/24 to 2032/33 the additional costs are estimated at £33 million. Here additional costs start at £3 million in 2023/24, rising to £4 million in 2032/33.

Table 6. Estimated monetised costs for SOADs (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1.BAU	6	6	6	6	6	6	7	7	7	7	**65**
Option 2.Policy	10	10	10	10	9	10	10	10	10	10	**98**
Additional cost	3	3	3	3	3	3	3	3	3	4	**33**

45. SOADs do not work full-time, as the SOAD activity usually complements other activities, so headcount figures were estimated. Dividing the estimated number of SOAD visits by caseload levels of 109 visits (estimate provided by the CQC) gives the estimated additional number of SOADs (headcount) required in future years – see table below.

Table 7. Estimated numbers of additional SOADs

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33
Option 1. BAU	140	140	140	140	140	140	150	150	150	160
Option 2. Policy	220	220	220	210	210	220	220	230	230	240
Additional Headcount	**80**	**70**	**70**	**70**	**70**	**70**	**70**	**80**	**80**	80

[18] NHS Digital (July 2018). Mental Health Act Statistics 2016-17 – Further Analysis to support the MHA review, July 2018. Unpublished.

Clinical Teams

46. Clinical teams will be formed of multiple disciplines including responsible clinicians (RCs), other clinicians and nurses not only in hospital but also in the community. These professionals are expected to play an increased role in MHA detentions following the implementation of the safeguards and also for those patients who have been discharged and wish to set up an ACD with the support of their community mental health care team (see Annex B.VI). Assumptions about additional workload were discussed and agreed with NHS England and will need to be refined alongside further development of the policy.

47. The additional costs are expected to arise in the following areas: CTP set up and review, contact with increased SOAD visits, applications and renewals of sections and supporting ACDs. Clinical teams also need to support tribunal hearings, which are estimated to decrease in the future. The estimated monetised costs for are summarised in Table 8 below.

48. For additional costs for MHT hearings for both Options 1 and 2 we calculated annual costs separately for each healthcare profession. This was done by multiplying the estimated time per hearing by the estimated staff cost (including salary, oncosts and overheads) and then taking the sum of costs for each healthcare profession. For additional healthcare costs, annual costs were also calculated separately for each healthcare profession by multiplying extra time required per detainee by estimated staff cost (including salary, oncosts and overheads). Next, the sum of each healthcare profession cost was calculated. Similarly, ACDs annual costs were assessed separately for each healthcare professional, multiplying estimated additional time required per ACD by the estimated staff cost (including salary, oncosts and overheads), and finally the sum was taken to reach the total cost. For further details see Annex B.VI.

49. Over the ten year period from 2023/24 to 2032/33 additional costs are at estimated at £88 million for supporting MHT hearings, £252 million for healthcare settings and £38 million for supporting ACDs. The total additional costs over the appraisal period is estimated at £378 million.

Table 8. Estimated monetised costs for clinical teams (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
MHT hearings – Option 1.BAU	32	32	32	32	32	32	32	32	32	32	**319**
MHT hearings – Option 2.Policy	37	37	44	41	41	41	43	41	42	42	**407**
MHT hearings - Difference	5	5	12	9	9	9	11	9	10	10	**88**
Additional healthcare settings costs (note)	27	26	25	25	24	24	25	25	26	26	**252**
ACDs	4	3	4	4	4	4	4	4	4	4	**38**
Total additional costs	36	34	41	37	37	37	39	38	39	40	**378**

Note. We only estimated additional healthcare setting costs (in both hospital- and community-based healthcare settings), as it was challenging to estimate and forecast BAU.

50. The estimated additional clinical staff in each year required across the 10 year period are presented in Table 9 below:

Table 9. Estimated numbers of additional staff required (FTEs)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33
Responsible Clinician (FTE)	80	90	110	100	100	100	110	100	100	110
Clinician (FTE)	60	60	60	60	60	60	60	60	60	60
Nurse (FTE)	50	50	70	70	70	70	70	70	70	70
Other clinical staff (FTE)	10	10	20	20	10	10	10	10	10	10
Care Coordinator (FTE)	20	40	60	50	60	60	60	60	60	60
Additional Clinician (FTE)	20	10	10	10	10	10	10	10	10	10
Community Supervising Clinician (FTE)	20	10	10	10	10	10	10	10	10	10

Quality Improvement Programme

51. The Government recognises that, while legislation is important, for some of its proposals, there is a strong case for the development of a QI Programme to support their successful and sustained implementation. As such, NHS England and Improvement (NHSEI) will establish a national QI programme relating specifically to the implementation of the MHA reforms identified as most likely to benefit from a QI approach. NHSEI are working with a range of stakeholders to scope the programme, and experts with experience taking a key role in its development and delivery alongside professionals.

52. The QI programme will support the mental health system to address issues around quality, patient experience, leadership and culture. It will drive a renewed focus on improving patient choice and empowerment, to bring about positive change to improve people's experiences of assessment and detentions under the MHA. It is estimated that the QI programme will cost around £2 million overall, including a robust co-design phase, followed by national implementation and evaluation – see table 10 below.

Table 10. Estimated monetised costs for the Quality Improvement Programme (£millions, 2020/21 prices, undiscounted)

	2021/22	2022/23	2023/24	Total
QI programme	0.5	0.75	0.75	**2**

<u>Monetised costs – Justice System</u>

53. In this section we present the costs associated with the Government proposals that have an impact in the Justice system. Further details on the analytical approach can be found in Annex C. The monetised impacts have been broken down by their impact on the MHT and associated legal aid costs, restricted patients and places of detention (prisons/immigration centres).

54. The evidence base for the analysis conducted in this section has largely come from stakeholder engagement with the tribunal judiciary and HMCTS operational colleagues.

55. Due to the inherent uncertainties in this type of analysis, we have conducted sensitivity tests and provided a low, central and high scenario in the aggregated analysis. More detail can be found in the sensitivity analysis section.

Mental Health Tribunal (MHT)

56. Broadly speaking, the role of the Mental Health Jurisdiction of the First-tier Tribunal (usually referred to as the Mental Health Tribunal or MHT) is to act as the ultimate safeguard for a patient being in detention. It has the power to consider whether the conditions for continuing treatment under compulsory powers are met and it may authorise treatment orders that specify the detention of a patient in a specific hospital or to reside at a specified place (when not able to reside at home).

57. The Government proposals aim to broaden the rights and liberties of users of mental health services. This is to ensure that patients have more say in their treatment and are more aware of their rights to have their case reviewed. Whilst we recognise this may have the added benefit that patients may not feel the need to appeal to the MHT as often, we have not been able to quantify this potential behavioural response and so it has not been reflected in the analysis presented in this IA.

58. Some patients within Part III of the MHA (i.e., those involved in criminal proceedings or under sentence) are subject to restriction orders due to the risk of serious harm they pose to others. These "restricted patients" cannot be transferred between hospitals, discharged or granted community leave without the consent of the Secretary of State for Justice. The MHT in England and the Mental Health Review Tribunal for Wales can also discharge restricted patients detained under a restricted hospital order if they conclude that the criteria for detention in hospital under the MHA is no longer met.

59. The Government proposals affecting the MHT can be categorised broadly into 5 themes:
    i. Automatic referrals to the tribunal – responding to the Review's recommendations 52, 53, 61, 64 and 137 on the frequencies of different types of referrals;
    ii. Detention criteria - responding to recommendations 46c on the maximum detention period and 46e on certifying 10 days in advance of a hearing that it still needs to proceed;
    iii. Treatment choices - the Review's unnumbered recommendation regarding the statutory Care and Treatment Plan (CTP) at the tribunal hearing and the new route of appeal following a SOAD review;
    iv. Expanded powers of the tribunal – responding to recommendations 18, 47, 96 and 146 (see non-monetised costs section of the IA below); and;
    v. Changes to tribunal procedures – responding to recommendation 97 on collecting protected characteristics data and recommendation 149 on streamlining activity undertaken between various bodies (see non-monetised costs section).

60. The themes in the paragraph above have been assessed in parallel, allowing some of the interactions between recommendations to be identified and incorporated into the analysis. Ahead of the individual themes being discussed separately throughout this section, the aggregated impact of all five themes on the MHT is presented below.

Central Scenario

61. Table 11 presents the total additional estimated costs, including legal aid, of implementing the Government proposals where they can be quantified. Total additional estimated costs cover automatic referrals (see Annex D), treatment choices, and legal aid impact, as shown below in more detail. They were estimated using a forecast of the number of receipts/hearings multiplied by the average sitting day costs for a MHT (see Annex C for further detail).

Table 11. Total estimated monetised costs for the Mental Health Tribunal, including legal aid, central scenario (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	40	40	39	39	39	38	38	38	37	37	**386**
Option 2. Policy	53	51	62	55	55	54	57	54	55	54	**549**
Additional cost	13	11	23	16	16	16	19	16	17	17	**164**

Automatic Referrals

62. Patients who are either detained or receiving treatment under the MHA will have their case automatically referred to the MHT at specified periods during their detention or treatment. This automatic referral will only occur if the patient, or someone on their behalf, has not already made an application or referral to the MHT within the specified time period. For this reason, automatic referrals can be thought of as mandatory (rather than discretionary) referrals. These recommendations impact on the mandatory referral periods that arise when a patient has not applied to the MHT themselves or had someone apply on a discretionary basis on their behalf. The automatic referral proposals impact distinct patient groups (e.g., recommendation 53 only impacts part III patients).

63. Since civil patients can be discharged at any point by the RC, the MHT's purpose is to offer a safeguard against unnecessary detention. Around a third of the section 3 cases (those admitted for treatment) disposed of annually involve the patient being discharged by their RC shortly before the MHT hearing[19]. To avoid overestimating tribunal activity as a result of these discharges prior to the hearings taking place, we used MHT hearing volumes instead of receipt volumes in the majority of the analysis for the potential additional MHT costs. However, given that some levels of legal aid fee can be claimed for preparation work relating to the MHT application rather than the full hearing itself, it was more appropriate to calculate legal aid costs using the number of MHT receipts rather than the number of hearings.

64. The legal aid costs of implementing these automatic referral proposals were estimated using a different average cost specific to the patient group in question, based on case level detail from the legal aid claim data. The majority of the potential costs relate to the implementation of recommendation 53.

65. As stated in the 2021 White Paper there are currently significant constraints on the MHT with regards to assembling a panel that has the relevant expertise and specialisms to be available at all hearings. The Government intends to take forward the following proposals:

    - Recommendation 52 - having an automatic referral to MHTs at 4 months, 12 months and annually after the start of the detention, which interacts with recommendation 46c on reducing initial maximum detention periods. These are both applicable to part II patients.
    - Recommendation 53 - part III patients only having an automatic referral once every 12 months.
    - Recommendations 61 and 64 - automatic referrals for people on a CTO in each time period, i.e., at 6 months and then, if renewed, at 6 months and at 12 months after the renewal.
    - Recommendation 137 - automatic referrals for people on conditional discharge after 24 months and at regular intervals of four years after that for those who have not applied directly.

66. The estimated costs of automatic referrals are presented in Table 12 – see Annex D for further detail. The potential costs in the first 2 years of implementation are driven entirely by recommendation 46c, which is a detention criteria recommendation, so it has an earlier implementation date than the rest of the automatic referral recommendations. However, it has been included with recommendation 52 for

[19] Source: Tribunal Service Case Management MARTHA data system, 2018-19 disposals.

the purposes of this analysis as the impacts on the MHT are analogous; both increasing access for section 2 patients.

Table 12. Estimated monetised additional costs, including legal aid, from implementing the automatic referral recommendations, including recommendation 46c (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	37	37	36	36	36	35	35	35	35	34	**357**
Option 2. Policy	44	42	54	48	48	48	51	47	48	47	**475**
Additional cost	7	6	18	12	12	12	15	12	13	13	**119**

Detention Criteria

67. As well as its costs being included alongside the automatic referrals category of recommendations, the methodology regarding accepted recommendation 46c (on reducing the initial maximum detention period under section 3 so that there are three detention periods in the first year at 3 months, 6 months and 12 months of detention) is discussed alongside recommendation 52 in Annex D.

68. Recommendation 46e stipulates that Section 3 patients should be certified as continuing to meet the criteria for detention 10 days in advance of a hearing at the MHT. The purpose of this recommendation is to reduce the burden of hearings cancelled at the last minute (deemed to mean within 48 hours) on the MHT – the impact of this proposal is presented in the monetised benefits section.

Treatment Choices

69. The Government proposes to allow the MHT to review the patient's CTP where concerns have been expressed, which was an unnumbered recommendation in the Independent Review.

70. The costs of this proposal are those associated with the additional time taken for the panel to review the patient's CTP, which could result in longer hearing times and fewer hearings per sitting day on average. The hearing volumes for each policy scenario use the expected hearing volumes from the automatic referrals recommendations as an input. The costs for each policy scenario thus reflect the additional costs from the increase in sitting days resulting from a lower hearings per sitting day ratio, for the same volume of hearings.

71. The analysis has focused on the following assumptions, which have been agreed with HMCTS colleagues:
    - That hearings relating to applications for discharge (excluding section 2) are likely to increase in year 1 (2023/24) by a central assumption of 40 minutes per hearing, resulting in fewer hearings on average being heard per sitting day.
    - This increase in total average hearing time is expected to decline as the process becomes more familiar. Therefore, a profile has been applied of a reduction of 50% of the expected increase over the first 3 years, with a steady state of 20 minutes per case achieved by 2026/27.

72. CTPs would become statutory for patients detained under section 2 of the MHA although we do not expect that reviewing a section 2 patient's CTP would affect the length of a MHT hearing, as existing patient plans already include reports to tribunals. Costs have therefore not been estimated for this subset of hearings to reflect this.

73. The estimated additional costs associated with the proposed change to treatment choices are presented in Table 13 below. There is a zero BAU because this element is entirely new.

Table 13. Estimated costs of increased treatment choices on the Mental Health Tribunal (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Additional cost	6	5	5	4	4	4	4	4	4	4	**41**

Legal Aid Impact

74. The total cost of legal aid for patients appealing to the MHT will be affected by the Government proposals. If a proposal results in a higher or lower MHT workload than would otherwise be the case, then legal aid expenditure will change in the same direction. Legal aid impacts have been provisionally estimated for all of the Government proposals, where possible.

75. Given that most of the preparation work for a MHT hearing, for which providers can claim a preparation level fee, will be done more than 10 days in advance of the hearing date, we do not expect the proposal giving effect to recommendation 46e would have much impact on the legal aid claim total. With regard to the unnumbered CTP recommendation, there is no impact on receipt volumes, so it has not been possible to estimate the potential legal aid costs associated with this recommendation. However, there is a chance it could increase the proportion of cases that escape the fixed fee scheme, which is the set fee legal aid providers can claim for the majority of their MHT work.

76. For the Review's recommendations 46c, 52, 53, 61, 64 and 137, the legal aid claim expenditure data was separated out by the available category groups of 'Part II' (i.e., non-restricted), 'Part III' (i.e., mostly restricted patients), 'Conditionally discharged' and 'CTO' to generate individual average costs per sitting day for these distinct patient groups.

77. The Option 1 (BAU) scenario will not match the published claim value for legal aid for various reasons. The first is that the cost estimates assume that uptake is 100% of eligibility, which may not be the case. As such, the estimated total legal aid costs may be an upper bound. Additionally, the BAU scenario is modelled for each recommendation individually using an approximate average cost for the patient group and receipt/hearing volumes, which are estimations of the actual work completed by legal aid providers.

78. Table 14 below shows the total estimated cost for legal aid which can be claimed by providers as a result of potentially increased receipts and hearings in the MHT. It is important to note that the estimated costs shown are based on the indicative workload expected to start in each year of implementation. The legal aid claim total for each year is likely to differ in reality as providers will usually submit a final bill after all work on a case has been completed, resulting in a lag between the hearing date and the legal aid claim.

Table 14. Estimated monetised costs for legal aid from increased receipts and hearings in the Mental Health Tribunal system, central scenario (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1.BAU	14	13	12	12	11	10	10	9	9	8	**108**
Option 2.Policy	17	16	19	16	15	14	14	13	13	12	**149**
Additional cost	3	3	6	4	4	4	5	4	4	4	**41**

The Prison System and Immigration Centres – Part III patients including restricted patients and those detained in Immigration Removal Centres (IRCs)

Leave and transfer for restricted patients

79. The aim of recommendation 133 is to speed up the process whereby restricted patients can access leave in the community or be transferred to a different hospital.

80. At present, the RC must seek the Justice Secretary's consent for leave or hospital transfer for all restricted patients in England and Wales. Historically, stakeholders (primarily patients and their family/carers but also hospitals/NHS, legal representatives and the MHT) have not had clear guidance on timescales for these decisions. Furthermore, at the time of the Independent Review published in 2018, there were substantial delays and a backlog of decisions, as the Mental Health Casework Section (MHCS), which is responsible for the management of restricted patients in England and Wales in HMPPS, was carrying a number of vacancies for some months.

81. While the Government agrees with the intention underlying recommendation 133, it has decided to take an alternative approach to improve the speed of decision-making and it has already invested time and resources in improving the current processes. HMPPS has increased the headcount of MHCS by 5 posts and is considering to recruit for an additional 5 staff in order to make further improvements. MHCS has published targets for the timeliness of decision-making[20] and has been delivering a programme of continuous improvement, in partnership and collaboration with health colleagues and other stakeholders, plus has recently refreshed its performance framework. MHCS has improved the timeliness of decision-making substantially in 2019/20 and again in 2020/21. It will continue to make improvements once any additional staff are in post.

82. The estimated costs of the additional staff[21] are provided in table 15 below.

Table 15. Estimated monetised costs for Recommendation 133 (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1.BAU	3	3	3	3	3	3	3	3	3	4	**32**
Option 2.Policy	3	3	3	4	4	4	4	4	4	4	**37**
Additional cost	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	**5**

Research on ethnicity and the Mental Health Act

83. The Independent Review of 2018 identified gaps in the evidence around the use of the MHA and made a number of recommendations on the need for research on these areas, in particular, research to inform future policy to tackle the rising rates of detention under the MHA and to address the disproportionate number of people from minority ethnic backgrounds subject to compulsory powers under the Act.

84. The National Institute for Health Research Policy Research Programme (NIHR PRP), on behalf of the Department of Health & Social Care (DHSC), has now funded four new research projects on how to tackle the rising rates of detention and understanding the experiences of people from minority ethnic backgrounds and family and friends of people who have been detained[22]. This funding in the

[20] Her majesty's Prison and Probation Service (2019), MHCS & NHS Joint performance management framework 2019/20, Accessed at https://www.gov.uk/government/publications/mhcs-and-nhs-joint-performance-management-framework-201920

[21] HMPPS staff salaries are assumed to increase by 1% in nominal terms each year.

[22] News: New research to improve experiences of people with serious mental health problems | NIHR

value of £3 million pertains to 2020/21 – as these costs were incurred in the past, they are not included in this IA in line with Government guidance[23].

85. The need to ensure that culturally-appropriate advocacy is provided consistently for people of all ethnic backgrounds has been recognised, in particular for individuals of black African and Caribbean descent and heritage. The Government has committed to launching a pilot programme of culturally-sensitive advocates in partnership with local authorities and others, to identify how best to represent the mental health needs of ethnic minority backgrounds and it has allocated some initial funding to conduct preliminary research on cultural appropriate advocacy in 2021/22.

Data and Digital

86. The Government accepts that improvements to data and digitising the MHA are two of the enablers that would help support the functioning of the MHA. The Government shares this view and is committed to working with all the organisations involved in the MHA system to bring about improvements here.

87. The NHS Mental Health Implementation Plan 2019/20 – 2023/24[24] (within the NHS LTP) states the commitment to improve substantially mental health data quality over the coming years by improving the coverage, consistency, quality and breadth of national data. Seeking improvements to MHA related data is a part of this plan. The ongoing refinements to the Mental Health Services Data Set (MHSDS)[25], where a large proportion of MHA data are held, will support this activity.

88. Improvements to the quality and consistency of the ethnicity data are also an important part of improving MHA data. The Race Disparity Unit (part of Cabinet Office)[26] worked closely with the Office for National Statistics on the ethnicity classifications for the 2021 Census. Once a new harmonised standard (reflecting the 2021 Census) has been agreed, the Race Disparity Unit will support delivery partners to reflect these changes in their reporting systems.

89. The UK Government proposes that NHS England should build on the work of the Mental Health Trust Global Digital Exemplars[27] and other trusts to test, evaluate and roll-out a fully digitised, consistent approach to the MHA. Digital transformation is at the heart of the NHS LTP. Through the wider transformation portfolio, including the Global Digital Exemplar and Local Health and Care Record programmes[28], all mental health providers are expected to progress, by 2024, to a core level of digitisation[29].

90. All of these workstreams will need to be considered under the priorities for developing the existing datasets, so no additional costs are included for Data and Digital in the NHS in this IA, excepting the digital discovery project mentioned above.

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[23] HM Treasury (2020). The Green Book: appraisal and evaluation in central government. Accessed at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

[24] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

[25] NHS Digital (9 October 2019). DCB0011: Mental Health Services Data Set. Accessed at: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0011-mental-health-services-data-set

[26] https://www.gov.uk/government/organisations/race-disparity-unit

[27] NHS England. Mental Health Global Digital Exemplars. Accessed at: https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/exemplars/mental-health-global-digital-exemplars/

[28] NHS England. Health and care data. Accessed at: https://www.england.nhs.uk/digitaltechnology/connecteddigitalsystems/health-and-care-data/

[29] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

91. With respect to the Justice system, Government proposal that *"statistics should be collected on the protected characteristics of those applying for a MHT hearing, and their discharge rates"* (recommendation 97) is already being taken forward as part of the wider HMCTS Reform Program[30]. As a result, any estimated costs and benefits relating to this proposal are not captured in this IA.

Non-Monetised Costs

Non-Monetised Costs – Health and Social Care System

Advance Choice Documents (ACDs)

92. There might be costs associated with staff training and setting up a system to ensure that ACDs can be stored securely and easily accessed by service users and staff. These could potentially be captured by Continuous Professional Development activity and current data management practices or they may require additional costings. These have not been captured in this IA.

New MHA detention criteria

93. The Government is proposing to amend the detention criteria of section 3 of the MHA and elsewhere so that detention for treatment is only undertaken when it is clear that this will be therapeutically beneficial for the individual. The Government is also proposing to amend the detention criteria for sections 2 and 3 of the Act, and elsewhere, so that, for someone to be detained, it must be demonstrated that there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person.

94. These changes are expected to result in fewer and shorter MHA detentions, all other things being equal, as a stronger and clearer detention criteria will mean that people are only detained when there is a clear justification for doing so and that they are discharged as soon as that justification ceases to be relevant.. It has not been possible to quantify these prospective reductions due to the absence of evidence on how much detentions could be reduced or shortened following changes in detention criteria, so we are unable to estimate potential costs in this IA.

Learning Disabilities and Autism

95. The Government proposed to limit the scope to detain people with a learning disability and autistic people under the Act. Under the proposals, people with a learning disability and autistic people could be detained under section 2 of the Act when their behaviour is so distressed that is considered to be a significant risk of harm to self or others and there is a probable mental health condition. The assessment process under section 2 should seek to find the driver of this distressed behaviour and if a mental health condition is identified as the driver then the patient may follow a treatment pathway for the mental health condition under section 3 of the Act. They should only be detained after other, less restrictive, alternatives have been considered. If no co-occurring mental health condition is identified, then the detention should end after a maximum of 28 days (under section 2). This proposal forms part of an overriding objective to reduce reliance on inpatient services for people with a learning disability and autistic people through development of community-based support.

96. The Government is committed to ensuring the right services are available in the community for people with a learning disability and for autistic people, both to prevent unnecessary admissions and to speed up discharges. To help achieve this, in the White Paper the Government proposed to introduce new duties on local authority and Clinical Commissioning Group (CCG) commissioners to ensure an adequate supply of community services specifically for people with a learning disability

[30] https://www.gov.uk/guidance/the-hmcts-reform-programme

and autistic people. To help reduce the length of detention and ensure that discharge is the priority from day 1, the Government proposed to put recommendations from Care (Education) and Treatment Reviews (CETR) on a statutory footing. In light of the responses received at consultation, the details of how both of these proposals will work in practice require further policy development, therefore potential costs cannot be quantified at this stage. Future analysis will also consider planned improvements to community services for people with a learning disability and autistic people, which are being delivered through the NHS Long Term Plan.

Cultural Change

97. Legislation alone will not drive changes in the day to day experiences of patients and staff. To achieve this, we need to bring about an overall culture change. This will require a whole system response and strong leadership from clinicians and experts by experience. The QI Programme and the Patient and Carer Race Equality Framework are important components of this work, as well as significant investment to transform services as set out in the NHS Long Term Plan.

98. The Department of Health and Social Care (DHSC) will continue to work with NHSEI, and other partners, to look at further national support requirements to drive change in the system including but not limited to: ensuring that staff are upskilled to deliver on the changes to the legislation; that training is centred around supporting meaningful co-production with the patient; that we drive up expert-by-experience leadership roles within providers and local systems.

Familiarisation and transitional costs

99. It is expected that there will be transitional costs to services associated with reforming the MHA, as a large number of organisations, such as local authorities, commissioners, and providers, will have to update their policies, procedures and documentation. It is likely that extra training would need to prepare those organisations whose roles will directly change as a result of the reforms to the Act. Since it is not clear at this stage to what extent some of Government's proposals already represent best practice in some organisations, and what will be taken forward as part of routine updates to clinical practice, it is not possible to obtain a clear estimate of what funding would be required to improve capability, so these costs remain unmonetised. We will estimate these costs when policy positions are more fully developed and the impact of the reforms on services can be better assessed.

Training costs for clinical staff

100. There will be a range of training requirements for clinical staff that will need consideration, including operational training on implementing the changes to the MHA and training aimed at embedding the cultural change the Government wants to achieve as part of the reform agenda – for example, ensuring that the patient has a greater say and control over their care and treatment. It is still not defined how this training will be designed, so these costs have not been monetised yet.

Non-Monetised Costs – Justice System

Treatment Choice

101. The Government accepts that patients should be able to appeal treatment decisions at the MHT following a SOAD review, as set out in recommendation 9 of the Independent Review. Currently, if a patient wishes to challenge the decision of the RC and SOAD, they must appeal treatment by way of Judicial Review. The impacts of this recommendation are presently unmonetised, given that further policy development is required. As part of our work to assess the costs, we will consider the proposal that there shall be a 'permission to appeal' stage prior to cases proceeding to full Tribunal hearing and that cases shall be heard by a single judge sitting alone in the MHT.

Expanded Powers

102. Several Government proposals would expand the powers of the MHT, to empower it to make decisions beyond determining an appeal for discharge. These proposals are discussed below:

Displacement of the Nearest Relative

103. The Government accepts the Review's recommendation 18 that the County Court power to displace a Nearest Relative, should be replaced by an MHT power to overrule or displace a NP on the grounds that the MHT is better placed to make this decision. To take forward this proposal, we need to understand how this change will work in practice and the extent to which it can be implemented. The Ministry of Justice (MoJ) plans to carry out further work before delivering change in this area.

104. As part of this further work, it is important that we consider the potential impact this proposal could have and that we ensure that the appropriate measures are in place so that it can be implemented effectively. For example, expanding the powers of the MHT in this way has the potential to increase the number of appeals it receives. As the MHT is already under significant pressure to manage its caseload, it may be necessary to recruit additional judicial office holders and obtain funding for the additional administrative resources required.

105. The Government will also be taking into consideration the implications for the legal aid fund, which currently pays for representatives for patients in these proceedings before the County Court on a means tested basis. Whether legal aid will remain means tested when the proceedings are transferred to the MHT will be considered further by the MoJ.

Additional training for panel members

106. The Government accepts the Review's recommendation 96 that training should be developed for MHT panel members in specialisms including children and young people, forensic psychiatry, learning disability, autism, and older people. Once trained, panel members could become 'ticketed' to sit in specialist areas and specifically allocated to sit on cases in which they had gained that specialism.

107. The Government agrees that the individual needs of the patient should be recognised. However, it is the judiciary, through the Judicial College, who are responsible for setting and developing the training for MHT panel members. This process is independent of Government. Furthermore, the decision as to whether ticketing should be introduced is the responsibility of the Senior President of Tribunals in consultation with the Chamber President to make.

Power to grant leave or direct transfer to a different hospital

108. The Government accepts the Review's recommendation 47 that the MHT should be able to grant leave or transfer when considering a patient's case. We must consider, however, the practical implications of implementing this proposal. For example, if the MHT grants the transfer of a patient to a hospital in a different location or with a lower level of security we recognise that – given the limited bed space – it might not be possible to give effect to the transfer immediately. The Government proposes that healthcare bodies should be given a period of 5 weeks to deliver the MHT's direction. We intend to include this in legislation, but propose to consult and seek views on whether five weeks is an appropriate amount of time. Until then, cost estimates cannot be provided here.

Power to direct leave or transfer when deciding not to grant an application for discharge for restricted patients

109. The MHCS already actions non-statutory recommendations from the MHT in relation to restricted patients. However, moving to statutory recommendations may mean the process around receiving

and responding to MHT decisions needs to be adapted, which could lead to an increased burden on staff. There is a possible opportunity cost of other work if these statutory recommendations are prioritised.

110. There is a risk that the statutory recommendations are used much more frequently and there is an initial surge in cases. If no additional staff are hired, then there could be a short term backlog. Policy discussions and work are still ongoing to understand and determine the effect of this proposal on caseload and staff.

Changing conditions of CTO

111. The Government wants to ensure the conditions attached to CTOs are proportionate, although it does not believe that the MHT should become overly involved in the details of a patient's CTO, which is a material risk of the Review's recommendation 63. Conditions applied to a CTO will still be determined by the patient's clinical team, who have day to day responsibility for the patient's care and treatment. If the MHT concludes that finds the least restrictive option is not attached to the CTO, the Tribunal will be able to recommend that the clinical team reconsider its decision.

Prison as a place of safety / Transfers to hospital from prisons and Immigration Removal Centres (IRCs)

Stopping prisons being considered as places of safety

112. The use of prison as a 'place of safety' on the grounds of mental health is a concept defined in two pieces of legislation:

- Bail Act 1976: Schedule 1 of the Act states that the defendant need not be granted bail if the court is satisfied that the defendant should be kept in custody for their own protection or, for a child or young person, for their own welfare.
- Part III of the Mental Health Act 1983: If a court wishes to send certain accused and convicted people to hospital on mental health grounds, but the hospital cannot immediately receive these people, the court may direct them to a place of safety in the interim (for a maximum of 7-28 days). In this context, a place of safety means (for adults) any police station, prison or remand centre, or any hospital the managers of which are willing temporarily to receive the person.

113. The Government has committed to stop prison being used in this way and will work to ensure that there is a timely pathway available to the courts to direct individuals with serious mental health need directly to a healthcare setting. We are not yet aware of the scale/impact associated with removing prison as a place of safety for those who meet criteria for detention under the MHA, as proposed in the Review's recommendation 130. This is because the relevant data are not centrally collected by HMPPS, although it is believed that the annual number of such prisoners is low. However, giving effect to this proposal is likely to reflect a shift in demand from one area of the public sector to another – the prison population of England and Wales would tend to be lower at any point in time, but the demand for alternative places (e.g., in secure hospitals) would be greater by an equal amount. The MoJ is working with health and justice partners in England and Wales to better understand the scale of the issue and, ultimately, the potential impact.

Transfers from prisons and Immigration Removal Centres

114. The Government has accepted the Review's three recommendations aimed at ensuring people in prison or immigration detention receive the care they need as quickly as possible:

- Recommendation 131 proposes the creation of a new statutory, independent role to manage transfers to a mental health hospital;

- Recommendation 132 suggests the introduction of a statutory 28 day time limit from the point of referral for a first assessment to a transfer taking place;
- Recommendation 140 extends the recommendation around creating a new statutory transfer manager role to IRCs as well as prisons.

115. The Government agrees that a new independent role should have oversight of referrals, assessments, transfers and remissions of prisoners and immigration detainees. However, the Government also believes that more work is required to scope exactly what the responsibilities of this role should be and how they differ from existing overlapping roles in this space before we can provide estimates on the impact of this proposal.

116. The scope of the role would also determine where it should sit (e.g., with Local Authorities, NHSEI or HMPPS) and how much it will cost. The consultation has indicated that a preference was for a role to either sit jointly in HMPPS/NHSE or in local authorities due to the goal of impartiality. Although some stakeholders suggested expanding AMHP roles, many felt this would be thinning capacity and prove ineffective. Further, the consultation established a clear need for detailed thought on the independent IRC transfer manager role, given the stark difference between IRCs and prisons. As such the role may be fairly different to the prisons role.

117. The Government agrees that it is desirable to introduce a 28 day time limit for transfers. It is proposed that there should be a delayed commencement of the statutory element of the recommendation, so as to allow time for updated NHSEI guidance setting out the 28 day time limit to be embedded. However, we are mindful of the views shared by various stakeholders (including the Royal College of Psychiatrists) that enshrining the time limit in statute could result in unintended consequences if not carefully managed.

118. For example, clinicians may avoid recommending hospitalisation if they, or their employing authority, are likely to be penalised for not meeting the deadline. As each case is different and complex, there may also be occasions when a longer assessment period is required. A further risk raised to guard against is a limit forcing transfer to a remote region away from a person's support, a consequence we want to avoid. We therefore need to be cautious in ensuring that a statutory timeframe does not prevent us from considering the most appropriate placement and treatment that can be provided for individuals. Through the consultation and engagement with key stakeholders and operational partners we are considering further stakeholder views of unintended consequences that a statutory time limit could produce, and the solutions.

119. The costs of accepting these proposals could lead to an increased risk of legal challenge to the Government in the case of failing to meet the new time limit, if it were made statutory. There are around 1,000 transfers from prison to mental health inpatient settings each year in England, around one third of which meet the current 14 day (non-statutory) target. About 50-60% of transfers are within the 28 day window proposed by the Review. In 2018/19, 4% of prisoners waited more than 140 days to be transferred.

120. Much work has been done over the past couple of years to improve processes and tackle delays. This work will continue and we are clear in the 2021 White Paper that the time limit will only be made statutory once the necessary operational improvements have been made. Revised NHSEI guidance was published in June 2021.[31]

Power to discharge restricted patients with conditions that restrict their freedom in the community

121. The Government accepts the Review's recommendation 136 that – for a very distinct group of restricted patients for whom the MHA is no longer providing therapeutic benefit from detention in

[31] https://www.england.nhs.uk/publication/guidance-for-the-transfer-and-remission-of-adult-prisoners-and-immigration-removal-centre-detainees-under-the-mental-health-act-1983/

hospital, but who pose such a significant risk to others, that they would need continuous supervision to be managed safely in the community – the MHT should have the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

122. The Government consulted on the introduction of a new power of Supervised Discharge to enable the discharge of this small cohort of restricted patients with conditions amounting to a deprivation of that person's liberty in order to adequately and appropriately manage their risk. The Government is proposing that patients on this type of order would have their cases reviewed by the MHT on an annual basis.

123. While stakeholders were broadly supportive of this new power, which would address a current legislative gap and support patients to be managed in the least restrictive way, some concerns about the potential for overuse and need for strong safeguards to protect the patient were raised. The Government plans to legislate to introduce the Supervised Discharge but further policy work is needed to define the appropriate safeguards, including the role of the Tribunal in reviewing these cases.

124. The cohort is expected to be small, although data are extremely limited[32]. At present, we are aware of approximately 40 patients in the intended cohort who are currently being managed on long-term section 17 leave (the interim operational policy) who would benefit from this new order. It is expected that patients may be subject to this order for many years and so numbers will increase over time. A marginal increase in MHT caseload can be expected, given the introduction of an additional annual review for these patients. However, a lack of reliable data and further policy work required to consider the role of the MHT means this impact cannot be assessed.

Summary of Costs

125. The estimated costs of the policy interventions under Option 2 have been summarised below in table 16. They have been split into costs relating to the NHS, Local Authorities and the Justice System. They are presented at constant prices (in table 16) and then discounted to take account of the time value of money [33] and presented in a similar table for ease of comparison in table 17.

126. Overall additional undiscounted costs for these three areas are estimated at £772 million for the 12-year period. Due to the phased implementation nature of the proposals, these costs are not evenly split over the 10 years starting from 2023/24 when the necessary legislation is assumed to be in place.

Table 16. Summary of total additional costs (£millions, 2020/21 prices, undiscounted)

	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	Total
NHS	1	1	40	38	44	40	40	40	43	42	43	43	**414**
Local Authority	-	-	25	20	20	19	19	19	18	18	18	18	**195**
Justice System (including legal aid)	-	-	13	11	23	16	16	16	19	16	17	17	**164**
Total	1	1	79	69	86	75	75	75	80	76	78	78	**772**

Note: Costs may not add up exactly due to rounding

[32] Data are derived from casework systems and management information.

[33] HM Treasury (2020). The Green Book: appraisal and evaluation in central government. Accessed at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

127. For each area, overall costs for the 12-year period are (with breakdowns by specific intervention further down):

- Additional NHS (Clinical Teams, SOADs, QI research, in tables 8, 6 and 10, respectively) costs are estimated at £414 million;
- Additional Local Authorities (IMHAs and AMHPs, in tables 2 and 4, respectively) costs are estimated at £195 million;
- Additional Justice system (tribunal procedure, automatic referrals inc. legal aid, treatment choice, expanded powers, and leave and transfer categorisation, see table 11) costs are estimated at £164 million.

128. **NHS and other healthcare resources opportunity costs**. The measurement and valuation of direct health benefits/ costs from a policy intervention is typically performed by estimating the number of Quality adjusted life years (QALYs) generated[34]. QALYs account for impacts on length of life (longevity) and health-related quality of life (QoL), where 1 QALY is equivalent to 1 year of life in full health or 2 years of life at half of full health.

129. In the Department for Health and Social Care, it is considered that an additional QALY (valued by society at £60,000) can be purchased for £15,000[35]. Where proposed health spending redirects resources from alternative use in the NHS, the opportunity cost of spending is 4 times the financial cost (£60,000 divided by £15,000 = 4).

130. Therefore, spending for new policies that is met from within existing resources will create an opportunity cost of £4 for every £1 of diverted resources and NHS and other healthcare related costs have been uplifted to reflect the opportunity costs of funding the policy interventions from within existing health and social care resources by multiplying them by a factor of 4. These healthcare opportunity costs were not applied in cost estimates presented above and will cover clinical teams and QI programme, which is delivered by NHSEI, and SOADs, which are under the CQC's remit.

131. **Discounting.** The summary tables for all monetised costs below show Present Value (PV) cost estimates [36]) and include overall discounted costs accounting for NHS and other healthcare opportunity costs.

132. The estimated total costs in Present Value terms, including opportunity costs (in 2020/21 prices) for these 3 areas are put at £1.8 billion for the 12-year period, between 2021/22 and 2032/33).

[34] For a full explanation of the QALY cost/ benefit methodology, please see Annex E.
[35] HM Treasury (2020). The Green Book: appraisal and evaluation in central government. Accessed at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent
[36] Present Value (PV) refers to the sum of the future costs of the policy in the 12-year appraisal period that have been discounted by the social time preference rate, at 3.5%, to bring them to today's value.

Table 17. Summary of total additional costs with and without opportunity costs (£millions, 2020/21 prices, discounted)

Note: Grey rows include NHS and other healthcare resources opportunity costs, white rows do not include opportunity costs

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
NHS (without opportunity costs)	1	1	39	36	41	37	36	36	38	36	37	37	**375**
NHS (with opportunity costs)	2	3	155	144	166	149	146	145	152	145	148	148	**1,502**
Local Authority	-	-	24	18	17	16	15	15	14	13	13	13	**158**
Justice System (including legal aid)	-	-	12	10	20	13	13	13	15	12	12	11	**131**
Total (without opportunity costs)	1	1	75	64	78	66	65	63	67	61	62	61	**664**
Total (with opportunity costs)	2	3	192	172	202	178	174	172	180	170	173	172	**1,790**

133. For each area, the estimated total cost in Present Value terms are estimated for the 12-year period:

- at £1.502 billion for the NHS including opportunity costs;
- at £158 million for Local Authorities;
- at £131 million for the Justice system, with a peak in 2025/26.

134. **Costs by Policy Intervention.** Tables 18 to 23 illustrate the costs broken down each intervention area in Option 2: healthcare, Local authority and Justice system. They are represented in both constant 2021/21 prices as well as in discounted opportunity cost.

Table 18. NHS - Additional cost (£millions, 2020/21 prices, undiscounted)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
SOAD	-	-	3	3	3	3	3	3	3	3	3	4	**33**
Clinical Teams	-	-	36	34	41	37	37	37	39	38	39	40	**378**
QI programme	1	1	1	-	-	-	-	-	-	-	-	-	**2**
Total	1	1	40	38	44	40	40	40	43	42	43	43	**414**

Table 19. NHS and other healthcare - Additional Cost (£millions, 2020/21 prices, discounted)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
SOAD	-	-	3	3	3	3	3	3	3	3	3	3	**30**
Clinical Teams	-	-	35	33	38	34	33	33	35	33	34	34	**343**
QI progr.	1	1	1	-	-	-	-	-	-	-	-	-	**2**
Total	1	1	39	36	41	37	36	36	38	36	37	37	**375**

Table 20. Local Authorities - Additional Cost (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
IMHA	15	15	15	15	15	15	15	14	14	14	**147**
AMHP	10	5	5	4	4	4	4	4	4	4	**48**
Total	25	20	20	19	19	19	18	18	18	18	**195**

Table 21. Local Authorities - Additional Cost (£millions, 2020/21 prices, discounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
IMHA	14	13	13	12	12	11	11	11	10	10	**118**
AMHP	9	5	4	4	3	3	3	3	3	3	**39**
Total	24	18	17	16	15	15	14	13	13	13	**158**

Table 22. Justice System inc. legal aid - Additional Cost (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Tribunal Procedures	-	-	-	-	-	-	-	-	-	-	**-**
Automatic Referrals	7	6	18	12	12	12	15	12	13	13	**119**
Treatment choice	6	5	5	4	4	4	4	4	4	4	**41**
Expanded Powers	-	-	-	-	-	-	-	-	-	-	**-**
Leave and transfer categorisation	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	**4**
Total	13	11	23	16	16	16	19	16	17	17	**164**

Table 23. Justice System inc. legal aid - Additional Cost (£millions, 2020/21 prices, discounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Tribunal Procedures	-	-	-	-	-	-	-	-	-	-	**-**
Automatic Referrals	6	5	15	10	10	10	12	9	9	9	**94**
Treatment choice	6	5	4	3	3	3	3	3	2	2	**33**
Expanded Powers	-	-	-	-	-	-	-	-	-	-	**-**
Leave and transfer categorisation	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	**3**
Total	12	10	20	13	13	13	15	12	12	11	**131**

Benefits

135. In our approach to estimating benefits, we distinguish between:
    - benefits to the Health & Social Care (H&SC) system, such as reducing the number and the length of detentions, and to the Justice system;
    - improved health outcomes for the individual, which are the primary aim of the proposed Government MHA reforms.

136. The only area where we have found more robust research findings on quantified benefits was for the reduction in the likelihood of compulsory readmission following ACDs, i.e., reducing the number of detentions. The reforms also encompass involvement in CTPs, improved access to independent advocacy and more opportunities to challenge treatment either within the health system or via tribunals within the justice system. We are not able to quantify the benefits attached to these proposals at this point.

137. Research findings suggest that involving patients in their treatment decisions could potentially improve patient satisfaction and adherence with treatment and lead to improved health outcomes, thereby reducing the likelihood of readmission (see section on non-monetised benefits below), but these studies do not provide quantitative evidence that could inform monetising additional benefits. Therefore, in addition to some monetised benefits, we will be replicating the breakeven analysis approach in the consultation IA to illustrate the benefits required to offset the costs of the policy in each year. These include benefits to the health system (in terms of reduced length of stay in hospital and reduced number of detentions) and increased health improvements for the individual (assessed in QALYs).

138. With regard to the Justice system, the only quantified benefits pertain to mitigating the burden of hearings cancelled within 48 hours on the MHT by proposing that Section 3 patients should be certified as continuing to meet the criteria for detention 10 days in advance of a hearing at the MHT.

Monetised benefits

Health and Social Care System - Reduction in compulsory admissions following ACDs

139. Interventions that focus on involving service users in defining preferences and planning for their care in the event of a future mental health crisis, including ACDs, have been identified as potentially beneficial in reducing the risk of compulsory admissions[37,38]. A recently published systematic review estimated the pooled benefit of five studies and found a 25% (range from 7% to 39%) reduction in compulsory admissions among those receiving crisis-planning interventions compared with those who did not receive the intervention[39]. There was no significant evidence of a reduction in voluntary admissions. We have therefore estimated monetised benefits associated with a 25% reduction in compulsory admissions for those service users estimated to have set up an ACD (central scenario), presented in table below (further detail in Annex B. VII).

140. To estimate the monetised benefits, we calculated the number of compulsory admissions under the MHA prevented due to an ACD and multiplied that by the total cost of a detention. There are two types compulsory admissions that could be avoided: i) the repeated detention avoided within the

[37] Molyneaux, E., Turner, A., Candy, B., Landau, S., Johnson, S. & Lloyd-Evans, B. (2019). Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open. 2019 Jul; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

[38] de Jong MH, Kamperman AM, Oorschot M, et al. Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2016;73(7):657–664. doi:10.1001/jamapsychiatry.2016.0501

[39] Molyneaux, E., Turner, A., Candy, B., Landau, S., Johnson, S. & Lloyd-Evans, B. (2019). Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open. 2019 Jul; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

same year as the ACD was set up after the first detention, and ii) the detention avoided due to establishing an ACD in previous years. The total cost of detention was calculated by the sum of cost of length of stay and the average cost of detention (see Annex B.I for further detail). These patients will still be using healthcare services when not in detention so we subtracted the estimated annual cost per patient with Serious Mental Illness for primary care, general hospital care and inpatient and community-based specialist mental health services (estimated at £4,989 at 2013/14 prices[40] and deflated to £5,954 at 2020/21 prices) from the costs of avoided detentions.

141. We have also estimated high and low benefits scenarios using the published range around the 25% reduction in detentions – 7% reduction in the low benefits scenario and 39% in the high benefits scenario.

142. Monetised benefits over the appraisal period are estimated at £336 million (ranging from £94 million to £524 million) – see table below.

Table 24. Estimated monetised benefits following Advance Choice Documents (ACDs), central scenario (£millions, 2020/21 prices, discounted at 1.5%)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Total estimated costs	4.7	4.5	4.6	4.7	4.8	4.9	5.0	5.1	5.2	5.3	**48.5**
Central scenario (40% ACD uptake rate and 25% detention prevention rate)											
Number of compulsory admissions prevented	1,190	1,800	1,840	1,870	1,910	1,950	1,990	2,030	2,070	2,120	**18,770**
Monetised benefits	23	34	34	34	35	35	35	35	35	36	**336**
High scenario (40% ACD uptake rate and 39% detention prevention rate)											
Number of compulsory admissions prevented	1,860	2,810	2,860	2,920	2,980	3,040	3,110	3,170	3,230	3,300	**29.280**
Monetised benefits	36	53	53	54	54	54	55	55	55	55	**524**
Low scenario (40% ACD uptake rate and 7% detention prevention rate)											
Number of compulsory admissions prevented	330	500	510	520	540	550	560	570	580	590	**5,250**
Monetised benefits	6	10	10	10	10	10	10	10	10	10	**94**

143. Comparing the total monetised benefits against the total estimated costs for ACDs (see Annex B.VII for costing approach), for £1 spent there is an estimated monetised benefit of £7 (ranging from £2 to £11) on average over the 10-year appraisal

Justice system – Detention Criteria

144. The Government proposes to reduce the burden of hearings cancelled at the last minute, which is deemed to mean within 48 hours, on the MHT by taking forward the Review's recommendation 46e (i.e., Section 3 patients should be certified as continuing to meet the criteria for detention 10 days in advance of a hearing at the MHT). Before estimating the impact of this recommendation on cancellation fees (due to assembling a panel that then does not sit), it is worth acknowledging that:

[40] Ride, J., Kasteridis, P., Gutacker, N., Aragon Aragon, M. J., & Jacobs, R. (2020). Healthcare Costs for People with Serious Mental Illness in England: An Analysis of Costs Across Primary Care, Hospital Care, and Specialist Mental Healthcare. *Applied health economics and health policy*, *18*(2), 177–188. https://doi.org/10.1007/s40258-019-00530-2. Also accessed at: Healthcare Costs for People with Serious Mental Illness in England: An Analysis of Costs Across Primary Care, Hospital Care, and Specialist Mental Healthcare (nih.gov)

- It may not always be possible to certify exactly 10 days before a hearing, as this may be on a Sunday for example, or there was no available resource on the tenth day prior to a hearing for an examination and certification to be conducted. Therefore, for the purposes of this analysis, we assume a physical examination can be conducted as close to 10 days of the hearing as possible, with a maximum of 17 days prior to the hearing, and certification itself is provided to the MHT 10 days prior to the hearing.
- The reasons for late cancellations are commonly (but not limited to) that the patient has been discharged within 48 hours of the hearing; there has been a change in a patient's circumstance; or that there has been late notification of discharge or a change in circumstances. For these reasons, in conjunction with the fact that not all cancelled panel members can find a suitable panel to sit on, even with 10 days' notice of cancellation, the proportion of all cancelled panels that can be reallocated with 10 days' notice of cancellation was assumed to be 50%.

145. The overall impact of this proposal is a cost saving from the reduction in cancellation fees, which can be claimed by the MHT's panel members. It is currently envisaged that some 50% of cancelled panels can still be utilised and therefore some restricted patients may have their hearings held earlier.

Table 25. Estimated monetised benefits of implementing recommendation 46e (£millions, 2020/21 prices)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Central scenario											
Undiscounted											
Option 1. BAU	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	**3**
Option 2. Policy	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	**2**
Estimated benefit (= Option 1 minus Option 2)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	**2**
Estimated benefit - discounted (at 3.5%)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
High scenario											
Estimated benefit - discounted (at 3.5%)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
Low scenario											
Estimated benefit - discounted (at 3.5%)	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**

Note: Estimated benefit = Option 1 minus Option 2

Non-monetised benefits

146. **For the Health & Social Care system.** Benefits associated with improving health outcomes, particularly for complex interventions such as the MHA reforms in such a complex system, are difficult to quantify and the published research is very scarce. Recent systematic reviews of qualitative evidence of patients' experiences of detention under mental health legislation and of interventions for involuntary patients using randomised controlled trials (RCTs) suggest that care planning interventions centred on the patient and increasing their involvement in decision-making, which are areas covered by the MHA proposed reforms (e.g., CTPs, ACDs), could improve patient

outcomes, including reducing the likelihood of these patients relapsing and being involuntarily readmitted[41,42].

147. There is also published evidence suggesting that the patient's satisfaction with involuntary mental health treatment is associated with a lower likelihood of readmission, and that providing information, respect, empathy, and engaging patients in treatment planning and including their preferences in treatment decisions can improve treatment satisfaction[43].Overall, these findings suggest that involving patients in their treatment decisions could potentially improve patient satisfaction and adherence with treatment and lead to improved health outcomes, thereby reducing the likelihood of readmission. There is also some evidence that improvements in patient experience are associated with improved use of resources such as length of stay, readmissions, and primary care use[44]

148. With respect to how patient experience benefits could translate into economic benefits, the NICE Guidance Development Group[45] considers that initial costs may be offset by reduced cost elsewhere (p. 19), and that there may be avoided cost due to improved safety, efficiency and effectiveness of healthcare (p.50). However, there is no available evidence on these potential benefits for mental health care interventions.

149. Once the improved safeguards that allow patients to be more involved in the decision making process are introduced, alongside more opportunities to review and challenge the detention and the replacement of the nearest relative with a NP, there is the potential for some detentions to be reduced in length. Since longer detentions have a direct cost pressure on NHS budgets, there could be large expected benefits realised if the improved safeguards were to result in a reduction in the average length of a detention. This would mean a cost saving for the NHS which could then be put to use elsewhere in the Healthcare system and generate further direct health benefits in the form of QALYs elsewhere in the economy. This benefit has not been monetised due to the lack of clear evidence on exactly whether or how much length of stays are likely to be reduced by following the introduction of the policy changes outlined in this IA. As an illustration, the breakeven analysis section explores further the degree to which average detention lengths would need to fall by for the costs of the policy to be offset by this benefit alone.

150. **For the individual.** With the proposed changes to the MHA, it is expected that there will be significant beneficial impacts on wellbeing and health for patients who are detained under the MHA compared to the status quo. For example, if patients participate in their CTP, have increased access to IMHAs, AMHPs and SOADs, are automatically referred to the MHT on a more regular basis, then they have more opportunities to voice any concerns and have their detention reviewed by the relevant professionals. Also, if they are eligible for discharge at this stage, this could happen sooner than it might otherwise have, reducing demand for hospital beds.

151. These health impacts may be realised in the form of improvements to the patient's original condition as a result of more personalised and targeted treatments or they could be gained through a reduction in the stress or anxiety that patients may face during detentions after the safeguards implemented by the policy improve the overall patient experience. As mentioned above, there is

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[41] Giacco, D., Conneely, M., Masoud, T., Burn, E., & Priebe, S. (2018). Interventions for involuntary psychiatric inpatients: A systematic review. *European Psychiatry, 54*, 41-50. doi:10.1016/j.eurpsy.2018.07.005. Also accessed at: Interventions for involuntary psychiatric inpatients: A systematic review | European Psychiatry | Cambridge Core

[42] Akther, S., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: Systematic review and qualitative meta-synthesis. *BJPsych Open, 5*(3), E37. doi:10.1192/bjo.2019.19. Also accessed at: Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis | BJPsych Open | Cambridge Core

[43] Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., Rose, D., Wykes, T. & Yeeles, K. (2009). Patients' views and readmissions 1 year after involuntary hospitalisation. The British Journal of Psychiatry, 194, 49–54. doi: 10.1192/bjp.bp.108.052266. Also accessed at: 49 49..54 (cambridge.org)

[44] Doyle, C., Lennox, L., & Bell, D. (2012) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013; 3(1). Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549241/

[45] National Institute for Health and Clinical Excellence (24 February 2012). Patient experience in adult NHS services: improving the experience of care for people using adult NHS services – Clinical guideline [CG138] (then go to 'Full Guideline'). Accessed at: https://www.nice.org.uk/guidance/cg138/evidence (or: https://www.nice.org.uk/guidance/cg138/evidence/full-guideline-pdf-185142637)

evidence that improvements in patient experience and patient engagement are associated with increased adherence to treatment and have a beneficial impact on health outcomes.

152. These improved outcomes would be expected to have some direct health benefits to patients. However, due to the wide range of the conditions and circumstances experienced by patients detained under the MHA, it has not been possible to quantify these benefits as a reduction in QALY losses[46].

153. **ACDs.** International and national evidence[47] suggests that the majority of people with severe mental illness are in favour of advance decision making, and research suggests people who have ACDs express feelings of self-determination, autonomy and empowerment[48]. They can also improve therapeutic relationships and trust in mental health professionals – there is evidence suggesting that ACDs may reduce negative coercive treatment experiences, which reduce willingness to interact with mental health services[49]. The collaborative approach of ACDs stimulate communication between health professionals and service users, which may aid in improving therapeutic relationships[50].

154. **Learning Disabilities and Autism.** The proposed reforms, in conjunction with the NHS Long Term Plan's commitments, aim to reduce reliance on specialist inpatient services for people with a learning disability and autistic people through development of appropriate care and support in the community. Evidence heard by the Joint Committee on Human Rights enquiry[51,52] and reports made by the CQC[53,54] have highlighted that the inpatient setting can often be inappropriate for people with a learning disability and autistic people and that it can fail to meet their specific needs, leading to protracted admissions with little therapeutic input. For example, the inpatient setting can be particularly challenging for autistic people as it can often fail to meet their sensory and communication needs. This can lead to a deterioration in their condition. The CQC's thematic review[55] states that sensory overload can result in severe distress which can be displayed as challenging behaviour. Inappropriate detentions risk excessive use of restrictive practices and of closed cultures developing where a person may be at risk of poor quality or abusive care. The Government's proposals aim to limit the scope for detention of individuals with a learning disability and autistic people under the Act and to mitigate against inappropriate detentions by improving community alternatives to avoid needs escalating and prevent crises, by making clear the purpose of detention. Where an individual has a co-occurring mental disorder that warrants treatment under the MHA, the Government's proposals will mean that detention should offer a demonstrable therapeutic benefit and that it is for the shortest time possible.

155. **Wider economic benefits resulting from potential improvements in mental health outcomes.** Under the proposed policy Option 2, it is also expected that there will be significant economic and social gains resulting from the improvements in health and wellbeing of patients detained under the

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[46] QALYs are explained in Annex E.

[47] G.S. Owen, T. Gergel, L.A. Stephenson, O. Hussain, L. Rifkin, A. Ruck Keene (2019). Advance decision-making in mental health – Suggestions for legal reform in England and Wales. International Journal of Law and Psychiatry. 2019; 64:162-177. doi:10.1016/j.ijlp.2019.02.002

[48] Zelle, H., Kemp, K. and Bonnie, R.J. (2015). Advance directives in mental health care: evidence, challenges and promise. World Psychiatry, 14: 278-280. doi:10.1002/wps.20268

[49] Zelle, H., Kemp, K. and Bonnie, R.J. (2015). Advance directives in mental health care: evidence, challenges and promise. World Psychiatry, 14: 278-280. doi:10.1002/wps.20268

[50] Jankovic, J., Richards, F., & Priebe, S. (2010). Advance statements in adult mental health. Advances in Psychiatric Treatment, 16(6), 448-455. doi:10.1192/apt.bp.109.006932

[51] Joint Committee on Human Rights: 'The detention of young people with learning disabilities and/or autism', 1 November 2019. Accessed at: Detention of children and young people with learning disabilities and/or autism (parliament.uk)

[52] Joint Committee on Human Rights: 'Human Rights and the Government's response to COVID-19: The detention of young people who are autistic and/or have learning disabilities', 12 June 2020. Accessed at: Human Rights and the Government's response to COVID-19: The detention of young people who are autistic and/or have learning disabilities - Joint Committee on Human Rights - House of Commons (parliament.uk)

[53] Care Quality Commission (May 2019). Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism. Accessed at: Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism | Care Quality Commission (cqc.org.uk)

[54] Care Quality Commission (October 2010). Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition. Accessed at: Out of sight – who cares? (cqc.org.uk)

[55] As above.

MHA, largely through the improvements in human capital but also through wider impacts on the economy.

156. The Organisation for Economic Cooperation and Development (OECD) has published a series of reports on the social and economic burden that arises as a result of mental ill-health in society[56] [57] [58]. The reports find that mental illnesses contribute significantly to unemployment, sickness absence and lost productivity at work. They also report that people with severe mental illness also die up to 20 years younger, have a much higher rate of unemployment and typically have lower incomes than the general population. There is evidence to support that higher numbers of health risks and health conditions are associated with lower levels of productivity[59]. It is therefore expected that mental health patients formerly detained under the MHA would contribute more to the economy due to better mental (and likely physical) health outcomes and overall improved wellbeing.

157. There is evidence demonstrating that mental health problems have negative impacts on an individual's family, peers, employers, and wider society[60]. There is also evidence that families of those with a range of physical health conditions, particularly those who are informal carers, are more likely to experience absenteeism or presenteeism, leading to reduced work productivity, poorer physical activity leading to a reduction in overall wellbeing and greater incidence of anxiety and depression[61,62]. If this is also true of family members of some of those with mental health conditions, implementation of the Government proposals that improve mental health outcomes could have significant benefits for patients' families and wider networks as well as societal benefits through human capital.

158. Only a proportion of patients and their families will impact labour market outcomes through their wellbeing gains. The largest impacts will be for those of working-age. Additionally, only wellbeing gains in the community will generate full productivity or workforce impacts, whereas wellbeing improvements for involuntarily detained patients will not impact the wider economy significantly until they leave hospital and feel ready to start working or volunteering, for example.

159. **Health research and improvements in data.** The NIHR funding for new research projects that aim to reduce the number of compulsory hospital admissions for people with serious mental health problems detained under the MHA and improve the experiences of patients and their families and friends should lead in the future to non-monetised benefits as, according to the literature, improved healthcare research could produce a range of wider benefits through 5 broad categories of impact: (1) 'primary research-related impact', (2) 'influence on policy making', (3) 'health and health systems impact', (4) 'health-related and societal impact', and (5) 'broader economic impact' [63,64].

160. The benefits associated with improvements in health and justice data are difficult to monetise. These are long term benefits that are likely to be instrumental to making the right decisions around patient care and treatment. For example, the Government proposals should help to deliver a better

[56] OECD (17 January2012). Sick on the Job? Myths and Realities about Mental Health and Work. Mental Health Work. Accessed: http://www.oecd.org/els/mental-health-and-work-9789264124523-en.htm
[57] OECD(8 July 2014). Making Mental Health Count. The Social and Economic Costs of Neglecting Mental Health Care. Accessed at: https://www.oecd.org/publications/making-mental-health-count-9789264208445-en.htm
[58] OECD (4 March 2015). Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work. Mental Health Work. Accessed at: http://www.oecd.org/employment/fit-mind-fit-job-9789264228283-en.htm
[59] Mitchell, R.J. & Bates, P. (2011). Measuring Health-Related Productivity Loss. *Population Health Management*, 14(2): 93–98. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128441/
[60] As above.
[46] Mazanec, S. R., Daly, B.J., Douglas, S.L. and Lipson, A.R. (2011). Work Productivity and Health of Informal Caregivers of Persons With Advanced Cancer. Research in Nursing & Health Nurs Health, 34(6): 483–495. doi: 10.1002/nur.20461 (also accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4381346/)
[47] Alzheimer's Disease International and Karolinska Institutet (4 July 2018). Global estimates of informal care. Accessed at: https://www.alz.co.uk/news/global-estimates-of-informal-care
[63] Cruz Rivera S, Kyte DG, Aiyegbusi OL, Keeley TJ, Calvert MJ (2017). Assessing the impact of healthcare research: A systematic review of methodological frameworks. PLoS Med 14(8):e1002370. https://doi.org/10.1371/journal.pmed.1002370. (also accessed at: https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002370)
[64] Kuruvilla, S., Mays, N., Pleasant, A. & Walt, G. (2006). Describing the impact of health research: a Research Impact Framework. BMC Health Services Research, 6:134. Accessed at: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-6-134

understanding of the relationships between individuals' protected characteristics and the likelihood of them responding in positive ways to particular types of care and treatment; and, in particular better able to identify risks around specific groups who may have more difficulty accessing the correct level of care and ending up 'falling through the cracks'.

Non-monetised economic benefits to the Justice system

161. It is anticipated that commitments to ensure that those in the criminal justice system are able to access care as quickly and early as possible (such as increasing the timeliness of transfers and stopping prison being used as a place of safety on the grounds of mental health) would also contribute to efficiency gains in other parts of the justice system of England and Wales.

162. It is known that for some mental health problems the earlier an individual receives mental health treatment the more effective it can be. This is because, if left untreated, especially in the wrong environment, the problem can worsen and become harder to eventually treat, and take more time and resource to resolve for health providers. Lengthy delays in prisoner transfer to secure hospitals can lead to mental health conditions deteriorating and becoming more entrenched. We anticipate that ensuring individuals are able to access appropriate care faster will therefore lead to improved health outcomes, both short and long term, and help ensure treatment is more cost-effective.

163. In terms of justice system impacts, prisoners awaiting transfer to secure hospitals and those remanded to prison with serious mental health needs can be highly demanding of prison staff time as they often require intensive monitoring and individualised support. Tackling lengthy delays in prison transfers and stopping prison being used as a place of safety on the grounds of mental health will therefore alleviate pressure on staff time within HMPPS which could be reallocated towards other priorities.

164. There would also be benefits in reducing the emotional and psychological toll on prison officers who must deal with prisoners in severe mental distress for prolonged periods, which should result in a happier and healthier workforce with reduced staff absences or turnover than would otherwise be the case. There is real risk of prison staff dealing with such situations for long periods who then experience a deterioration in physical and mental health themselves.

165. However, it is not possible to make an accurate assessment of the scale of these expected Justice system impacts.

166. **Other non-monetised benefits.** There are also expected to be large, wider social benefits resulting from the tackling racial disparity where those from ethnic minority backgorounds, particularly those of black African and Caribbean heritage, are currently far more likely to be subject to compulsory powers under the MHA, whether in hospital or in the community.

167. The Government is introducing a new Organisational Competency Framework, which will support NHS mental healthcare providers work with their local communities to improve the ways in which patients access and experience treatment. This should be addressed by the NHS Long-Term Plan's commitment to develop a Patient and Carer Race Equality Framework (PCREF) in line with the findings of the Independent Review with the goal of improving access, experience and outcomes for black and minority ethnic people[65].

168. Finally, there is evidence that ACDs could provide significant benefits to black service users. Studies from the United States and United Kingdom have shown that ACDs may be most effective among service users of black ethnicity compared to those of other ethnic backgrounds. ACDs

[65] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

resulted in black service users being more likely to have an increased sense of autonomy[66] and being the more cost-effective option[67] compared to other ethnic backgrounds. This is of importance as people of black ethnicity are disproportionately represented in detentions under the MHA. In England during 2019/20, black people were more than four times as likely as White people to be detained under the MHA[68]. Therefore, ACDs may help to reduce the racial disparity that exist among service users and by proportionately reducing rates of compulsory admissions for black service users, and lead to levelling up of these racial disparity.

Summary of quantified benefits and Breakeven Analysis

169. The benefits associated with the proposed policy option are likely to be significant. However, due to the absence of quantitative evidence for these impacts, as explained above, we were only able to monetise some impacts from ACDs and from tribunal cancellation fees in the Justice system – see table below. They are estimated at £337 million over the appraisal period in a central scenario (ranging from £95 million to £525 million).

Table 26. Summary of total monetised benefits (central scenario, £millions, 2020/21 prices, discounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Central scenario											
Reduced detentions following ACDs	23	34	34	34	35	35	35	35	35	36	**336**
MHT cancellation fees	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
Total	23	34	34	35	35	35	35	35	35	36	**337**
High scenario											
Reduced detentions following ACDs	36	53	53	54	54	54	55	55	55	55	**524**
MHT cancellation fees	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
Total	36	53	54	54	54	54	55	55	55	56	**525**
Low scenario											
Reduced detentions following ACDs	6	10	10	10	10	10	10	10	10	10	**94**
MHT cancellation fees	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
Total	7	10	10	10	10	10	10	10	10	10	**95**

Notes: Monetised benefits were discounted at 1.5% per year for those associated with the Health system and at 3.5% for those associated with the Justice system

[66] Elbogen, Eric & Van Dorn, Richard & Swanson, Jeffrey & Swartz, Marvin & Ferron, Joelle & Wagner, H. & Wilder, Christine. (2007). Effectively implementing psychiatric advance directives to promote self-determination of treatment among people with mental illness. Psychology, public policy, and law : an official law review of the University of Arizona College of Law and the University of Miami School of Law. 13. doi:10.1037/1076-8971.13.4.273.

[67] Barrett B, Waheed W, Farrelly S, Birchwood M, Dunn G, Flach C, et al. (2013) Randomised Controlled Trial of Joint Crisis Plans to Reduce Compulsory Treatment for People with Psychosis: Economic Outcomes. PLoS ONE 8(11): e74210. doi:10.1371/journal.pone.0074210

[68] Mental Health Statistics Annual Figures 2019/20. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures

Breakeven analyis

170. To complement this approach, we estimate how large non-monetised benefits need to be in order for the costs of the policy to be offset by them and illustrate them using required reductions in length of stay, reductions in readmissions and improved quality of life.

171. We first estimate the base cost of a length of stay using NHS Reference costs[69] and add on the additional estimated policy costs associated with detentions in Option 2 (i.e., excluding costs associated with CTOs, informal patients and ACDs); then we divide this total cost by the number of detentions to give an indication of the new average cost of a detention following the implementation of the policy (see annex B.I).

172. To provide an idea of the magnitude of the additional cost per detention, we have also estimated the current average cost of a detention under BAU using the same method with BAU costs rather than policy costs. We can then determine that, if the average cost of a detention following policy implementation is £1,100, for example, compared to an average BAU cost per detention of £1,000, this would be an increase in costs of £100 or close to 10%.

173. Once we subtract the BAU cost of a detention from the policy cost of a detention (see Annex B.I), we estimate how large the non-monetised benefits need to be to offset the extra cost – e.g., if the additional cost per patient is £100 then we would need benefits valued at around £100 to offset this cost. The estimated additional average unit cost of a detention across the 10 year legislation period increases by around 5% or around £1,200 (undiscounted cost) after the policy implementation (see annex F).

174. **Reduced length of stay.** The current average length of a detention is roughly estimated to be 51 days (see Annex F), and the average daily cost of a detention is estimated at around £490 under BAU (£24,600 divided by 51) and at around £510 after the implementation of the policy (£25,700 divided by 51). This would suggest that, if the only benefit that is realised after the introduction of the policy was a reduced length of stay in the average detention by 2.3 days (around £1,200 the difference between cost of a detention under BAU and under the policy, divided by the estimated daily cost of a detention under BAU at £490) and the subsequent increase in available beds for other patients, then the policy costs would be offset by the benefits – see Annex F for further detail. This could be achieved through the deinstitutionalisation of patients who previously were subjected to long-term detentions but now have better access to appeals and care treatment plans and therefore a higher chance of discharge.

175. **Repeated detentions.**Similarly, improved patient safeguards and involvement in decision making could also lead to improved treatment adherence and, in turn, a reduction in the number of people with repeated detentions. On average from 2017/18 to 2019/20, around 15.4% of people are detained more than once in a year – under 6,500 people in 2019/20[70]. Dividing the additional annual policy cost by the estimated cost of a detention[71] produces the required reduction in the number of detentions to make the overall policy cost effective – this is estimated at around 3,000 per year on average during the 10-year period. Assuming that, in the absence of intervention, the proportion of repeated detentions would remain constant at around 15.4% for the 10 year legislation period, we estimate that this would need to fall to 10.5% for the costs of this policy to be completely offset by the savings gained from a reduction in the number of repeat detentions – see Annex F for further detail.

[69] NHS England and NHS Improvement (January 2020). 2018/19 National Cost Collection data – National schedule of NHS costs (tab MHCC – Mental Health Care Clusters). Accessed at: https://www.england.nhs.uk/national-cost-collection/

[70] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019/20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

[71] The overall policy proposals do not focus on detainees only, i.e., also include interventions on ACDs, CTOs, and involuntary patients. When we estimated the additional policy costs associated with those detained only, then it is sufficient to reduce repeated detentions by around 700 per year (reducing the percentage of repeated detentions from 15.4% to 13.4%) to make the policies associated with detentions cost effective.

176. **Direct health improvements**. Alternatively, benefits may be realised in terms of direct health improvements, which materialise either after detained patients respond better to treatment (where they are more involved) or simply through patients experiencing less stress and anxiety resulting from a poor experience whilst being detained. For these health benefits to completely offset the costs of the policy in each year, we divided the additional overall cost of the policy in each year by £60,000 to work out the number of QALYs this would be equivalent to. Then this was divided by the number of people detained (i.e., some with repeated detentions) in each year to work out the health gains that would need to be gained per detention. It is estimated that each detention would need to provide a health improvement (reduction in health loss) equal to 0.03 QALYs for the costs of the policy to be offset, and would suggest that, illustratively, the person would need to experience perfect health for around 10 days in the year following treatment (0.03*365 days = 10 days)[72].

177. **Changing the first detention renewal point from 6 months to 3 months and improvements in patient safeguards and patient experience** are expected to reduce the length of detentions and improve health outcomes. This change may also help to disperse the spike in discharges currently seen at 6 months, potentially saving over 25,000 detention days per year, equivalent to around 0.4 days per detention. This alone would not offset the costs of the policy but is another example of the potential ways that the Government proposals could lead to potential monetary savings in the form of reduced detention lengths. Annex F contains further detail of this calculation.

178. It is not expected that any of these potential benefits will offset the costs of the policy entirely when analysed in isolation. However, since the policy is expected to lead to improvements in all three areas, it is very plausible that some combination of these benefits could offset the costs of the policy.

Risks and Assumptions

179. This section explores how sensitive the estimated total discounted costs over a 12-year period (i.e. the Net Present Value, NPV[73]) are to potential variations in key input variables or assumptions. These are presented separately for the Health and Social Care system and for the Justice system.

Sensitivity Analysis – Health and Social Care System

180. We present in the table below the key assumptions in each model for the central scenario and for alternative scenarios – a best and worst case scenario (these are the highest and lowest possible costs estimates). The different models for detentions and CTOs are explained in their respective annexes; for the other models, in the absence of other evidence, various logical ranges have been applied to try and understand how costs in Present Value terms will change if the central scenario does not arise.

181. Due to the complexity of the modelling, we have limited this section to the assumptions that have the greatest impact on costs – see table 27 below. We then present the impact on costs when each key assumption varies and all the other remain constant under a central scenario. This is followed by a summary section covering two scenarios where we vary some key assumptions simultaneously and assess the impact on estimated total costs.

[72] When using cost associated with policies focussing on detentions only (i.e., not including ACDs, CTOs, and involuntary patients), then each detention would need to provide a health improvement (reduction in health loss) equal to 0.01 QALYs for the costs of the policy to be offset, i.e., the person would need to experience perfect health for around 2.3 days in the year following treatment (0.01*365 days = 2.3 days).

[73] According to the Green Book, Net Present Value (NPV) is a generic term for the sum of a stream of future values (that are already in real prices) that have been discounted (in the Green Book by the social time preference rate) to bring them to today's value.

Table 27. Summary of key assumptions and sensitivities

Models	Assumption	Central scenario	Low cost scenario	High cost scenario
Detention population	Growth factor	2.05% increase per year	1.64% increase per year	2.46% increase per year
	Decrease due to the NHS LTP	10% decrease per year (on top of the 2.05% increase above, so 7.95% decrease overall)	12% decrease per year (on top of the 2.05% increase in the central scenario, so 9.95% decrease overall)	8% decrease per year (on top of the 2.05% increase in the central scenario, so 5.95% increase overall)
CTO population	Decrease due to recommendations	40% decrease over 5 years	48% decrease over 5 years	32% decrease over 5 years
IMHAs	IMHA uptake	40%	32%	48%
	Salary unit costs (including oncosts and overheads)	£51,977	-20%	+20%
AMHPs	Additional workload due to the proposals	30.3 hours	-20%	+20%
	Salary unit costs (including oncosts and overheads)	£76,921	-20%	+20%
SOADs	Rate of SOAD visits per Detainee type (Refusal, Incapable, ECT, CTO)	0.07-1.64	-20%	+20%
	Unit costs per visit	£403	-20%	+20%
Clinical teams	Additional workload due to recommendations	Central estimates across different staff types	-20%	+20%

Number of detentions and Community Treatment Orders (CTOs)

182. **Detentions**. In the central scenario we assume that detentions would increase by 2.05% over the appraisal period – this is a change from the 6% annual increase assumption in the consultation IA, which was revised in light of more recent data (see Annex B.I for further detail). We assume that the increase may range from 1.6% (which is based on average changes year-on-year for providers submitting good quality data to the Mental Health Services Dataset since 2016/17)[74] to 2.5%, which is the highest yearly change observed in the last few years (in 2014/15).

183. The impact of the NHS LTP, which includes ambitions to improve mental health community services and crisis care is assumed to lower detentions by an approximately 10%. However, the exact impact of the LTP is not known and we are assuming a range of 8% change (worst case) or 12% decrease (best case).

184. **CTOs**. In the central scenario we assume that detentions would remain constant with the average of MHSDS 2017/18 to 2019/20 as the baseline in the absence of any policy changes – this is a change from the 1.2% annual increase assumption in the consultation IA, which was revised in light of more recent data (see Annex B.II for further detail). This assumption is based on historical data from the previous ten years not showing any obvious trend, when considering both the previous dataset before 2016/17 (KP90) and the new dataset (MHSDS) since 2016/17 (see Annex B.II). After consulting colleagues from NHSD, we have decided to assume a flat forecast for the central scenario. Since we assumed a 'remains constant' forecast, we do not consider this assumption as part of the sensitivity analysis. We also assumed that the impact of the Independent Review recommendations would lower the number of CTOs – in the absence of evidence we assume a

[74] NHS Digital. Mental Health Act Statistics, Annual Figures. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures

decrease of around 40% in the central scenario, which is aligned with the expectations of the Review, with a range from 32% (worst case) to 48% decrease (best case).

185. Using the assumptions in table 27 at the start of this section, our estimates are in the table below. They show that the clinical teams and SOAD models are both sensitive to the forecast of detentions, with the clinical teams costs possibly increasing or decreasing by around £25 million (±2%) based on the two scenarios that have been tested. On the other hand, the percentage change of AMHPs is sensitive to alterations made to the assumptions that forecast CTOs, with costs changing by over £3 million (±7-8%) if CTOs were to decrease by 32% a year rather than a 40% under the central scenario.

Table 28. Impact of varying assumptions for detentions and Community Treatment Orders (CTOs) on NPV relative to the central scenario (2020/21 prices, discounted, including opportunity cost)

Assumption	Scenario	IMHAs		AMHPs		SOADs		Clinical teams		Total effect	
		Change in NPV (£millions)	% change in NPV	Change in NPV (£millions)	% change in NPV	Change in NPV (£millions)	% change in NPV	Change in NPV (£millions)	% change in NPV	Change in NPV (£millions)	% change in NPV
Model: Detentions											
Growth factor	Central 2.05%	118.3	-			121.6	-	1,372.2	-	1,790.1	-
	1.64%	1.6	1%			-4.3	-4%	-25.0	-2%	-27.6	-2%
	2.46%	-1.7	-1%			4.4	4%	25.5	2%	28.2	2%
Decrease due to the NHS LTP	Central – 10%	118.3	-			121.6	-	1,372.2	-	1,790.1	-
	8%	-0.9	-1%			2.2	2%	13.1	1%	14.5	1%
	12%	0.9	1%			-2.2	-2%	-13.1	-1%	-14.5	-1%
Model: CTOs											
Decrease under the MHA Review recommendations	Central 40%	118.3	-	39.2	-	121.6	-	1,372.2	-	1,790.1	-
	32%	0.8	1%	3.1	8%	1.0	1%	19.9	1%	24.8	1%
	48%	-0.8	-1%	-2.8	-7%	-1.0	-1%	-19.9	-1%	-24.5	-1%

Professional groups: IMHAs, AMHPs, SOADs and clinical teams

186. Using the assumptions in tables 27 and 28 at the start of this section, our estimates are in the table below. The first key impact to highlight is the clinical teams' increase in hours following the implementation of the recommendations, as flexing these times by 13% could increase or decrease costs by around £230 million. The overall costs of SOAD visits are also quite sensitive to changes in the rate of visits and unit costs associated with these visits, where an illustrative increase or decrease of 20% could lead to an increase or decrease of around £24 million in costs.

Table 29. Impact of varying assumptions for professional groups on the Net Present Value (NPV) in relation to the central scenario (2020/21 prices, discounted, including opportunity cost)

Assumption	Scenario	Profession		Total effect
		Change in NPV (£millions)	% change in NPV	% change in NPV
IMHAs				
	Central	118.3		
Uptake (Central: 40%)	32%	-25.0	-21%	-1%
	48%	25.0	21%	1%
Salary unit costs (including oncosts and overheads) (Central: £51,977)	-20%	-21.6	-18%	-1%
	+20%	21.6	18%	1%
AMHPs				
	Central	39.2		
Additional workload (Central: 31.15 hours)	-20%	-7.7	-20%	0%
	+20%	8.1	21%	0%
Salary unit cost (including oncosts and overheads (Central: £76,921)	-20%	7.9	-20%	0%
	+20%	-7.9	20%	0%
SOADS				
	Central	121.6		
Rates of SOAD visits (Central: 2017/18 rates: 0.07-1.64)	-20%	-24.3	-20%	-1%
	+20%	24.3	20%	1%
Unit costs (Central £403)	-20%	-24.0	-20%	-1%
	+20%	24.0	20%	1%
Clinical teams				
	Central	1,372.2		
Additional workload (Central)	-20%	-225.7	-16%	-13%
	+20%	225.7	16%	13%

Sensitivity Analysis – Justice System

187. Due to the uncertainties involved with economic appraisal, sensitivity analysis has been conducted with respect to the Government proposals.

188. Some of the principal assumptions, and the associated ranges are set out below. Additional details regarding the automatic referral proposals are contained in Annex D:

- Recommendation 46c detention periods: expected increase in section 3 applications of between 25% and 50%, the central scenario employs the midpoint of 37%.
- Recommendation 53 automatic referrals for Part III patients: expected increase in section 71(2) referrals of between 290% and 360% due to varying estimation methodologies; the central scenario employs the midpoint of a 325% increase;
- Recommendation 137 automatic referrals for people on conditional discharge: the annual volumes of referrals vary depending on the success rate of achieving absolute discharge (i.e., no conditions attached because the criteria for detention are no longer met) for the cohort of patients being automatically referred in previous years. These success rates differ depending on the duration spent on conditional discharge at the time of the tribunal hearing. At the 2 year point the success rate varies between 3% and 7%; the central scenario employs the midpoint of 5%. At the 6 year point the success rate varies between 30% and 36%; with the central scenario employs the midpoint of 33.
- Recommendations 61 and 64 automatic referrals for CTO patients: reduction of CTO volumes of 60% in the low cost scenario, a 20% reduction in the high cost scenario and a 40% reduction in the central cost scenario; these parameters reflect the assumptions used in the Health and Social Care system sensitivity analysis;
- Recommendation 46e certifying 10 days in advance of a tribunal hearing that a section 3 patient continues to meet the criteria for detention: the estimated benefits are dependent on the assumption that, across all scenarios, MHT panel members can be reallocated in 50% of cancellations, which would mean that there are no cancellation fees to be claimed in these instances.
- Unnumbered recommendation CTP treatment choice: the additional costs are generated by the expected increase in hearing times from considering the statutory CTP. The extra time is put at 20 minutes in the low cost scenario, 40 minutes in the central cost scenarios and 60 minutes in the high cost scenario, as advised by HMCTS operational experts.
- Recommendation 133 leave and transfer of restricted patients: varying annual rate of wage inflation for HMMPS staff ranging of 1%, 2% and 3% for the low, central and high cost scenarios, respectively.

189. The cost estimates of the 3 scenarios are set out in tables 30 and 31 across all of the Government proposals. The total additional cost to the Justice system could range between around £80 million and £210 million in constant prices over the time horizon.

Table 30. Low Cost scenario impacts (£millions, 2020/21prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1.BAU	37	36	34	33	31	30	29	28	27	25	**311**
Option 2.Policy	44	41	49	41	40	38	39	35	34	33	**391**
Additional cost	7	5	14	8	8	8	10	7	8	7	**81**

Table 31. High Cost scenario impacts (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1.BAU	37	36	34	33	31	30	29	28	27	25	**311**
Option 2.Policy	55	51	64	55	54	51	52	47	46	44	**520**
Additional cost	18	15	30	22	22	21	23	19	20	19	**209**

Summary of Sensitivity Analysis

190. Table 32 below shows the impact on the Present Value cost estimates from combining all the high and low assumptions attached to the 3 scenarios. The analysis suggests that all the pessimistic assumptions could cause the total estimated cost of Option 2 to rise to £2.307 billion. In contrast, the optimistic assumptions could case the total additional costs to fall to £1.410 billion.

Table 32. Summary of scenario analysis impacts (£millions , 2020/21 prices, discounted, including NHS opportunity costs)

Policy area	Central cost estimate NPV	High cost scenario NPV	Low cost scenario NPV
IMHAs	118	138	98
AMHPs	39	60	35
SOADs	122	186	73
Clinical Teams	1,372	1,667	1,099
Automatic Referrals	94	191	80
Treatment choice	33	53	16
Leave and transfer categorisation	3	5	2
QI	8	8	8
Total	**1,790**	**2,307**	**1,410**

Private Sector Costs

191. If the burden in the private sector is above £5 million in each year, then an IA requires consideration by the Regulation Policy Committee (RPC, an independent advisory committee) and clearance by the Reducing Regulation Committee (RRC, a Cabinet Sub-Committee). For reassurance that the accepted recommendations in the Independent Review of the MHA will not impose a substantial burden in the private sector, the cost estimates for the private sector are presented below for:
    - the Health and Social Care system – see Annex H for detail on the method;
    - the Justice system.

Health and Social Care System

192. For the Health and Social Care system, the main costs are expected to fall in the professional groups supporting the implementation of improved safeguards: AMHPs and IMHAs, both employed by Local Authorities, SOADs, who are employed by the CQC and clinical teams, either in the NHS or in the independent sector. That is, clinical staff (see section on costs for clinical teams) is the main area where the private sector could potentially incur costs from changes in the MHA.

193. To estimate the impact to the independent sector, we use estimates of independent sector market shares for bed provision for private patients since the most impact will be on those detained in hospital. We assume a worst and highly unlikely scenario that this market share is for detentions. This would also compensate for this market share (beds) not capturing any potential CTOs for private patients in the independent sector – CTOs are patients treated in the community under specific conditions, so outside hospital and not occupying a bed.

194. The acute and secure mental health hospital bed capacity can be split by sector (public or independent sector supply) and by type of funding (public or private funding). In 2018, NHS beds are estimated to account for 67.5% of MH bed provision (public funding/public supply), whilst 29.6% of bed capacity is for services outsourced by the NHS to the private sector and only 2.9% of bed capacity represented privately funded services in independent hospitals[75].

195. The overall average additional cost of clinical teams has been estimated at around £378 million per year (2020/21 prices) for all detained patients, that is, including public and private funding for patients in the public and independent sector.

196. To estimate the costs for private funding and independent sector supply, we applied the 2.9% market share to the overall estimated cost in each year and that provides an estimate of around £1 million per year over the period – this is below £5 million in each year (see table below).

Table 33. Estimated additional monetised costs for the private sector (£millions, 2020/21 prices)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Total additional clinical team costs (undiscounted)	36	34	41	37	37	37	39	38	39	40	**378**
Assuming 2.9% of these costs are for the independent sector/ private patients											
Undiscounted	1	1	1	1	1	1	1	1	1	1	**11**
Discounted	1	1	1	1	1	1	1	1	1	1	**10**

[75] Source: Laing & Buisson (2018). Healthcare Market Review, 31st Ed. London

Justice System

197. Legal Aid is provided by legal firms/ solicitors, but it has not been presented as a direct cost to business as the Government proposals are not a regulatory provision, so they are excluded from the Small Business, Enterprise and Employment Act 2015[76]. In other words, private sector impacts for the Justice system are considered not to have direct cost to business.

Summary and preferred option

198. Overall, Option 2 is considered to be the preferred option as the implementation of the Government proposals is expected to help achieve the policy objectives and make the MHA more fit for purpose. The proposals are expected to bring significant benefits to patients interacting with the MHA through increasing patient choice and autonomy over their treatment, ensuring they are treated with dignity and respect, improving inpatient therapeutic environments and promoting equality throughout the process. This also aligns with the general view from the responses to the public consultation, which overall support the view that the proposed changes in the MHA would bring significant benefits to patients through increasing patient choice and autonomy over their treatment, ensuring they are treated with dignity and respect, improving inpatient therapeutic environments and promoting equality throughout the process.

199. Over the 12 year time horizon, the estimated net benefit are estimated to be -£1,450 million in 2020/21 prices and in Present Value terms. This pertains to monetised benefits estimated at £340 million minus costs (including health opportunity costs) estimated at £1,790 million. Whilst only a narrow range of benefits has been monetised at this time, the evidence on the cost effectiveness of improving mental health outcomes suggests that there would likely be considerable tangible and intangible benefits associated with a policy that specifically improves safeguards and the patient journeys of people with mental health conditions. Option 2 is therefore expected to be an overall net benefit when compared to the counterfactual, Option 1.

[76] http://www.legislation.gov.uk/ukpga/2015/26/section/22/enacted

Annex A. List of acronyms

ACD – Advance Choice Document

AMHPs – Approved Mental Health Professionals

BAU – Business As Usual

CETR – Care (Education) and Treatment Reviews

CQC – Care Quality Commission

CTO – Community Treatment Order

CTPs – Care and Treatment Plans

DHSC – Department of Health and Social Care

ECT – Electro-Convulsive Therapy

FTE – Full-Time Equivalent

HMCTS – Her Majesty's Courts and Tribunals Service

HMPPS – Her Majesty's Prison and Probation Service

IA – Impact Assessment

IMHAs – Independent Mental Health Advocates

IRCs – Immigration Removal Centres

MHA - Mental Health Act 1983

MHCS – Mental Health Casework Section

MHRTW – Mental Health Review Tribunal for Wales

MHT – Mental Health Tribunal

MoJ – Ministry of Justice

NHS – National Health Service

NHS LTP – NHS Long Term Plan

NHSD – NHS Digital

NHSEI – NHS England and Improvement

NIHR PRP – National Institute for Health Research Policy Research Programme

NP – Nominated Person

PCREF - Patient and Carer Race Equality Framework

QI – Quality Improvement

RC – Responsible Clinician

SOADs – Second Opinion Appointed Doctors

Annex B. Methodological summaries of models used in estimating costs and benefits concerning the Health and Social Care System

B.I. Estimating the baseline and forecasting the number of detentions under the Mental Health Act and their average cost

1. The number of detentions under the MHA anticipated in future years will directly affect the cost and benefit estimates of implementing the policy proposals set out in the White Paper (Option 2).

2. The scenario on how detentions could change in the future is included in the business as usual (BAU) option, which pertains to the status-quo with no new national policies implemented (Option 1).

3. In brief, the BAU approach assumes that:

    - Detentions under the MHA would increase by 2.05% per year (based the adjusted average estimates from NHSD) if no policy improvements took place.
    - Then, we assume in our central scenario that detentions would decrease by 10% per year, following improvements in mental health community care proposed and implemented within the NHS Long Term Plan (LTP)[77]; this reduction is in line with the expectations in the Independent Review.
    - This is modelled as a 10% phased decrease over 5 years from 2023/24 (i.e., reaching 10% decrease on 2027/28) and the number of detentions will continue to increase by 2.05% after the reduction effect has fully take place in 2027/28.

Summary of model

4. Purpose of model: To estimate the number and cost of detentions during the policy period for BAU, split by MHA section.
5. Main outputs:
    - Number of detentions
    - Estimated cost of a length of stay (i.e., excluding MHA assessments
6. Main data sources: Mental Health Services Data Set (MHSDS), from 2016/2017 to 2019/20
7. Data caveats**:**
    - The Mental Health Services Data Set (MHSDS) data are still improving and undercounts detentions
    - Estimated increase in detentions from NHSD from 2016/17 to 2019/20 is based on a subset of providers providing good quality data in 2015/16 (KP90), and in 2016/17 to 2019/20 (see Annex H for change in data collection method)
    - There are only 4 years of MHSDS data, with an undercount of detentions in the first two years
8. Main assumptions – Option 1 (BAU)
    - Baseline number of detentions: The baseline is set at 2019/20 MHSDS data and is estimated at 50,900 detentions.
    - Annual increase in detentions is assumed to be 2.05% − this is based on the estimated change included in the annual MHSDS reports. The estimation is based on a subset of providers providing good quality data in 2015/16 (KP90) and in the subsequent years in MHSDS. For 2019/20, instead of using the estimate in the annual report (as it is only based on a small set of 24 providers), we use the actual percentage change in the number of detentions from 2018/19 to 2019/20.

[77] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

- Then, this increase in detentions is countered by a reduction in detentions following from planned improvements in mental health community and crisis care services in the NHS LTP. The NHS LTP is assumed to contribute to a reduction in the number of detentions from 2023/24, which we estimated to be a gradual reduction of 10% over 5 years. From the fifth year and onwards the forecast for detentions is assumed to continue to increase by 2.05% annually.

9. Main assumptions – Option 2 (Policy)
    - The baseline number of detentions and the assumed effect of the NHS LTP will remain the same under the policy option. A further reduction in the forecasted number of detentions is expected under the policy option due to the preventative effect of Advance Choice Documents (ACDs) – we subtract in each year the estimated number of reduced detentions following ACDs (see Annex B.VII for detail).
10. Cost of length of stay (not including MHA related activities)
    - The cost of the length of stay in hospital was calculated by multiplying the mean unit cost per bed day (£422) by the average of the median length of stay of detentions subject to section 2 and 3 (51 days). The cost was then inflated to 2020/21 prices using a GDP deflator. The cost of the length of stay in a hospital during a detention in 2020/21 prices is estimated at £23,300.

Data sources and baseline

11. Data published prior to 2016/17 were collected using the KP90 data collection, which was an aggregate data collection[78] (see Annex H). The 2016/17 MHA Statistics publication[79] was the first to use the Mental Health Services Data Set (MHSDS) alongside the 'Annual uses of the Mental Health Act 1983 in English acute trusts' (Acute) collection for 2016/17 and 2017/18[80] (which are not in scope for MHSDS[81]).

12. In our analysis, we mostly make use of data points from MHSDS only as data collected using KP90 and MHSDS is not directly comparable. Although there is an undercount of detentions for the first two years (2016/17 & 2017/18) of MHSDS data, there are 4 data points (2016/17 - 2019/20) from MHSDS and we believe the data quality from MHSDS has improved over the years and become more reliable.

Data caveats

13. KP90 and MHSDS are not comparable data sets:
    - KP90 data were collected in an aggregate form, which did not allow for identifying transfers to another hospital and, therefore, double counted some detentions.
    - This is recorded in the MHSDS, and so can be identified and excluded from the total number of detentions in the year – estimated at 15% in 2016/17.

14. There is an undercount of detentions in 2016/17 and 2017/18:
    - The number of providers submitting data has been improving but not all eligible organisations were yet submitting data, particularly for independent sector providers;

[78] NHS Digital (9 November 2016). Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures. Accessed at: https://webarchive.nationalarchives.gov.uk/20180328135613/http://digital.nhs.uk/catalogue/PUB22571

[79] NHS Digital (30 November 2017). Mental Health Act Statistics, Annual Figures 2016/17 – Experimental Statistics. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/mental-health-act-statistics-annual-figures-2016-17-experimental-statistics

[80] Information on the uses of the Act in hospital emergency departments has been collected via the Emergency Care Data Set (ECDS) from 2018/19, the first year of this dataset.
Source: NHS Digital (29 October 2019). Mental Health Act Statistics, Annual Figures 2018-19: Background Data Quality Report (p.3). Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures

[81] This was approved as a temporary collection method pending the introduction of a new Emergency Care Data Set, which records uses of The Act in hospital emergency departments. Source: NHS Digital (30 November 2017). Mental Health Act Statistics, Annual Figures 2016/17: Background Data Quality Report – Experimental Statistics. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/mental-health-act-statistics-annual-figures-2016-17-experimental-statistics

- Data for individual providers are also incomplete, particularly for independent sector providers and acute trusts.

Option 1. BAU Model

15. This model is intended to project the number of detentions under the counterfactual. To do this we have calculated a baseline number of detentions and an annual growth rate. We also estimated the cost of a length of stay, which was then added to the estimated cost of MHA related activities and used in the breakeven analysis of costs/benefits.

16. Detention baseline:
    - The baseline is assumed to be the latest published annual number of detentions in 2019/20 MHSDS data[82], which is 50,893. We rounded up the number to the nearest hundreds to 50,900.
    - This baseline was projected forward using the growth assumption.

17. Growth rate – we used an estimated annual percentage increase of detentions of 2.05% per year:
    - We are aware of the data quality issues of the first two years of MHSDS data (2016/17 & 2017/18). However, after considering the low comparability of the KP90 and MHSDS data, the new data points for MHSDS data (2018/19 & 2019/20) and how NHSD has used the smaller subset of provider to estimate the annual percentage increase in MHSDS data, we have decided to use only the data collected from MHSDS.
    - The estimates of annual percentage increase of detentions by NHSD published in their annual report are based on a subset of providers that has submitted good quality data in 2015/16 (KP90) and continue to do so since the switch to MHSDS. We used these estimates until 2018/19.
    - The number of providers included in the subset has been falling and were only 24 in 2019/20 – see table below. This is a limited number of providers and we were concerned about not underestimating the annual increase in detentions. Therefore, to estimate the annual percentage change from 2018/19 to 2019/20, we used the published annual number of detention figures – see table below.

Table BI.1. Number of detentions in England, and percentage increase estimated by NHS Digital

	2016/17	2017/18	2018/19	2019/20	Average
Number of detentions	45,864	49,551	49,881	50,893	
Percentage increase year-on-year				1.81%	
Estimated annual increase based on the subset of providers published by NHSD	2%	2.4%	2%	0.8%	
Number of providers included in the subset of providers for NHSD estimates	35	33	28	24	
Percentage increase for calculating annual growth rate	2%	2.4%	2%	1.81%	2.05%

Notes:
- The published number of detentions in 2016/17 and 2017/18 (45,864 and 49,551, respectively) were considered an undercount and therefore we used the estimated percentage increase published by NHSD in their annual MHA Statistics for these years[83,84].

[82] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019/20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

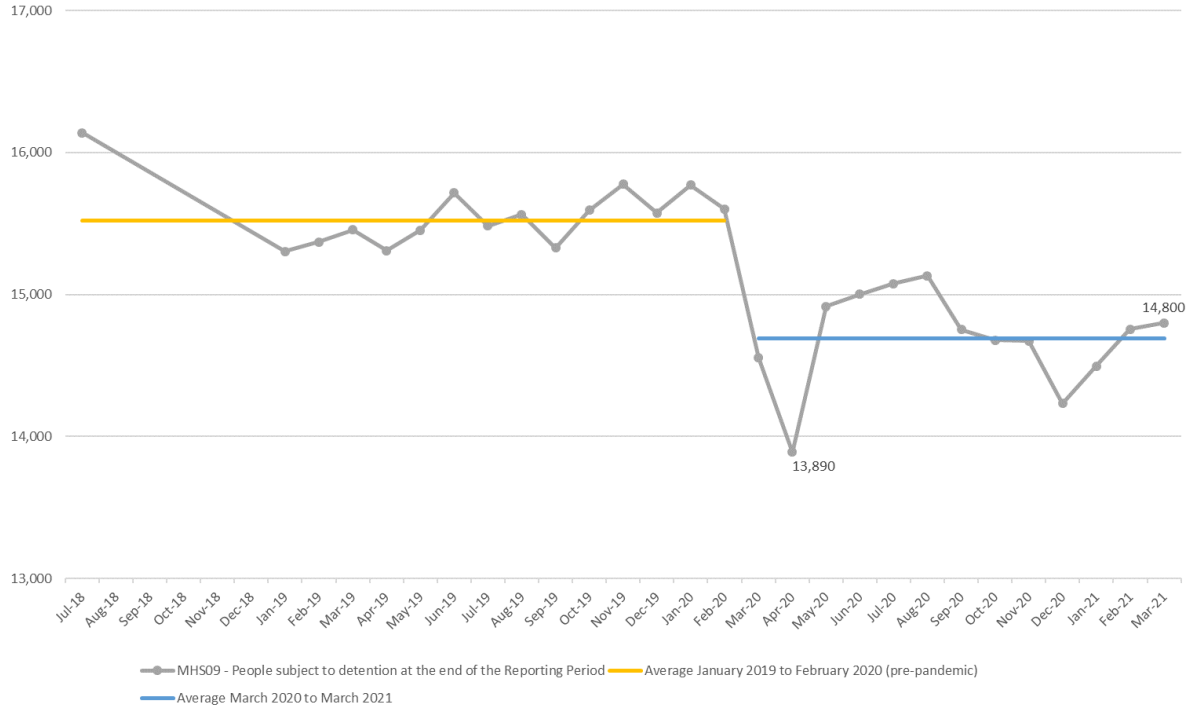
[83] NHS Digital (30 November 2017). Mental Health Act Statistics, Annual Figures 2016/17 – Experimental Statistics. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/mental-health-act-statistics-annual-figures-2016-17-experimental-statistics

[84] NHS Digital (9 October 2018). Mental Health Act Statistics, Annual Figures 2017/18. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures

- To estimate yearly changes, NHSD uses a subset of providers who have provided good quality data since 2015/16, the last year of KP90, and this number has been decreasing from 35 in 2016/17 to 33 in 2017/18, 28[85] in 2018/19 and 24[86] in 2019/20.
- We took a conservative approach and decided not to use the change in 2019/20 as it is based on a small number of providers and could potentially bias the average yearly change in detentions to lower values. The estimated percentage increase in detentions by NHSD in 2019/20 in relation to 2018/19 has not been included in the calculations for the average estimated annual increase in detention from 2016/17-2019/20.

18. **Impact of the COVID-19 pandemic on detentions under the MHA.** We explored whether the COVID-19 pandemic could have led to an increase in detentions from March 2020 (when the first lockdown started), which would have affected the baseline number of detentions in the forecast. The monthly number of detentions from January 2019 to March 2021 is displayed in the figure below, which shows that the number of detentions decreased from around 15,500 in February 2020 (in the run up to the first lockdown) to under 14,000 in April 2020, oscillating in subsequent months around an average of around 14,700, and has not reached pre-pandemic levels yet. Therefore, we have not changed the baseline number explained above to a lower number, as this decrease is most likely due to the response to the pandemic.

Fig. 4. Number of patients detained at month end in mental health hospitals, January 2019 to March 2021
(MHS09 - People subject to detention at the end of the Reporting Period)



Note. The graph displays measure MHS09 - People subject to detention at the end of the Reporting Period.
Source: NHS Digital. Mental Health Services Monthly Statistics. Accessed at: Mental Health Services Monthly Statistics - NHS Digital

19. The Care Quality Commission 2019/20[87] report on monitoring the MHA suggests a few reasons for this decrease in detentions during the pandemic:

[85] NHS Digital (29 October 2019). Mental Health Act Statistics, Annual Figures: Background Data Quality Report - England, 2018-19 Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures
[86] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019-20: Summary Report V1.1. Accessed at: https://files.digital.nhs.uk/99/3916C8/ment-heal-act-stat-eng-2019-20-summ-rep%20v1.1.pdf
[87] Care Quality Commission (2020). Monitoring the Mental Health Act in 2019/20 – The Mental Health Act in the COVID-19 pandemic. Accessed at: Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic | Care Quality Commission (cqc.org.uk)

- Before the first lockdown, all NHS hospitals, including MH trusts, were asked by the NHS Chief Executive to free-up inpatient capacity and maximise staff availability;
- NHS MH services were also asked to review all inpatients with a view to discharge where it was possible and safe to do so;
- At the start of the pandemic, many services saw a reduction in mental health inpatient admissions overall, with some services reporting a larger proportion of first-time admissions under the MHA and more emergency admissions; noting also that more patients seemed to be more acutely unwell than previously.

20. **Reduction in detentions following improvements in services.** The Independent Review expects that if its recommendations are accepted then detentions under the MHA will decrease. It acknowledges that there is "no clear single driver for the rising rates of detention, similarly there is there no simple solution to addressing them" (p. 103)[88]. It also acknowledges that there is not sufficient evidence on the drivers for detentions and that improved research and evaluation should cover alternatives to detention in inpatient settings, interventions to prevent crisis or the escalation of crisis, and the social factors that lead to crises.

21. Their consultation/collection of evidence on what could reduce detentions is summarised by the recommendations below (p.109)[89]:
    - Improved mental health crisis and community-based mental health services, aiming at increasing access to all and to "different disadvantaged groups, including but not limited to LGBTQ+, ethnic minority backgrounds, people with learning disabilities or autism, and asylum seekers and refugees." (p. 106)
    - Research into service models and clinical social interventions that prevent detentions, and consequent policy development of alternatives to detention and crisis prevention.
    - A "concerted, cross-organisation, drive to tackle the culture of risk aversion."

22. The first recommendation above on improved crisis and community services is being taken forward as part of addressed by the NHS LTP[90], published on January 2019. It is further detailed in the NHS Mental Health Implementation Plan 2019/20 – 2023/24[91], published in July 2019, which informs that:
    - From 2019/20, local services are expected to "stabilise and bolster current core community services" (p.26).
    - By 2023/24, there will be 100% coverage of 24/7 age-appropriate crisis care, including (p.30):
        - "24/7 Crisis Resolution Home Treatment (CRHT) functions for adults (…);
        - 24/7 provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions (…)
        - A range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways;
        - A programme for mental health and ambulances, including mental health transport vehicles, training for ambulance staff and the introduction of nurses and other mental health professionals in Integrated Urgent Care Clinical Assessment Services."
    - Also, by 2023/24, all general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults.

23. The Independent Review also recommends further research into service models and clinical social interventions that prevent detentions and actions to tackle the culture of risk aversion. We consider that development into these areas will take longer and will not affect significantly the number in

[88] Department of Health and Social Care. (December 2018). Modernising the Mental Health Act - Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Accessed at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review
[89] As above.
[90] NHS England (January 2019). The NHS Long Term Plan. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[91] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

detentions in the near future in a way that we are able to include them in our estimates of the reduction in detentions.

24. In line with the Review's expectations, we assume that these improvements could lead to a reduction in detentions of around 10%. This reduction is assumed to start in 2023/24, the first year of full implementation of the improvement in crisis care services in the NHS LTP – we assume this to be a 10% phased decrease over 5 years from 2023/24 (i.e., reaching 10% decrease on 2027/28), with number of detentions continue to increase after 2027/28 at the rate of 2.05%.

Option 2. Policy option

25. Under the policy (Option 2), the number of detentions is expected to be lower than in BAU (Option 1) due to the introduction of Advance Choice Documents (ACDs). The calculation of the detentions baseline, growth rate and the impact of NHS LTP are all calculated in the same way as the BAU scenario.

26. The introduction of ACDs under Option 2 is estimated to lead to a reduction in the number of detentions by more than 1,200 every year and around 21,000 detentions in total over the 10-year appraisal period (for details, please see table BI.2 below and Annex B.VII).

Table BI.2. Forecast of detentions under BAU and policy options from 2020/21 to 2032/33

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
Option 1. BAU	51,900	53,000	54,100	54,100	54,000	54,000	53,900
Option 2. Policy	51,900	53,000	54,100	52,900	52,200	52,100	52,100
Reduction in detentions following ACDs	0	0	0	1,200	1,800	1,800	1,900

	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	53,900	55,000	56,100	57,300	58,500	59,700	**776,400**
Option 2. Policy	52,000	53,000	54,100	55,200	56,400	57,500	**755,200**
Reduction in detentions following ACDs	1,900	2,000	2,000	2,000	2,100	2,100	**21,000**

Average cost of a length of stay (not including Mental Health Act assessments and other MHA related activity)

27. The average cost of a length of stay was calculated by multiplying an estimated mean unit cost per bed day (£422) by the mean of the median length of a detention subject to section 2 or section 3 (51 days). The cost was then inflated to 2020/21 prices using a GDP deflator. The cost of length of stay in 2020/21 prices is estimated at around £23,300. This estimate was used in the breakeven analysis of costs/benefits.

28. **Unit cost.** The mean average cost of a MH bed per day is estimated to be £422 (± 1 standard deviation = £379 and £464) (2018/19 prices) – see table below.

Table BI.3. NHS reference costs per bed day by mental health care cluster, 2018/19[92]

Currency Description	Unit cost per occupied bed day
Cluster 00: Variance (unable to assign mental health care cluster code)	£383
Cluster 01: Common mental health problems (low severity)	£371
Cluster 02: Common mental health problems (low severity with greater need)	£408
Cluster 03: Non-psychotic (moderate severity)	£405
Cluster 04: Non-psychotic (severe)	£399
Cluster 05: Non-psychotic (very severe)	£414
Cluster 06: Non-psychotic disorders of over-valued ideas	£411
Cluster 07: Enduring non-psychotic disorders (high disability)	£412
Cluster 08: Non-psychotic chaotic and challenging disorders	£422
Cluster 10: First episode psychosis	£428
Cluster 11: Ongoing recurrent psychosis (low symptoms)	£401
Cluster 12: Ongoing or recurrent psychosis (high disability)	£407
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	£414
Cluster 14: Psychotic crisis	£469
Cluster 15: Severe psychotic depression	£406
Cluster 16: Dual diagnosis	£420
Cluster 17: Psychosis and affective disorder (difficult to engage)	£411
Cluster 18: Cognitive impairment (low need)	£492
Cluster 19: Cognitive impairment or dementia (moderate need)	£502
Cluster 20: Cognitive impairment or dementia (high need)	£498
Cluster 21: Cognitive impairment or dementia (high physical or engagement)	£477
Cluster 99: Patients not assessed or clustered	£326
DHSC analysis:	
Mean average (see note)	£422
Mean - 1 standard deviation (lower estimate)	£379
Mean + 1 standard deviation (upper estimate)	£464

Note: The average includes all the services above, that is both lower cost services that, at face value, seem unlikely for a detention under the MHA, and higher cost services covering dementia, which may also be used less often for detention.

29. **Average length of stay.** As the majority of the detentions under MHA is subject to section 2 and section 3, we decide to use the average of the median length of stay for detentions subjected to section 2 and 3. In 2019/20[93] the median length of stay was 19 days for Section 2 detentions and 82 days for Section 3 detentions, and their average is 51 days.

30. **Limitations of the length of stay data**. This is the first year of publication of the data for length of detention and the statistics are experimental. Continuous spells under the MHA can often be very long and, as MHSDS started data collection in January 2016, the data for length of stay in 2019/20 is likely to be an undercount of the true position due to:
    - Individual MHA periods that ended before January 2016 that were part of a longer spell ending in 2019/20 will not be included.
    - As data quality and coverage can be seen to have increased over time, there will be an unknown number of MHA periods which may have been in scope that have not been submitted to the dataset.

[92] Source: NHS England and NHS Improvement (January 2020). 2018/19 National Cost Collection data – National schedule of NHS costs (tab MHCC – Mental Health Care Clusters). Accessed at: https://www.england.nhs.uk/national-cost-collection/

[93] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019/20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

31. **Estimating costs.** The number of days was multiplied by the cost of a bed day – see table below.

Table BI.4. Estimated cost of a detention under the MHA, 2018/19 (deflated to 2020/21 prices)

Average of median length of stay, days (Formally detained under Mental Health Act Section 2 & Section 3)	Cost (in 2020/21 prices, rounded to the nearest hundred)		
	Lower estimate £415	Mean £462	Upper estimate £508
51	£21,000	£23,300	£25,700

Notes:

- The cost estimates above do not include MHA assessments.
- The lower and upper estimates correspond to the mean minus or plus one standard deviation.

Average cost of a detention

32. To estimate the average cost of a detention, we added the average cost of a length of stay by the average cost of the policies under Option 2 focussing on detentions. We estimated the percentage of overall additional costs for each professional group/policy area by group of patients as shown below:

    - IMHAs: 65% of overall cost pertains to detentions; 30% to informal patients; 6% to ACDs;
    - AMHPs - 90% of overall cost pertains to CTOs, 10% to ACDs;
    - SOADs - 97% of overall cost pertains to detentions, 3% to CTOs;
    - Clinical teams - 95% of overall cost pertains to detentions, 5% to ACDs;
    - Tribunals - 88% of overall cost pertains to detentions, 12% to CTOs

33. Then we added the obtained costs and divided them by the number of detentions in each year to obtain an estimated average cost per detention – see table below.

Table BI.5. Average costs per detention (£, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Average
Option 1.BAU	24,600	24,600	24,600	24,600	24,600	24,600	24,600	24,500	24,500	24,500	**24,600**
Option 2.Policy	25,600	25,600	25,900	25,800	25,800	25,800	25,800	25,700	25,800	25,700	**25,700**
Difference	1,000	1,000	1,300	1,200	1,200	1,200	1,300	1,200	1,200	1,200	**1,200**

Sensitivity analysis

34. See Risks and assumptions section.

B.II. Estimating the number of Community Treatment Orders

1. The use of Community Treatment Orders (CTOs) is expected to reduce following the implementation of the Government proposals following from the Independent Review, particularly due to revised CTO criteria and better discharge planning. It is also likely that improvements in community mental health services will allow for more hospital discharges to be made without the need of a CTO, but we are not accounting for this possibility in the modelling.

2. If all the Review recommendations are implemented, then the Review expected that CTOs would decrease by half in 5 years after implementation. In the absence of evidence supporting this assumption and considering that the detention criteria are not being reviewed at this point, which would affect the potential number of CTOs, we assume that, after 5 years of gradual implementation of the Government proposals, CTOs will decrease by around 40% (instead of the 50% expected reduction).

3. The scenario on how the number of CTOs could change in the future if no change takes place will be included in the business as usual (BAU) option, which pertains to the status-quo with no new national policies implemented. Proposed policy options on reducing CTOs under the MHA can be compared against the BAU Option 1 (the counterfactual) to estimate additional costs and cost savings, staff requirements, etc. and benefits associated with these options.

4. The table below summarises the key assumptions and calculations conducted to estimate the baseline number of CTOs forecasting.

Summary of model

5. **Purpose:** To estimate the number of CTOs during the policy period for BAU and for the policy option.

6. Main outputs: Number of CTOs, Workforce costs relating to CTOs (includes responsible clinicians, nurses, and care co-ordinators, and Potential cost savings from the reduction of CTOs

7. Main data source: MHSDS data from 2017/18 to 2019/20. Note: MHSDS data from 2016/17 has a known downward bias and derived rates and is dropped from the estimation[94,95]. KP90 from 2010/11 to 2015/16 was taken as reference when constructing the model.

8. Data caveats: See section on detentions above.

9. Main assumptions – Option 1 (BAU)

    a. Start date of policy is assumed to be 2023/24, once legislation is expected to be in place.

    b. CTO BAU forecast assumes the number of CTO to remain constant based on the average number of CTO from MHSDS 2017/18 to 2019/20.

    c. Following advice from clinicians, we assumed that contact time (assessment and total contact time for a new patient) for each CTO is as follows: 3 hours for consultants and 27 hours for care coordinators

    d. Hourly costs for consultants and care coordinators are estimated to be £113 and £34 (in 2019/20 price, £121 and £36 when inflated to 2020/21 price).

[94] Although the number of CTOs recorded is similar to previous years as reported under KP90, variation in reporting of preceding and subsequent uses of the Mental Health Act may require further investigation and the figures are affected by recording issues. The data submitted in Table MHS404 indicated CTOs ending with a revocation, this number did not tally with uses of section 3 that could be identified as a detention following revocation. For more details, please refer to page 19 of the background data quality report 2016/17.

[95] NHS Digital (10 October 2017). Mental Health Act Statistics, Annual Figures 2016/17: Background Data Quality Report. Accessed at: https://files.digital.nhs.uk/36/E95A5F/ment-heal-act-stat-eng-2016-17-back-data-qual-rep1.pdf

10. Main assumptions – Option 2 (Policy)

    a. CTOs are assumed to reduce gradually by 40% from 2023/24 with a gradual change over 5 years until 2027/28 and thereafter this lower number will remain constant.

    b. Contact time with clinical staff:

        i. Current responsibilities use the same contact time as BAU

    c. Additional responsibilities – for ease, these estimates were done in the clinical teams model (see Annex B.VI)

Option 1. BAU Model

11. The number of CTOs[96,97] has been fluctuating in the previous ten years with no obvious trend. After consulting NHSD and NHSEI, we decided to have a flat CTO forecast instead of using the average percentage increase of MHSDS or the average percentage increase from 2010/11 to 2019/20.

12. Staff costs for RCs include salary, oncosts and overheads and were estimated based on the costings for a hospital-based consultant in psychiatry, with the total cost per hour estimated at £112.69 (in 2019/20 prices) or £120.65 (in 2020/21 prices); staff costs for nurses and care co-ordinators were assumed to be the same and were estimated based on the average unit costs per hour (includes salary, oncosts, and overheads) for bands 4 and 5 hospital-based nurses £33.80 (in 2019/20 prices) or £36.19 per hour (in 2020/21 prices)[98]. All costs were inflated to 2020/21 prices using a GDP deflator[99].

13. All patients were assumed to access a RC and 50% were assumed to access a care co-ordinator/nurse.

14. Following advice from clinicians, staff time for RCs (assessment and total contact time for a new patient) was assumed to be three hours for consultants and 27 hours for care co-ordinators.

Option 2. Policy Model

15. We assume that the start date of the policy is 2023/24 once legislative changes are in place and that it goes through a five-year gradual implementation period. Staff contact time (RCs and care co-ordinators) for current responsibilities was assumed to remain the same post- policy implementation. Estimates for the new additional responsibilities are done in the clinical teams model and presented in Annex B.VI.

16. Under the policy (Option 2), we have assumed a 40% reduction in the number of CTOs taking place gradually over 5 years from 2023/24 until 2027/28 and the number of CTOs will remain flat after 2027/28.

[96] NHS Digital (9 November 2016). Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures. Accessed at: https://webarchive.nationalarchives.gov.uk/20180328135613/http://digital.nhs.uk/catalogue/PUB22571

[97] NHS Digital (27 Oct 2020). Mental Health Act Statistics, Annual Figures 2019-20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

[98] Curtis, L. & Burns, A. (2018) Unit Costs of Health and Social Care 2018, Personal Social Services Research Unit, University of Kent, Canterbury. https://doi.org/10.22024/UniKent/01.02.70995 (also accessed at: https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2018/)

[99] HM Treasury (31 March 2021) GDP deflators at market prices, and money GDP March 2021 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2021-quarterly-national-accounts

B.III. Estimating the impact on Independent Mental Health Advocates (IMHAs)

1. The purpose of this model was to assess the impact on the IMHA workforce and related expenditure as a result of the Government proposals. Three key changes relating to the IMHA workforce are:

2. Advocacy will move towards an opt-out service model where service users would be proactively approached by an IMHA.

3. Advocacy entitlement will widen to cover all mental health hospital patient admissions[100].

4. The workload of an IMHA will increase.

5. The table below summarises key assumptions and outputs of the model. These assumptions are based on our broad assessment of additional responsibilities and were discussed with stakeholders and service providers.

Summary of model

6. Purpose: To forecast the number and costs relating to IMHAs as a result of the Government proposals. Advocacy will become opt out and will cover all mental health inpatients.

7. Main outputs: Number of people entitled to IMHA support, numbers of people taking up services, number of staff required, and cost of providing and training IMHAs.

8. Main data sources:

    a. Detention and CTO scenario forecasts flow through from the DHSC models.

    b. Conditionally Discharged Restricted Patients forecasts are aligned with the MoJ model.

    c. Advocacy providers for information on uptake, caseload, salary and potential additional workload.

9. Main assumptions – Option 1 (BAU)

    a. Current levels of advocacy uptake are 40%.

    b. IMHA staff costs (salary, oncosts and overheads) are estimated at £52,000 per year, and costs to train new IMHAs are £1,600.

    c. An advocate has a caseload of 100 people per year.

    d. Detention, and CTO forecasts feedthrough from their respective models.

    e. Conditionally discharged restricted patients increase by 4% per year, up until 2024/25, there after annual change varies between -14% and 10% based on estimates from MoJ forecast modelling.

    f. Those subject to guardianship fall by 7% per year.

    g. Section 57 and 58A treatment and ECT remain constant at 5 and 1 cases per year.

10. Main assumptions – Option 2 (Policy)

    a. Advocacy uptake remains at 40% for those currently entitled to an IMHA and also for informal mental health inpatients.

    b. The staff costs (salary, oncosts and overheads) and cost of training an IMHA remain the

[100] Entitlement to an IMHA is assumed to only include lengths of stay greater than 72 hours

same.

c. An IMHA's caseload increases by 12 hours per CTP (only 6 hours for Section 2 detainees), 6 hours per SOAD interaction, 12 hours per CTO case, 6 hours per tribunal and 2 hours per ACD.

d. Detention and CTO forecasts flow from the respective models.

e. The forecast for conditionally discharged restricted patients is aligned with MoJ modelling.

f. BAU forecasts are maintained for guardianship, serious mental health surgery, and ECT.

g. Mental Health inpatient numbers are assumed constant at 2016/17 levels, and voluntary patients are assumed to be the difference between inpatients and detainees.

Eligibility

11. Under the current MHA, those who are eligible[101] to use IMHA services are:

    a. People detained under the MHA (even if currently on leave of absence from hospital) but excluding people who are detained under certain short-term sections:
        i. Section 4 − an emergency application for detention in hospital up to 72 hours
        ii. Section 5(2) − a temporary hold of an informal service user on a mental health ward for an assessment
        iii. Section5(4) − a temporary nursing holding power to ensure the immediate safety of a hospital in-service user
        iv. Section 135 − power to remove a person from a dwelling
        v. Section 136− power to remove a person from a public place
    b. People in supervised community treatment orders (CTOs)
    c. Conditionally discharged restricted patients
    d. People subject to guardianship under the Act
    e. Other patients, who are informal, are eligible for IMHA services if they are being considered for section 57 or section 58A treatment (i.e., treatments requiring consent and a second opinion)
    f. People under 18 and being considered for electro-convulsive therapy

12. The forecasts for the number of people detained or on CTOs feed through from the respective DHSC models.

13. Offender Management statistics**[102]** show that the population of restricted patients currently conditionally discharged from hospital increased by an average of 4% per year between 2014 and 2018. We therefore use 4% annual growth in the forecast for BAU. There are a number of proposals that will impact on this group, including those relating to automatic referrals. Consequently, the forecast for these patients is aligned with the modelling outputs from the MoJ model.

14. Public data on Guardianship under the MHA were obtained from NHS Digital (NHSD)[103], with annual figures available up until the year 2015/16. Estimates from 2016/17 onwards use the mean annual decrease of 7% seen between 2003/04 and 2015/16. We do not expect the Government proposals to impact this group so the BAU forecast holds post implementation.

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[101] Social Care Institute of Excellence (October 2014). Understanding Independent Mental Health Advocacy (IMHA) for mental health staff - SCIE At a glance 67. Accessed at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/understanding/

[102] Ministry of Justice (2019) Offender Management statistics quarterly, England and Wales, October to December 2018, National Statistics. Accessed at: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2018

[103] NHS Digital (2016) Guardianship under the Mental Health Act 1983, England 2015-16, National Statistics. Accessed at : https://digital.nhs.uk/data-and-information/publications/statistical/guardianship-under-the-mental-health-act-1983/guardianship-under-the-mental-health-act-1983-england-2015-16-national-statistics

15. Discussions with the CQC suggest fewer than 5 people per year might be informal patients being considered for section 57 or section 58A treatment. The model assumes 5 people per year with no change between BAU and post implementation.

16. The number of courses of ECT in England in 2016/17 was 2,153[104]. The rate of 1.08 courses per patient for the UK and Ireland was applied to the England courses of ECT to derive an estimate of 2 patients. However, only 0.1% of ECT patients are under 18, and 52% are informal. We therefore assume that only 1 patient is captured in this cohort and this is consistent in BAU and the policy scenario.

17. The Government proposes that the statutory right to an IMHA should be extended to include all mental health inpatients. We assume only inpatients with a length of stay greater than 72 hours will be offered an IMHA (in line with current procedures for detainees under the MHA).

18. Data from NHSD[105] indicate that the number of mental health inpatients over recent years has been fairly consistent. We therefore assume that the number of mental inpatients remains fixed at 2016/17 levels of around 103,000. We assume that voluntary patients are equal to the difference between total inpatients and detentions. That is, we assume that there is no increase in mental health inpatient beds in the future.

19. This proposal increases the eligible population by 20% in 2023/24 falling to a 1% increase on the BAU in later years to account for a stable number of inpatients in recent years. That is, when detentions increase, the number of voluntary patients decrease as we are assuming a stable number of inpatients (voluntary and detentions).

Uptake

20. No official data are available on the number of detainees who use IMHA services. Therefore, we looked to published academic literature on IMHAs for estimation. We found two studies that reviewed IMHA quality − Newbigging et al. (2012)[106] and Newbigging et al. (2015)[107]. A rounded average uptake of 40% was derived from these two studies and this estimate was supported in discussions with providers of IMHA services.

21. Newbigging et al (2012) reviewed advocacy using a sample of eight sites. Across each of the eight sites two metrics were reported on IMHA uptake: people using IMHA as a percentage of number of qualifying patients detained in hospital and people using IMHA as a percentage of qualifying patients on CTOs. From this an average uptake was estimated by taking the mean value of the two metrics across the eight sites to give an estimation of 31%.

22. Newbigging et al. (2015) reviewed IMHA quality and use over eight sites. Here the authors did not publish uptake across each site, nor did they report a mean estimate across all sites. Instead they only reported the maximum and minimum uptakes, range of 19% to 92% for detentions, and 5% to 55% for CTOs. For both detentions and CTOs the midpoint was estimated respectively (58% and 30%), and then an average was taken of the two midpoints to give a single estimation of 44% IMHA uptake.

23. Responses to the consultation suggested that the uptake for IMHAs is likely higher than 40% but did not suggest what a likely range could be.

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[104] Royal College of Psychiatrists (2017) ECT Minimum Dataset 2016-17. Accessed at https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/electro-convulsive-therapy-clinics-(ectas)/ectas-dataset-report-2016-17.pdf?sfvrsn=8120becc_2

[105] NHS Digital (2017) Mental Health Bulletin: 2016-17 Annual Report, England 2016-17, Accessed Mental Health Bulletin: 2016-17 Annual Report - NHS Digital

[106] Newbigging, K., et al. (2012) The Right to Be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England. Accessed at: The Right to Be Heard - UCLan

[107] Newbigging, K. et al. (2015) "When you haven't got much of a voice": An evaluation of the quality of Independent Mental Health Advocate (IMHA) Services in England. Accessed at: http://clok.uclan.ac.uk/10968/1/When%20you%20haven%27t%20got%20much%20of%20a%20voice.pdf

Additional Workload

24. The Government proposals implement safeguards in the detention process, which despite not specifically aimed at the IMHA service will result in additional responsibilities for IMHAs.

25. The table below sets out the specific points in the pathway where we expect the additional IMHA input and the estimated additional hours that will be required. This additional workload is then applied to the appropriate type of MHA interaction to work out the total IMHA support required.

Additional Workload aspect	Additional hours required per patient
CTPs for section 3 detainees	12
CTPs for section 2 detainees	6
SOAD interaction	6
CTOs	12
Tribunal	6
ACDs - 1 to 1 session with service user	1
Support of drafting ACD	1

Caseload

26. The average caseload of an individual IMHA is assumed to be 25 cases at any one time, with the majority of cases being open between one and three months, based on data from Newbigging et al. (2015) assessing advocacy services in England[108]. Based on this, an annual caseload of 100 is assumed (25 cases every three months = 100 in 12 months).

27. Assuming a FTE IMHA works 1,930 hours per year (52.143 weeks multiplied by 37.5 hours per week), then each case currently takes an average of 19.6 hours.

Salary

28. The annual salary of a FTE IMHA is estimated as £25,000 in 2019/20 prices using feedback from service providers. Salary is assumed to account for 51% of total costs, with oncosts and overheads accounting for the remaining 49%. This is in line with approaches for other staff groups and gives a total cost of £51,977 (in 2020/21 prices).

29. Training costs for IMHAs are assumed to be £1,606 (2020/21 prices) based on offers in the public domain from professional training companies.

Sensitivity Analysis

30. The projected number of voluntary patients is the most important assumption in the IMHA model, as the recommendations mean that all inpatients will become eligible to receive assistance from an IMHA.

31. The key assumption is the assumed level of uptake for IMHAs once the recommendations are implemented. Under the policy scenario, the assumption is that 40% of people would use IMHA services. However, this is an uncertain estimate, despite considered reasonable by stakeholders and so this is increased and decreased to 48% and 32% in the sensitivity analysis respectively.

32. The cost of providing IMHA services is also an influential assumption. We have been provided with a salary estimate of £25,000 from advocacy providers, which is scaled to estimate a unit cost. These

[108] Newbigging, K. et al. (2015) "When you haven't got much of a voice": An evaluation of the quality of Independent Mental Health Advocate (IMHA) Services in England. Accessed at: http://clok.uclan.ac.uk/10968/1/When%20you%20haven%27t%20got%20much%20of%20a%20voice.pdf

salaries are uncertain over long time scales.

B.V. Estimating the impact on Second Opinion Appointed Doctors (SOADs)

1. This Annex provides the methodology for modelling the impact on the number and cost of Second Opinion Appointed Doctors (SOADs) due to forecast changes in detentions and CTOs, and changes in the use of SOADs.

2. SOAD reviews are currently triggered where a patient is refusing or lacks capacity to consent to medication for a mental disorder which they have been receiving for more than 3 months. At present, where a patient is not consenting to treatment, a SOAD must certify that treatment 3 months after it began. The Government proposes bringing this forward from 3 months to 2 months. It also proposes access to a SOAD at day 14 of detention, at the request of the patient or their representative, if the patient is receiving treatment that they have refused.

3. The modelling of SOAD provision has made use of data from pre-Covid-19 pandemic years, as it was unclear at this stage how representative any data from 2020/21 may be.

Summary of model

4. Purpose**:** To forecast the number of SOAD visits and associated costs due to changes in the number of detentions and CTOs, and changes in the use of SOADs.

5. Main data sources:

    a. Section 3 Detentions and CTO forecasts from the relevant models.

    b. CQC Management Information: SOAD visits, Service Costs and SOAD Workforce and Caseload, 2018-19.

    c. NHS Digital (NHSD) bespoke dataset*:* Number of days detained under the MHA per single-provider hospital spell, 2016-17.

6. Main assumptions:

    a. Breakdown of SOAD visits: 81% of SOAD visits are to review medication – 11% for refusals and 70% for those lacking capacity. 11% of SOAD visits are in relation to ECT and 8% for CTOs.

    b. Rates of SOAD Visits per Detainee: There were 0.27 visits for refusals per Section 3 Detainee, 1.64 visits for those lacking capacity, 0.07 visits for ECT and 0.23 visits for CTO in 2018/19. The model assumes the same proportions in future years.

    c. Length of Stay (LOS): 31% of Section 3 detainees have a stay of 3 months or more. 62% have stays between 15 days and 3 months, and 16% have stays between 2 months and 3 months. The model assumes the same proportions in future years.

    d. Time between notification and SOAD visit: There is an assumed 14 days between notification to the CQC and the SOAD visiting. This time lag alters the proportion of Section 3 detainees to 26% for those notifying at 3 months or more, 50% for those between 15 days and 3 months, and 11% for those between 2 months and 3 months.

    e. Cost of a SOAD Visit: Each SOAD visit is assumed to cost £403 in 2020/21 prices.

    f. Caseload: A SOAD conducts a mean of 109 visits per year.

    g. Training: Training of new SOADs is short, and it is assumed that SOADs needed in year Y are trained in year Y. As well as mandatory training, there is optional training – it is assumed that 50% take up of the optional training.

7. Option 1 (BAU) Model:
    a. Models the number of SOAD visits and associated costs for those currently eligible:
    b. Section 3 Detainees refusing medication (length of stay beyond 3 months)
    c. Section 3 Detainees lacking capacity (length of stay beyond 3 months)
    d. Section 3 Detainees receiving ECT (any length of stay)
    e. Those on CTOs (any length)
8. Option 2 (Policy) Model:
    a. Models number of SOAD visits and associated costs for those eligible after implementation of proposals:
    b. Section 3 Detainees refusing medication (length of stay beyond 14 days)
    c. Section 3 Detainees lacking capacity (length of stay beyond 2 months)
    d. Section 3 Detainees receiving ECT (any length of stay)
    e. Those on CTOs (any length)
9. Main outputs:Number of SOAD visits, cost of providing the SOAD service, and number of SOADs required.

Model Description

10. The model estimates the demand for SOADs due to forecasted changes in the number of detainees and CTOs following proposed changes to the MHA.
11. The BAU model estimates the number of SOAD visits, SOADs and costs, based on the modelled number of Section 3 detainees and CTOs from the DHSC models. BAU covers Section 3 detainees who have lengths of stay longer than 3 months; CTOs and ECTs.
12. The policy scenario model explores changes to the usage of SOADs as a result of the Government proposed changes to provision. These are: extending SOAD provision to section 3 detainees for refusals from 14 days and for those lacking capacity from 2 months; reduced CTO numbers from the CTO model; there is no change in modelled ECT numbers.
13. SOAD costs and estimated numbers under the Scenario are compared to the BAU.
14. The main model input is the forecast number of Section 3 detentions drawn from the DHSC Detentions model. The model also draws on the estimated number of CTOs from the DHSC CTO model.

Option 1. BAU Model

15. Section 58 of the MHA directs that, except in an emergency and after the initial three months from its first administration, medicines for mental disorder cannot be given without either capable consent of the patient, or in the absence of such consent, the authorisation of a SOAD. The BAU model estimates the costs and demand for SOADs based on the current SOAD provision.
16. The BAU usage of SOADs for Section 3 detainees is modelled as follows:

Number of SOAD visits *equals*:

Refusals: Number of Section 3 detentions with lengths of stay longer than 3 months multiplied by rate of refusal visits per detainee *plus*
Lacking Capacity: Number of Section 3 detentions with lengths of stay longer than 3 months multiplied by rate of lacking capacity visits per detainee *plus*
CTOs: Number of CTOs multiplied by rate of CTO visits per CTO *plus*
ECT: Number of Section 3 detentions with all lengths of stay multiplied by rate of ECT visits per detainee

Number of SOADs *equals*
Total Number of SOAD visits divided by SOAD caseload

Cost of SOAD Service *equals*
Total number of SOAD visits multiplied by Unit Cost per SOAD visit *plus*
Cost of training additional SOADs required

Length of Stay

17. The percentage of people detained for different lengths of stay has been calculated using a bespoke unpublished NHSD dataset on length of stay for 2016/17, which is used to estimate the number of SOAD visits as explained in the box above.

18. Currently, there is an approximate 2 week time period between notification to the CQC and a SOAD visit for medicine review. To estimate how many people would require a SOAD visit, we took into account this two week lag – for example, those with a length of stay between 15 to 30 days would require a visit around 14-15 days to comply with the new proposals, and those with a stay shorter than 14 days would not be covered by a SOAD visit.

19. It is assumed that both the length of stay proportions and 2 week wait are consistent in future years. Breakdowns for other lengths of stay are listed below.

Number of days detained under S3	Proportion*	Lagged Proportion (adjusting for 2 weeks wait between notification and SOAD visit)
< 15 days	7%	17%
>=15 days to <31 days	17%	16%
>=31 days to <61 days	30%	22%
>=61 days to <91 days	16%	11%
>=91 days	31%	26%

20. *Proportions may not sum due to rounding

21. To note, the LOS data for 2016/17 may have an undercount of longer lengths of stay and an overcount of shorter lengths of stay due to cases where a detainee has moved provider, as this is not counted as continuous detention.

Rates of SOAD Visits

22. The average proportion of SOAD visits for each type of SOAD visit was calculated from available CQC data across 2014/15 to 2017/18. Approximately 81% of SOAD visits are for medication reviews (11% for refusals, 70% for those lacking capacity to consent). 11% of SOAD visits were for ECT and 8% for CTOs.

23. Applying these proportions to the total SOAD visits in 2018/19 and combining with numbers of Section 3 detainees and CTOs in 2018/19 gives the below rates of SOAD visits.

Type of SOAD Visit	Visits per Section 3 Detention
ECT	0.07
CTO	0.23
Medication Review - Refusals	0.27
Medication Review – Lacking Capacity	1.64

SOAD Caseload

24. CQC data for 2018/19 show SOADs had a mean caseload of 109 visits per SOAD. This figure was similar to previous years and is therefore used as a constant estimate of caseload in future years. However, the caseload distribution is fairly skewed – for instance, the median level was 56 visits with a range of 3 to 850 visits.

Option 2. Policy Model

25. The main change modelled is the additional SOADs and costs associated with providing earlier access to a SOAD than the current position of longer than 3 months: notably from 14 days for those refusing medication and from 2 months for those incapable of consenting.

26. The usage of SOADs for Section 3 detainees post implementation is modelled as follows:

Number of SOAD visits *equals:*
Refusals: Number of Section 3 detentions with lengths of stay longer than 14 days multiplied by rate of refusal visits per detainee *plus*
Lacking Capacity: Number of Section 3 detentions with lengths of stay longer than 2 months multiplied by rate of lacking capacity visits per detainee *plus*
CTOs: Number of CTOs multiplied by rate of CTO visits per CTO *plus*
ECT: Number of Section 3 detentions with all lengths of stay multiplied by rate of ECT visits per detainee

Number of SOADs *equals*
Total Number of SOAD visits *divided by* SOAD caseload

Cost of SOAD Service *equals*
Total number of SOAD visits multiplied by Unit Cost per SOAD visit *plus*
Cost of training additional SOADs required

Length of Stay

27. The NHSD length of stay data indicate that an additional 50% of Section 3 detainees are captured from the move from 3 months to 15 days for refusals. It also shows that an additional 11% of Section 3 detainees would become eligible if SOADs were triggered from 2 months rather than 3 months for those lacking capacity.

Rates of SOAD Visits

28. In the absence of any other information, it is assumed that the current rates of SOAD visits are the

same for all detainees regardless of their length of stay. These rates may be an overestimate of potential SOAD usage, particularly for shorter lengths of stay.

Costs

29. The costs associated with the SOAD service cover a number of areas including SOAD fees; Management and Support costs; Travel and Subsistence; Other General Supplies and Services; Overheads/ other indirect costs; Employer pension contributions.

30. The CQC have provided a high level breakdown of the cost of running the SOADs provision for 2018/19. These have been averaged over all 14,354 visits in 2018/19 to calculate a unit cost per visit[109]:

	2018/19 Cost	**Cost per SOAD Visit**
SOAD Fees	£3,376,839	£235
Management and Support	£452,471	£32
Travel & Subsistence	£218,501	£15
Other General Supplies and Services	£40,683	£3
Overheads and Indirect Costs	£954,444	£66
From April 2019:		
- Additional employer pension contribution		£15
- Management employer pension contribution		£2
	£5,042,938	£368
2020/21 Unit Cost of SOAD Visit		**£403**

31. The reasoning behind attributing all these as an average cost per SOAD visit is that these will tend to scale with additional visits. The CQC confirmed, for example, that the Management and support input would increase in line with additional visits.

Appraisals

32. A SOAD is expected to have an annual appraisal which involves an audit of a sample of their most recent SOAD paperwork prior to their appraisal. This attracts both auditor fees and appraiser fees. A SOAD should also undergo a 5-year revalidation within which each doctor must obtain 360 feedback.

33. The average total cost of all of the elements above has been calculated as £558 per SOAD in 2020/21 prices. CQC data indicate that 45% of SOADs were appraised by CQC in 2018/19 and this proportion is assumed constant in future years and applied to the total number of SOADs needed in each year. The remaining 55% would be appraised by their sponsoring provider/organisation. It is assumed that appraisers can be absorbed into the existing workforce rather than needing extra SOADs to act as appraisers.

Training of Additional SOADs

34. Training of new SOADs is short, but the model assumes that SOADs needed in year Y are trained in year Y. Mandatory training consists of a one day course at a cost of £843 in 2020/21 prices. There is also optional training at a cost of £876 at 2020/21 prices. It is assumed that 50% of new SOADs take up the optional training.

Sensitivity Analysis

35. The SOAD model is mainly driven by two assumptions: the rates of SOAD visits per detainee (in

[109] Care Quality Commission (2020). Monitoring the Mental Health Act in 2018/19. Accessed at: Monitoring the Mental Health Act in 2018/19 (cqc.org.uk)

particular the rate for those lacking capacity); and changes in the unit cost of a SOAD visit (essentially has a proportional change in overall costs).

B.VI. Estimating the impact on Clinical Teams

1. The purpose of this model was to assess the impact on clinical teams (includes responsible clinicians, nurses, and care co-ordinators), and related expenditure, as a result of the Government proposals – primarily support to tribunal hearings challenging detention, shorter detention periods, more engagement with SOADs, setting up/reviewing Care Treatment Plans (CTP) and ACDs.

2. Under the Business As Usual (BAU) option, which pertains to the status-quo with no new national policies implemented, we assumed that clinical teams support for tribunal hearings challenging detention remains flat alongside tribunal hearings, and that most patients (90%) already have a CTP[110]. Proposed policy options on increasing clinical teams working hours under the MHA can be compared against the BAU option (the counterfactual) to estimate additional costs, staff requirements, etc. associated with these options.

Summary of model

3. Purpose: To estimate the impact on clinical teams during the policy period for BAU and for the policy option.

4. Main outputs: Staff time and costs (can be viewed separately for type of staff and by section under the MHA).

5. Main data sources:

    a. Tribunal receipts were provided by the MoJ.

    b. Receipts were provided separately for sections 2, 3, 37, and for CTOs.

    c. Detentions and CTOs models flow through this model.

6. Main assumptions – Option 1 (BAU)

    a. Tribunal numbers are assumed to remain the same (at 2018/19 levels) for all sections.

    b. Staff:

        i. Three staff assumed to be potentially present at each tribunal: a responsible Clinician (RC), nurse, and care co-ordinator – this is considered to be worst-case-scenario because usually only the RC and a nurse **or** a care co-ordinator will attend, not both

        ii. 7.5 hours (including: tribunal, travel, and report writing) of staff time per tribunal – same number of hours assumed for RC, nurse and care co-ordinator

        iii. Staff costs can be adjusted to GDP year – 2020/21 year prices currently selected

7. Main assumptions – Policy option:

    a. Assumes that different staff times all increase by specific amounts post policy implementation. These amounts were agreed with NHSEI as reasonable increases.

    b. Assumes that 90% of patients already have CTPs as stated by a 2018/19 CQC report.[111]

[110] Care Quality Commission (2020). Monitoring the Mental Health Act in 2018/19. Accessed at: Monitoring the Mental Health Act in 2018/19 (cqc.org.uk)
[111] As above.

Data sources

8. Tribunal receipt data were obtained from the MoJ. Data were available for ten years from 2009/10 to 2018/19 and separately for sections 2, 3, 37, and CTOs.

Option 1. BAU Model

9. Staff time per tribunal is assumed to remain the same pre- and post- policy implementation: 7.5 hours (one full day of work) each for RCs, care co-ordinators and nurses. For RCs, this time assumes four to eight hours to write the report, and one to two hours for the tribunal to take place, including travel time. For care co-ordinators and nurses, report writing is assumed to be two to four hours, and one to two hours for the tribunal to take place, including travel time to and from the tribunal venue.

10. Staff costs for RCs, additional clinicians and Community Supervising Clinicians include salary, oncosts and overheads, and they were estimated based on the costings for a hospital based consultant in psychiatry (associate specialist)[112]. The total cost per hour is estimated to be £108 (in 2017/18 prices). Staff costs for Nurses, care co-ordinators and other clinical staff were assumed to be equal and were estimated based on the average unit costs per hour (includes salary, oncosts, and overheads) for bands 4 and 5 hospital-based nurses (£32.50 per hour, in 2017/18 prices)[113].

11. All costs were inflated to 2020/21 prices using a GDP deflator[114].

Option 2. Policy Model

12. The start date of the policy is assumed to be 2023/24, and the implementation period is assumed to be gradual over five years from the start date.

13. Firstly, the modelling assumes that clinicians, nurses and care coordinators all now undertake extra responsibilities and that each staff member has to work an extra number hours for each detention. These extra hours are illustrated in the below tables. These extra hours are then costed up at the same rate as in the BAU to estimate the increase in costs under the policy option.

Section 2			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
CTP Set Up	Responsible Clinician	Any S2 with stays beyond 7 days	4
CTP Review	Responsible Clinician	Any S2 with stays beyond 14 days	4
Second Clinical Opinion from medical/clinical director	Clinician or Doctor	S2 with stays beyond 14 days	3
Tribunal	Responsible Clinician	Tribunal Hearings	6
Tribunal	Nurse	Tribunal Hearings	6
Tribunal	Care Coordinator	Tribunal Hearings	6
Section 3			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
CTP Set Up	Responsible Clinician	Any S3 with stays beyond 7 days	4
CTP Review	Responsible Clinician	Any S3 with stays beyond 14 days	4
Contact with SOAD	Responsible Clinician	Increased Visits	1.5
Contact with SOAD	Nurse	Increased Visits	1.5

[112] Curtis, Lesley A. and Burns, Amanda (2018) Unit Costs of Health and Social Care 2018. Accessed at: https://kar.kent.ac.uk/70995/
[113] As above.
[114] HM Treasury (31 March 2021) GDP deflators at market prices, and money GDP March 2021 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2021-quarterly-national-accounts

Contact with SOAD	Other clinical staff	Increased Visits	1.5
Renewal	Responsible Clinician	S3 with stays beyond 3 months	4
Certification for Tribunal	Responsible Clinician	All S3 receipts (MoJ Costs)	0.3
Tribunal	Responsible Clinician	Tribunal Hearings	6
Tribunal	Nurse	Tribunal Hearings	6
Tribunal	Care Coordinator	Tribunal Hearings	6
CTO			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
Application	Community Supervising Clinician	All CTOs	4
Renewal	Additional Clinician	CTOs over 6 months	4
Tribunal	Responsible Clinician	Tribunal Hearings	6
Tribunal	Nurse	Tribunal Hearings	6
Tribunal	Care Coordinator	Tribunal Hearings	6
Other sections			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
Tribunal	Responsible Clinician	Tribunal Hearings	6
Tribunal	Nurse	Tribunal Hearings	6
Tribunal	Care Coordinator	Tribunal Hearings	6
ACDs			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
Identification/initial signposting/referral/arrangement of follow up	Care coordinator	Those who were discharged	0.25
Information session (could be group session e.g. 10 service users/individual, in person or online)	Care coordinator Peer supporter	Those who were discharged	1 1
Support for drafting ACD (in person or online)	Care coordinator	Those who were discharged	1
Meeting with service user, carer, professional to discuss ACD contents and confirm capacity.	Medical consultant Care coordinator	Those who were discharged	1 1
Administrative support (coordinating meetings, uploading and distributing document)	Administrative staff	Those who were discharged	0.25

14. Secondly the modelling takes into consideration the increase in the number of tribunals expected based on the Government proposals pertaining to the justice system, that is, this increase is the same as modelled in the models affecting the justice system. These extra tribunals are also reflected in the increase in clinical team working times and are estimated at the same time/ cost rate as in the BAU option.

Sensitivity Analysis

15. The clinical teams' model is mainly driven by assumptions on clinical team working hours increasing after the introduction of the Government proposals. The central assumptions on staff hours were made following a discussion with NHSEI to understand the impact on clinical teams. However, there is a degree of uncertainty around these assumptions due to the heterogeneity of patients' cases, practitioner efficiency, system efficiency and synergies between tasks. Therefore, it has been seen as prudent to sensitise these assumptions to best case and worst-case scenarios – see Risk and

assumptions section for further detail.

B.VII. Estimating costs and benefits for Advance Choice Documents

1. The Government is proposing that the legislation will require Advance Choice Documents (ACDs) to be offered to people who have been previously detained, and that anyone who is at risk of detention should also be offered the opportunity to make an ACD..

Estimating costs

2. We have consulted with stakeholders and service providers to create a provisional task list of what will be required to produce an ACD, the responsible professional associated with each task (which also aligns with views from the Government consultation), and the median time it would take to complete each task, which will enable cost estimates.

3. There will be additional costs that we are currently unable to monetise, including the cost of a secure digital database to ensure ACDs can be readily accessed by service users and health and social care professionals, as well as training costs of the professionals involved in any aspect of ACDs.

4. The assumptions used to create the ACDs staff-cost model are:

5. ACDs will be developed in the community, with the service user, following their discharge when the individual has the relevant capacity.

6. The tasks required to produce an ACD are listed in the table below, along with the estimated median time required to complete each task and the professionals involved.

7. Any reviews of the ACD will add to staff costs, but as we are unable to quantify what proportion of individuals would like an ACD review it has not been included in the costings model.

8. For modelling costings purposes, we are assuming that the care coordinator role will be performed by a Band 6 community-based nurse or an AMHP in the ratio of 4:1, as this is the rough ratio of nurses to AMHPs in a community mental health clinical team; the peer support role by a Band 5 community-based nurse or AMHP, also in the ratio of 4:1; administrative staff by band 4 community-based scientific and professional staff; and have used the average salary of an NHS consultant[115] as a proxy for the medical consultant, but there are a range of possible providers for each role – see table below.

9. Everyone who has been detained under the MHA will be offered an ACD shortly after discharge if they do not already possess an ACD. Therefore, in a given financial year, 100% of multiple detainees will be offered an ACD (as they will have been detained at least twice throughout the year), whereas 65.8% of single detainees are discharged and offered an ACD, based on the 2019/20 discharge rate of detainees in England[116] (previous years' figures are unavailable). The estimated number of detentions forecast was gained from the detention model used in the IA.

10. Evidence[117,118] suggests that the uptake rate of facilitated ACDs would be between 30-50%, therefore

[115] All staff costings except for medical consultants, IMHAs and AMHPs were sourced from Curtis, L. & Burns, A. (2020) Unit Costs of Health and Social Care 2020, Personal Social Services Research Unit, University of Kent, Canterbury. DOI: 10.22024/UniKent/01.02.84818. For IMHAs and AMHPs costings, see annexes b.iii and b.iv respectively. The medical consultant salary was derived from the average salary of NHS consultants from Pay scales for consultants in England, British Medical Association https://www.bma.org.uk/pay-and-contracts/pay/consultants-pay-scales/pay-scales-for-consultants-in-england. Oncosts and unit costs for medical consultants were estimated based on the average proportional split of those from community-based professional staff in Bands 8c-9.

[116] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019/20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

[117] Owen, G., Davies, T. L., Stephenson-Coles, L. A., Hussain, O., Rifkin, L., & Ruck Keene, A. C. E. (2019). Advance decision-making in mental health - suggestions for legal reform in England and Wales. International Journal of Law and Psychiatry, 64, 162-177. doi.org/10.1016/j.ijlp.2019.02.002

[118] Hindley, G. F., Stephenson, L. A., Ruck Keene, A., Rifkin, L., Gergel, T., & Owen, G. (2019). Why have I not been told about this?: A survey of experiences and attitudes to advance decision-making amongst people with bipolar. Wellcome Open Research. https://doi.org/10.12688/wellcomeopenres.14989.1.

the central scenario is a 40% uptake rate of ACDs in each year.

11. The average multiple detention rate in England from 2017/18 to 2019/20 was 15.4%[119]. We have assumed this rate also applies between years, i.e., 15.4% of detainees in a year would have been detained in earlier years, and 40% of these (using the central scenario) would already possess an ACD and therefore would not be offered an ACD, except in the first year of the ACD rollout (2023/24) where no detainees would have an ACD at the beginning of the year.

Task	Median time (minutes)	Professional	Example of possible provider
Initial signposting or referral	15	Care coordinator (Band 6 or Approved Mental Health Professional)	Inpatient or community-based nurse/doctor/occupational therapist/psychologist/Advanced Mental Health Practitioner/Independent Mental Health Advocate
Information session (assumed to be 1 to 1 but could be in a small group)	60	Care coordinator (Band 6 or Approved Mental Health Professional) and peer support (Band 5 or Approved Mental Health Professional)	Inpatient or community-based nurse/doctor/occupational therapist/psychologist/Advanced Mental Health Practitioner/Independent Mental Health Advocate
1 to 1 session with service user	60	Independent Mental Health Advocate	Independent Mental Health Advocate
ACD drafting support	60	Care coordinator (Band 6 or Approved Mental Health Professional) and Independent Mental Health Advocate	Community-based nurse/doctor/occupational therapist/psychologist/Advanced Mental Health Practitioner/Independent Mental Health Advocate
Meeting with service user to discuss ACD contents and confirm capacity	60	Medical consultant (CP) and care coordinator (Band 6 or Approved Mental Health Professional)	Community-based doctor and community-based nurse/ occupational therapist/psychologist/Advanced Mental Health Practitioner
Administrative support (coordinating meeting, uploading and distributing documents)	15	Administrative staff (Band 4)	Community-based administrative staff

Caveats:

12. The future number of detentions is a forecast and may not accurately represent the number of detentions in future years, which will impact the number of ACDs being created in each year.

13. The discharge rate of detainees is only based on one year of data (2019/20 MHSDS) due to not being published in previous years, and may vary in future years, which cannot be adjusted for in the model.

14. There are no published statistics showing the proportion of detentions where the detainees have been detained in earlier years, meaning we had to utilise the in-year multiple detention rate as a proxy for this figure.

15. The Mental Health Services Data Set (MHSDS) data are still improving and may not provide a full

[119] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019/20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

accurate picture of discharge and detention rates.

16. The ACD uptake rate was derived from several studies, some of which had small sample sizes, were not based in England or were limited to a certain mental health condition; therefore, this rate may be inflated or underestimated from the true uptake rate.

Estimating monetised benefits – Reduction in compulsory admissions

17. To estimate monetised benefits, we calculated the number of compulsory admissions under the MHA prevented due to an ACD and multiplied that by the total cost of a detention. There are two types compulsory admissions that could be avoided: i) the repeated detentions avoided within the same year as the ACD was set up after the first detention, and ii) the detentions avoided due to establishing an ACD in previous years. The total cost of detention was calculated by the sum of cost of length of stay and the average cost of detention (see Annex B.I for further detail).

18. The assumptions used to calculate the reduction in compulsory admissions as a result of ACDs are:

19. The estimated number of detentions and the cost of a detention was gained from the detention model used in the IA.

20. Evidence from a recent systematic review[120] suggests there is a 25% reduction in compulsory admissions among those receiving crisis-planning interventions, such as ACDs, compared to those who did not (risk ratio 0.75, 95% CI 0.61-0.93). We have therefore estimated a 25% reduction in compulsory admissions for those service users estimated to have set up an ACD as the central scenario. This was done by summing the estimates of:

21. 25% of future detentions where the detainee possesses an ACD from a previous year and would have been detained in the current year. This cohort was estimated by assuming the average multiple detention rate in England within a year also applies between years (15.4% from 2017/18 to 2019/20[121]), i.e., 15.4% of detainees in a year would have been detained in a previous year, and 40% of these (using the central scenario of the ACD uptake model) would already possess an ACD; therefore 25% of this cohorts' compulsory admissions in the year would not occur due to the benefits of the ACD. This is consistent in all modelled years except in the first year of the ACD rollout (2023/24) where no detainees would possess an ACD at the beginning of the year.

22. 25% of future detentions of multiple detainees in the current year who set up an ACD during the year, assuming that the ACD was established shortly after their first detention of the year. The proportion of detentions where the individual had been detained more than once in the current year was estimated by using the average proportion of detentions that were multiple detainees from 2017/18 to 2019/20, which was 28.8%[122].

23. Caveats:

24. The systematic review used was the most recent robust source of evidence for an estimate of the reduction in compulsory admissions due to ACDs; however, some of the studies used were relatively old or not based in England, meaning the results may not accurately reflect the true reduction in compulsory admissions for current and future English service users.

25. ACDs may not be established after the first detention, but this assumption was required to estimate the number of detentions prevented from multiple detainees in the year who established their ACD

[120] Molyneaux, E., Turner, A., Candy, B., Landau, S., Johnson, S. & Lloyd-Evans, B. (2019). Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open. 2019 Jul; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

[121] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019/20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

[122] As above.

within the year.

26. There are no published statistics showing the proportion of detentions where the detainee has been detained in a previous year, meaning we had to utilise the in-year multiple detention rate as a proxy for this figure which may be an underestimate.

27. The Mental Health Services Data Set (MHSDS) data are still improving and may not provide a full accurate picture of discharge and detention rates.

Estimating monetised benefits – Costs of healthcare when not in detention

28. These patients will still be using healthcare services when not in detention so we subtracted the estimated annual cost per patient with Serious Mental Illness for primary care, general hospital care and inpatient and community-based specialist mental health services (estimated at £4,989 at 2013/14 prices[123] and deflated to £5,954 at 2020/21 prices) from the costs of avoided detentions.

Sensitivity analysis

29. We have also estimated high and low benefits scenarios using the published range around the 25% reduction in detentions – 7% reduction in the low benefits scenario and 39% in the high benefits scenario.

[123] Ride, J., Kasteridis, P., Gutacker, N., Aragon Aragon, M. J., & Jacobs, R. (2020). Healthcare Costs for People with Serious Mental Illness in England: An Analysis of Costs Across Primary Care, Hospital Care, and Specialist Mental Healthcare. *Applied health economics and health policy*, *18*(2), 177–188. https://doi.org/10.1007/s40258-019-00530-2. Also accessed at: Healthcare Costs for People with Serious Mental Illness in England: An Analysis of Costs Across Primary Care, Hospital Care, and Specialist Mental Healthcare (nih.gov)

Annex C. estimation approach for Justice system impacts

Counterfactual (BAU)

Receipt and Hearing Volumes

1. One of the principal inputs was Mental Health Tribunal (MHT) receipts and hearing volumes. These were taken from the MARTHA management information system. We used the receipts and hearings for the latest full year available (2020/21), which were then assumed to repeat for each year between the start of the implementation period (2023/24 when legislative changes are assumed to be in place) until the end of the time horizon (2032/33).

2. A "flat" projection was advised by operational colleagues at HMCTS. This methodology was employed because MHT workload, as measured by total annual receipts, has been relatively stable since 2014/15, despite the increase in the number of MHA detentions over the same period. Consequently, it is apparent that the relationship between total annual detentions and MHT workload is not a simple linear relationship in the real world.

3. The rationale for the varying use of either receipts or hearing volumes as the input is discussed separately, where relevant, within the individual sections.

Average costs

4. Average sitting day costs in the MHT have been used in line with advice from HMCTS on how best to estimate the cost of an additional hearing/receipt. These sitting day costs have been taken from the 2019/20 outturns, which averages the total cost of a sitting day based on estate costs, judicial salaries/fees and pensions and other staff costs.

5. The average cost used for a MHT sitting day was put at about £2,260 in 2019/20. From 2020/21 onwards, it was assumed that the average cost in nominal prices would change in line with general price inflation, as defined by the UK GDP deflator.[124]

6. Average costs for medical members and non-panel members have been included within the sitting day costs and therefore have not been disaggregated in the analysis.

7. Legal aid average costs are derived from actual spend and are split by the category of work relating to the section of the MHA under which the patient is currently detained. It was assumed that the average cost of legal aid payments remain the same in nominal prices over the time horizon because the fees paid to providers are from a fixed fee scheme, as set out in the provider's contract, with rates set out in regulations that change infrequently.

Hearings per sitting day

8. This input variable underpins the cost estimates of all of the automatic referral proposals as well as the proposal concerning the CTP unnumbered Review recommendation. Hearing volumes are divided by the hearings per sitting day ratio, which determines the number of sitting days needed to sit a given workload of MHT cases. The estimated average cost for a sitting day is then applied.

9. HMCTS aims to list two cases per working day, although this is not always possible or appropriate. While most hearings will be scheduled for a half day, some will be scheduled for 1 or 2 full days due to their nature.

10. Hearings taking longer than expected, late cancellations and adjournments are just some of the

[124] HM Treasury (31 March 2021) GDP deflators at market prices, and money GDP March 2021 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2021-quarterly-national-accounts

reasons why the hearings per sitting day ratio is estimated at 1.36, which is used in this IA.

Cancellation fees

11. Cancellation fees can be claimed by panel members when hearings are cancelled, and panel members have not been able to be reallocated.

12. Daily sitting fees for non-restricted judges, medical members and specialist lay members in 2019 were provided by the MARTHA data system[125]. It was assumed that the average sitting fee in nominal prices for each group would change in line with general price inflation, as defined by the UK GDP deflators in subsequent years to provide the annual estimated cancellation fee.

13. Due to recent fluctuations in claims, an average of the last 5 years (between 2014/15 and 2018/19) for each tribunal member was derived as the counterfactual for annual Section 3 claim volumes, as set out in the following table. This annual volume was multiplied by the average cancellation fee by group and a 50% reduction applied, given the assumption that half of the cancellation fees no longer need to be paid as a result of the Government proposal.

Table C1. Cancellation fee claim volumes actuals from 2013/14 to 2018/19 with an average from 2019/20

Tribunal member	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20 onwards
Judge	199	175	202	214	193	297	216
Medical Member	252	271	457	221	218	308	295
Specialist Member	238	220	233	237	197	303	238

Automatic Referrals

14. In addition to MHT receipt and hearing volumes, the automatic referrals proposals also used the Mental Health Casework Section (MHCS) published statistics[126] as inputs.

15. These statistics present data on the volume of restricted patients detained under part III of the MHA, including the population of patients who are currently conditionally discharged in the community and the volume of conversions annually from conditional to absolute discharge.

16. Internal MHCS management information regarding the profile of conditionally discharged patients in the past was used to understand (i) the current mean duration of conditional discharge for all patients; and (ii) the mean length of time patients were on a conditional discharge section before they were absolutely discharged.

17. The estimation approach also used Length of Stay data from NHSD[127] to estimate the proportion of section 3 patients detained longer than a year.

[125] Source: Tribunal Service Case Management MARTHA data system, 2018-19 disposals.

[126] Ministry of Justice (25 April 2019). Offender Management statistics quarterly: October to December 2018. Accessed at: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2018

[127] NHS Digital (July 2018). Mental Health Act Statistics 2016-17 – Further Analysis to support the MHA review, July 2018. Unpublished.

Annex D. Cost estimates for automatic referrals

1. The Government proposals related to automatic referrals are one of the 5 themes of recommendations considered in the Justice systems impacts of the IA.

2. The first proposal considered in this category is the Review's recommendation 52 ("There should be an automatic referral to the tribunal 4 months after the detention started, 12 months after the detention started, and annually after that."). This interacts with recommendation 46c, which falls under the Detention Criteria group ("The detention stages and timelines should be reformed so that they are less restrictive through reducing the initial maximum detention period under section 3 so that there are three detention periods in the first year of 3 months, 3 months and 6 months".).

3. Following the Government's acceptance of recommendations 52 and 46c, these will have the impact of shortening the application and referral periods for those people detained under section 3 of the MHA. Recommendation 46c has the impact that patients will be able to apply in the first 3 months of their detention and, with recommendation 52, the first automatic referral point would be after 4 months rather than 6 months. Together, they have the consequence that 100% of all patients will have the opportunity to apply or instead be automatically referred to the MHT in the first 4 months of their MHA detention.

4. Given the data limitations around determining what proportion of patients currently go to the MHT in the first 4 months, an alternative methodology was devised. Recommendation 46c would mean patients are able to apply 3 times in their first year of detention as opposed to twice. This would be an approximate 50% increase. Across 3 years, patients would have an increase from 4 to 5 chances to apply, which is a 25% increase. These ranges were averaged to create the central scenario of a 37% increase. Using assumptions on the proportion of section 3 detentions that last longer than 1 year from the Length of Stay data provided by NHS Digital (NHSD)[128], an increase in the volume of actual section 3 applications annually was estimated.

5. With regard to the impact on referrals of recommendation 52, it was assumed that the move from 6 to 4 month mandatory referrals would induce a 'bring forward' effect only on the volume of section 3 MHT receipts and subsequent hearings. Thus, the main impact would be the move from referrals every 3 years to annual referrals, which has been captured as a 100% increase on the volume of these hearings annually – under section 68(6). The table below illustrates the total estimated costs of implementing the Government proposals set out in recommendations 52 and 46c.

Table D1. Estimated monetised additional costs for Recommendations 52 & 46c, including legal aid (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option1. BAU costs rec 46c	16	16	16	16	15	15	15	15	15	15	**153**
Option1. BAU costs rec 52	7	7	7	7	6	6	6	6	6	6	**64**
Option 2. Policy costs rec 46c	23	23	23	22	22	22	22	21	21	21	**220**
Option 2 costs rec 52	7	7	9	9	9	9	9	8	8	8	**81**
Total Option1 Costs	23	22	22	22	22	22	21	21	21	21	**217**
Total Option 2 Costs	30	29	31	31	31	30	30	30	30	29	**301**
Total Additional cost	7	7	9	9	9	9	9	9	9	8	**84**

6. The Government has accepted recommendation 53 ("For part III patients, automatic referrals should

[128] NHS Digital (July 2018). Mental Health Act Statistics 2016-17 – Further Analysis to support the MHA review, July 2018. Unpublished.

take place once every 12 months"), which would have the impact that 100% of patients detained under part III of the MHA will have the opportunity to apply or instead be automatically referred to the MHT in the first 12 months of their detention. We know the volume of restricted patients detained under part III of the MHA and the volume of applications to the MHT by each section of the MHA, but not the volume of non-restricted part III patients. Therefore, an assumption was made that the proportion of restricted part III patients who apply to the MHT will be the same as for the non-restricted population. By using this proportion and the estimated volume of detained patients under Part III, it is possible to estimate the expected annual increase in MHT receipts. This methodology also assumes that the proportion of direct applicants remains constant and that the volume of patients detained under part III of the MHA is steady. The table below illustrates the total costs of implementing recommendation 53.

Table D2. Estimated monetised additional costs for Recommendation 53 (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	3	3	3	3	2	2	2	2	2	2	**25**
Option 2. Policy	3	3	11	11	11	11	11	11	11	11	**93**
Additional cost			**9**	**9**	**9**	**9**	**8**	**8**	**8**	**8**	**68**

7. The Government proposal to accept recommendation 137 introduces a completely new right for conditionally discharged patients ("There should be an automatic referral for people on conditional discharge to the tribunal after 12 months and at regular intervals after that for patients who have not applied directly".). Currently, such patients are eligible to apply to the MHT once in the first 12-24 month period and then every 2 years, but there is no automatic referral process.

8. Consequently, there is no real safeguard for such patients, particularly those who may not have capacity to apply, or would only apply if their care team supported absolute discharge. It may be the case that some patients remain subject to conditional discharge for an extended period of time when a Tribunal may have considered them suitable for absolute discharge at an earlier stage.

9. Because this would be a completely new right under the MHA for patients, the counterfactual annual volume and cost of the status quo is zero here. There is also no available information on what proportion of receipts might follow through into hearings. Therefore, receipt volumes were used, rather than hearings.

10. The estimation approach uses data on the length of time that previous patients were on conditional discharge before being given an absolute discharge on the grounds that the profile of these previous patients is representative of the current sample. Length of detention is not a direct indicator for suitability for absolute discharge as this will depend on individual circumstances (e.g., diagnosis, current presentation, potential for risk of harm in the future if relapse occurs, likelihood of relapse). However, it gives an indication of the volume of current conditional discharge patients that could be suitable for immediate absolute discharge.

11. The White Paper proposes setting the threshold for the first automatic referral after 24 months rather than the 12 months set out in the Independent Review. The analysis then estimates the number of people who have another automatic referral 4 years after the first. A steady influx of patients being given a conditional discharge and a stable proportion of direct applications to the MHT is assumed.

12. The current success rate of applications to the MHT under section 75(2) is around a quarter[129]. However, it is felt by operational colleagues that it is very unlikely the majority of patients would meet the criteria for absolute discharge after 2 years – the mean duration of conditional discharge before

[129] Source: Tribunal Service Case Management MARTHA data system, 2018-19 disposals.

absolute discharge is 6 years 8 months[130]. Success rates are likely to be higher at the second automatic referral, so differing success rates are used depending on the duration spent on conditional discharge at the time of the tribunal. At the 2 year point the success rate varies between 3% and 7%, with the central scenario using 5%. At the second automatic referral (the 6 year point) the success rate varies between 30% and 36%, with the central scenario using 33.3%. The table below illustrates the total estimated costs of implementing the Government proposal associated with recommendation 137.

13. Table D3. Estimated monetised additional costs for Recommendation 137 (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 2. Policy		0	5	0	2	1	5	1	3	3	**20**

14. The Government has accepted recommendations 61 and 64 regarding the rights of patients released on a CTO to appeal to the MHT. Patients are currently automatically referred after the first 6 months and at 3-year intervals after that. The Independent Review suggests changing this 3-year referral period to an annual one, much like with section 3 referrals.

15. The estimation approach involved trend analysis, utilising the known volumes of referrals under sections 68(2) and 68(6) currently. It is worth noting that the intention of the Review recommendations was to bring the overall volume of CTOs down by half over the first 5 years of implementation. Therefore, while the individual proposals considered in this section have the impact of increasing potential receipts to the MHT, they do so within the context of an overall reduction in CTO volumes.

16. The cross-cutting assumption used for this analysis was a 60% reduction in CTO volumes over 5 years from 2023/24 (see Annex B.II) and a 75% increase in section 68(6) referral volumes from 2024/25 onwards.

17. Currently, hospital managers must refer a case when a CTO is revoked under section 68(7). The table below illustrates the possible effect of the Government proposals associated with recommendations 61 and 64.

Table D4. Estimated monetised overall cost savings for Recommendations 61 and 64 (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	12	12	12	12	11	11	11	11	11	11	**114**
Option 2. Policy	11	10	6	5	5	5	5	5	5	5	**61**
Difference in costs	-0	-1	-6	-6	-7	-7	-7	-7	-7	-7	**-53**

[130] Source: Internal Mental Health Casework Section management information.

Annex E. Estimates of the NHS cost of providing an additional QALY, and society's valuation of a QALY

1. This Annex defines and describes two distinct, but related concepts:

    - The cost per Quality Adjusted Life Year (QALY) provided "at the margin" in the NHS;
    - The societal value of a QALY.

2. It then provides an illustrative example of how these two figures are used in DHSC Impact Assessments.

The cost per QALY "at the margin" in the NHS (£15,000)

3. The NHS budget is limited, in any given time period. This means that there are potential activities, or beneficial uses of funds that would generate QALYs, but which cannot be undertaken because the budget is fully employed. If additional funds were given to the NHS, additional QALYs would be generated by funding these activities. Similarly, if funds were taken from the NHS, QALYs would be lost - as some activity "at the margin" could no longer be funded and would necessarily be discontinued.

4. The cost per QALY "at the margin" is an expression of how many QALYs are gained (or lost) if funds are added to (or taken from) the NHS budget. It has been estimated by a team led by York University, and funded by the Medical Research Council, to be £12,981. Expressed in 2016, and adjusted to give an appropriate level of precision, DHSC interprets this estimate as a cost per QALY at the margin of £15,000.

5. This implies that every £15,000 re-allocated from some other use in the NHS is estimated to correspond with a loss of 1 QALY. Conversely, any policy that releases cost savings would be deemed to provide 1 QALY for every £15,000 of savings released.

The social value of a QALY (£60,000)

6. Society values health, as individuals would prefer to be healthy and to avoid death. This value can be expressed as a monetary "willingness to pay" for a QALY – the unit of health.

7. The value society places on a QALY is also, in principle, a matter of empirical fact that may be observed. DHSC currently estimates this value to be £60,000, based on analysis by the Department for Transport of individuals' willingness to pay to avoid mortality risks.

8. Note that the estimated social value of a QALY significantly exceeds the estimated cost of providing a QALY at the margin in the NHS. This implies that the value to society of NHS spending, at the margin, significantly exceeds its cost. Adding £15,000 to the NHS budget would provide 1 QALY, valued at £60,000, according to these estimates.

Example of an Impact Assessment calculation

9. Suppose a project costs **£15 million** – and these costs fall on the NHS budget. It is expected to generate health gains to patients amounting to **1,200 QALYs**.

10. The costs and benefits, and the overall net benefit of the project would be calculated as follows:

    - The <u>costs</u> of the project are the QALYs that would be gained if the funds were used elsewhere in the NHS, but which are foregone if the project is undertaken. Using the standard DHSC estimate that one QALY is gained elsewhere for every £15,000 of funding, this gives an 'opportunity' cost of **1,000 QALYs lost**. Monetising these costs at the DHSC estimate of the social value of a QALY gives a monetary equivalent of **<u>£60 million</u>**.

- The benefits of the project are simply the QALYs gained – that is **1,200 QALYs gained**. Monetising these costs using the DHSC estimate of the social value of a QALY gives a monetary equivalent of **£72 million**.
- The net benefit of the project is therefore **200 QALYs**, or, expressed in monetary terms **£12 million.**

11. In principle, costs and benefits in the above example can be expressed either in QALYs or in £, and give the same (correct) result. However, many projects have other impacts besides NHS costs and QALYs, and it is important to be able to express all the impacts in the same currency. For example, a project might generate cost savings to business, which are denominated in £s.

12. This is why normal DHSC practice is to convert all ultimate impacts into £, as recommended in the HMT Green Book. If policy specific cost-effectiveness information is not available, costs falling on the NHS budget are considered to have a cost-effectiveness equivalent to margin in the NHS, and thus are converted into QALYs (at £15,000 / QALY), and then monetised (at £60,000 / QALY).

Annex F. Breakeven analysis – method

Reduction in length of stay

1. One of the potential benefits required to offset the policy costs pertains to a reduction in length of stay for detainees.

2. To estimate the daily cost of a detention under Option 1 (BAU) and under Option 2 (after the implementation of the policy):

    - We estimate the average cost of a detention in each year by dividing the total healthcare and justice costs in that year by the forecast number of detentions in that year. For the 10 year period from 2023/24 to 2032/33, this was estimated at an average of around £24,600 per detention under BAU and at around £25,700 under the policy scenario, that is, each detention is estimated to cost an additional £1,200 under the policy scenario.

    - The current average length of a detention is roughly estimated to be 51 days[131] and we assume that this applies to the 10-year policy period.

    - To estimate the daily cost of a detention after the implementation of the policy, we divide the average cost of a detention under the policy scenario by the length of stay (£25,800 divided by 51 days), and obtain an estimate of around £510.

3. The additional daily cost per detention is estimated at around £1,200, which is equivalent to the cost of 2.3 days in detention (£800 divided by £485). This would suggest that, if the only benefit that is realised after the introduction of the policy was a reduced length of stay in the average detention by 2 days, and the subsequent increase in available beds for other patients, then the policy costs would be offset by the benefits.

Reduction in readmissions

4. One of the potential benefits required to offset the policy costs pertains to a reduction in repeated detentions within the year. We suggest, based on published evidence, that improved patient safeguards and involvement in decision making could lead to improved treatment adherence and, in turn, a reduction in the number of people with repeated detentions.

5. Currently, 15.4% of people are detained twice or more in a year – around 6,400 people in 2019/20[132]. Dividing the overall annual additional cost of the policy (see Table 16) by the estimated cost of a detention (£25,700 as explained above) produces the required reduction in the number of detentions to make the policy cost effective – this is estimated at around 3,000 per year on average during the 10-year period.

6. We assume that in the absence of policy intervention, the proportion of repeated detentions would remain constant at 15.4% for the 10 year period from 2023/24 to 2032/33. Following policy implementation, we estimate that this would need to fall to 10.5% for the costs of this policy to be completely offset by the savings gained from a reduction in the number of repeat detentions.

7. To illustrate the method, we use a worked example for 2023/24. We estimate that the reduction in repeated detentions required to offset policy costs would be around 2,800 (out of the 3,000 required to

[131] Based on a bespoke (and unpublished) NHS Digital data extract from the MHSD showing number of hospital spells by the number of days detained (in five-day bandings and summary statistics) for 2016/17. This extract only covers spells in a single provider and does not include detentions in acute providers – see Annex B.I.

[132] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019/20. Accessed at: Mental Health Act Statistics, Annual Figures 2019-20 - NHS Digital

offset the costs of the policy).

8. **BAU.** In 2023/24, our forecast under BAU is around 54,000 detentions (see Fig. 1 and table BI.4). Applying the proportion of detainees detained once, twice or 3 times or over in the year (around 72%, 22%, 6%, respectively), we assume that there are around 39,000 detentions for those detained once, 12,000 detentions for those detained twice and 3,500 detentions for those detained 3 times or more.

9. To estimate number of people detained, we divided these numbers of detentions by 1, 2 or 3 detentions respectively and obtained around 39,000 people detained once, 6,000 people detained twice, and 1,000 people detained three times or more; around 46,000 people detained in total. That is, around 15.4% of people are detained twice or more times (6,000+1,000 divided by 46,000).

10. **Option 2. Policy scenario.** In 2023/24, and considering a decrease by around 3,000 repeated detentions, we would have around 51,000 detentions (54,000 minus 3,000):

    - Around 41,000 detentions for those detained once - those already assumed to be detained once plus those people who would have been detained twice under BAU and are now detained once. That is, the estimated 39,000 detentions for those detained once plus 2,500.

    - Around 9,000 detentions for those detained twice – the number of detentions pertaining to those assumed to be detained twice (12,000) minus the assumed decrease of 2,500 detentions (those detained twice under BAU and now detained once) multiplied by 2 detentions, plus the 700 people (detained three times or more under BAU and are now detained twice) multiplied by 2 detentions. That is, 12,000 minus 2,500*2 detentions plus 700*2 detentions.

    - Around 1,500 detentions for those detained three times or more – the number of detentions pertaining to those already assumed to be detained three times or over (3,500), minus the assumed decrease of 700 people detained 3 times or more under BAU and now detained twice, multiplied by 3 detentions That is, 3,500 minus 700*3 detentions.

11. The estimated number of people detained would be the same as under BAU, but readmissions or repeated detentions would decrease. We divided the number of detentions above by 1, 2 or 3 detentions respectively and obtain 41,000 people detained once, 4,300 people detained twice, and 500 people detained three times or more (around 46,000 detainees in total). That is, over 10% of people are detained twice or more times (4,300+500 divided by 46,000).

Changing the first detention renewal point from 6 months to 3 months

12. The Government proposes shortening detention periods so the first renewal point for Section 3 patients changes from 6 months to 3 months. This means there would be three renewals in the first year (3 months, 3 months and 6 months, that is, after 3 months since start of detention, after 6 months after the start of detention and after 12 months since the start of detention), as opposed to two (6 months and 6 months).

13. There seems to be a spike in the number of days detained around 6 months, that is, the current first renewal point. Around 2.5% of section 3 detentions are estimated to be discharged between 181 and 185 days after commencing detention – see graph below. This is based on a bespoke NHSD dataset on detainee length of stay for 2016/17[133] that provides the number of hospital spells for those patients formally detained under MHA Section 3 by the number of days detained (in five-day bandings and summary statistics). 2.5% seems to be a disproportionately high number compared to other detentions lengths and suggests that people are potentially being discharged just before the detention renewal

[133] NHS Digital (July 2018). Mental Health Act Statistics 2016-17 – Further Analysis to support the MHA review, July 2018. Unpublished.

takes place.

14. Reducing the initial section 3 detention length from 6 to 3 months might focus on the potential for earlier discharge. This would imply that some of the people now discharged at six months would be discharged across the period 90 to 180 days. We assumed that the percentage of detentions discharged at 6 months would be in line with the trend from 90 days to 180 days (around 0.6% rather than 2.5% of detentions), and that the 1.9% excess detentions would be discharged across the period 90 to 180 days – this redistribution is illustrated in red in the graph below.

15. To illustrate the monetised impact, this reduction is estimated at 23,000 days of detention in 2023/24, which is equivalent to around 0.5 days per detention (23,000 days divided by the forecast of detentions for 2023/24), or around £12 million in 2023/24 (23,000 days multiplied by the estimated average daily cost of a detention).

Increase in health benefits

16. The last potential benefit we used to illustrate offsetting the policy costs was direct health improvements, which can materialise either after detained patients respond better to treatment (where they are more involved) or simply through patients experiencing less stress and anxiety resulting from a poor experience whilst being detained.

17. We explained before in the body of the IA that the measurement and valuation of direct health benefits/ costs from a policy intervention is typically performed by estimating the number of quality adjusted life years (QALYs) generated. In Annex E, we said that the value society places on a QALY has been estimated at £60,000.

18. To estimate the health benefits following from the policy intervention completely offsetting the costs of the policy in each year, we divided the additional cost each year by £60,000 to work out the number of QALYs this would be equivalent to. Then this was divided by the estimated number of people in detention (including those who may have repeated detentions) in each year to work out the health gains that would need to be gained per detention.

19. To illustrate the method, we use a worked example for 2023/24:

20. the overall annual additional cost of the policy in that year is estimated at £76 million (see Table 16), which divided by the social value of a QALY at £60,000, gives an estimated number of over 1,270 QALYs;

21. dividing this number of QALYs by the estimated number of people detained (around 46,000 detainees in total, as explained in the section above) produces an estimate of a health gain per patient at around 0.03 QALYs.

22. In sum, it is estimated that each person detained would need to experience an additional health improvement (reduction in health loss) equal to 0.03 QALYs for the costs of the policy to be offset. This may seem small, but would suggest that, illustratively, the person would need to experience perfect health for around 10 days in the year following treatment (0.03*365 days = 10 days).

Annex G. Private Sector Costs for the Health and Social Care System

1. For the Health and Social Care system, the main costs are expected to fall in the professional groups supporting the implementation of improved safeguards. They are:

    - Approved Mental Health Professionals (AMHPs), who are employed by local authorities and have specific roles under the MHA, including assessing patients to decide whether an application for detention should be made[134];
    - Independent Mental Health Advocates (IMHAs), who are responsible for supporting patients by providing them with information on their statutory position and rights; by law, Local Authorities are responsible for commissioning IMHA services[135];
    - Second Opinion Appointed Doctors (SOADs), responsible for deciding "whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient, and appointed by the CQC[136];
    - Clinical teams typically consist of a responsible clinician, a care co-ordinator and/or primary nurse. These professionals are employed by the healthcare provider, so we are assuming this is the area where the private sector could potentially incur costs from changes in the MHA.

2. To estimate impact to the independent sector, we use estimates of independent sector market shares for bed provision for private patients since the most impact will be on those detained in hospital. This share should cover both private voluntary patients and private detained patients, but we have no data on this breakdown. However, the 2018 Lang & Buisson Healthcare Market Review[137] states that "(…) that about half of acute psychiatry and nearly all addiction treatment is privately paid (…). About a quarter of brain injury rehabilitation (or neuro-rehabilitation) is privately paid from a variety of sources. The NHS pays for nearly all other independent mental health hospital provision, including the remainder of acute psychiatry and brain injury rehabilitation, and virtually all patients detained under sections of the MHA who are receiving medium secure, low secure and non-secure treatment." (p. 62-63).

3. We assume a worst and highly unlikely scenario that this market share is for detentions. This would also compensate for this market share (beds) not capturing any potential Community Treatment Orders (CTOs) for private patients in the independent sector – CTOs are patients treated in the community under specific conditions, so outside hospital and not occupying a bed.

4. The acute and secure mental health hospital bed capacity can be split by sector (public or independent sector supply) and by type of funding (public or private funding). In 2018, NHS beds are estimated to account for 67.5% of MH bed provision (public funding/public supply), whilst 29.6% of bed capacity is for services outsourced by the NHS to the private sector and only 2.9% of bed capacity represented privately funded services in independent hospitals[138] (see table G1 below).

[134] Care Quality Commission (March 2018). Briefing: Mental Health Act – Approved Mental Health Professional services. Accessed at: https://www.cqc.org.uk/publications/themed-work/briefing-mental-health-act-approved-mental-health-professional-services
[135] Care Quality Commission (January 2019). Monitoring the Mental Health Act in 2016/17. Accessed at: https://www.cqc.org.uk/news/stories/monitoring-mental-health-act-201617-amendments
[136] Care Quality Commission. Second opinion appointed doctors (SOADs). Accessed on 22 August 2019 at: https://www.cqc.org.uk/guidance-providers/mental-health-services/second-opinion-appointed-doctors-soads
[137] Laing & Buisson (2018). Healthcare Market Review, 31st Ed. London
[138] Source: Laing & Buisson (2018). Healthcare Market Review, 32nd Ed. London

Table G1. Segmentation funding/supply Mental Health hospitals, England 2011-2018

Book edition	25th	26th	27th	28th	29th	30th	31st	32nd
Year of data collection	**2011**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2018**
Funding/ Supply								
Public funding/public sector supply (%)	70.5	69.4	66.8	71.0	68.7	70.1	69.4	67.5
Public funding/independent sector supply (%)	25.6	26.5	29	25.2	27.9	26.6	28.8	29.6
Private funding/public sector supply (%)	0	0	0	0	0	0	0	0
Private funding/independent sector supply (%)	3.9	4.1	4.2	3.8	3.4	3.3	1.8	2.9

Note: 32nd[t] edition: "Segmentation has been revised from last year as a result of the upward revision of the overall independent sector mental health hospital market value. All of the upward revision is attributed to NHS purchase of independent sector supply, resulting in a reduction in the residual private pay, private supply segment." (p. 65)

Source: Laing & Buisson. Healthcare Market Review. London

5. The only area that may bring costs for the private sector pertains to clinical teams in two main areas:

    - on the time clinical teams spend preparing for and attending MHTs;
    - on the time and resource required to deliver the other additional safeguards (e.g., setting up and reviewing care and treatment plans).

6. The overall additional cost of clinical teams has been estimated at around £36 million in 2023/24 to £40 million in 2032/33 (2020/21 prices, undiscounted) for all detained patients, that is, including public and private funding for patients in the public and independent sector – see section on clinical teams (which also includes costs– and for ACDs being offered in the community).

7. To estimate the costs for private funding and independent sector supply, we applied the 2.9% market share to the overall estimated cost in each year and that provides an estimates of around £1.1 million per year over the period – this is below £5 million in each year, the threshold for an Impact Assessment to require consideration by the Regulation Policy Committee (RPC, an independent advisory committee) and clearance by the Reducing Regulation Committee (RRC, a Cabinet Sub-Committee).

B.IV. Estimating the impact on Approved Mental Health Professionals

1. The purpose of this model was to assess the impact of the Government proposals on the Approved Mental Health Professional (AMHP) workforce (and related expenditure).

2. We assumed that the additional support would occur mainly at specific points of the pathway, specifically with impacts relating to Community Treatment Orders (CTOs) and Advance Choice Documents (ACDs). There will likely be other impacts on detentions, but the relevant policies are still in development, so these impacts have not been defined and costed yet.

3. One key impact we expect on the AMHP workforce is an increase in workload resulting from needing to perform more frequent assessments for CTOs. Here, despite an expected increase in workload, we expect the AMHP workforce needed to reduce due to the forecast decreases in CTOs.

4. AMHP workforce is also expected to increase in their workload in supporting a variety of tasks for setting up an ACD.

5. Responses to the Government consultation indicated that the AMHP workforce is ageing (e.g., a response informed that within their local area around ¾ of the AMHP workforce was over 50 years old) and that will have an impact in recruitment and retention – we are grateful for these views and will be considering them in future analysis.

6. For Option 1 (BAU), we assume that the current number of AMHPs would change in the future as a function of the number of patients only – this reflects the status-quo with no new national policies implemented. Proposed policy options under Option 2 can be compared against the BAU option (the counterfactual) to estimate additional costs and cost savings, staff requirements, etc. and benefits associated with these options.

7. The table below summarises the main assumptions and outputs of the model. All the assumptions used here were discussed with professionals (both AMHPs and commissioners) and considered by them to be sensible for a consultation IA.

Summary of model

8. Purpose: To forecast the number and costs relating to AMHPs (FTEs and training for headcount) as a result of the Government proposals.

9. Main outputs: Number of additional AMHP staff required (FTEs and headcount) and related additional costs.

10. Main data sources: CTO and ACD model data flow through to this model.

11. Main assumptions – Option 1 (BAU):

    a. Uses figure of 140,000 assessments a year[139].

    b. Number of assessments assumed to be flat across the policy period.

12. Main assumptions – Option 2 (Policy):

    a. Start date of policy is assumed to be the year MHA legislation changes should be in place – 2023/24.

    b. Workload increases by 30.3 hours per CTO.

[139] AMHPs, Mental Health Act Assessments & the Mental Health Social Care Workforce 2018. Accessed at https://www.adass.org.uk/national-findings-amhps-mental-health-act-assessments-the-mental-health-social-care-workforce

c. Workload increases by 0.85 hours per ACD (as we assume that AMHPs could cover around 20% of ACDs in each year).

Option 1. BAU Model

13. **Number of assessments.** These are assumed at 140,000 assessments a year[140], and to be flat across the policy period.

14. **Salary, oncosts and overheads:** based on £38,800 salary (2019/20 prices)[141] inflating this to £41,540 (2020/21 prices), then adding oncosts and overheads (assumed at 54% of total costs) using the proportion of these costs in the salary of the social worker in adult services[142].

15. **Full Time Equivalents (FTEs).** The number of FTE AMHPs for 2023/24 was estimated to be around 980. This was estimated by taking the current estimated number of assessments carried out by AMHPs (140,000) and multiplying by the time taken to perform an assessment (the sum of 12 hours per assessment plus an average travel time of 1.4 hours, see section on policy model below). This figure is divided by the standard working hours in a year (1,929) to estimate the number of FTE AMHPs in England.

16. **Costs.** To obtain overall costs, the estimated number of FTEs is then multiplied up by the average salary of an AMHP including on-costs and overheads.

Option 2. Policy Model

17. **Salary, oncosts and overheads for professionals during training:** based on estimates from the PSSRU report on Unit Costs of Health and Social Care 2020, the annual salary for a social worker is used as a proxy for the salary of the professional training as an AMHP – this is £34,982 in 2019/20 prices[143]. We also estimated oncosts based on published costs for social worker in adult services[144]. Oncosts were estimated to be £9,583, which gives a total cost of £44,565 (in 2019/20 prices). Next, we assumed training time is six months, giving a total training cost of £26,004 (in 2019/20 prices. Finally, total costs were inflated to 2020/21 prices (£27,840 in 2020/21 prices) using a GDP deflator[145].

18. **Additional working hours per patient.** AMHPs will be required to perform extra assessments for each patient on a CTO and to perform tasks in support of establishing ACDs. These are expected to result in an increase in overall workload. Through engagement with professionals, we have assumed an approximate number of hours required for each new responsibility.

19. For each CTO:

- Two additional assessments at 6 and 12 months into CTO – each estimated to be 12 hours (2 * 12 hours)
- One additional meeting with the patient, Nominated Person (NP) and the community team before the CTO is finalised – estimated to last 2 hours.
- Average travel time per assessment/meeting is assumed to be 1.4 hours (4.3 in total for the two assessments and the additional meeting).

[140] As above.
[141] Department of Health and Social Care & Skills for Care (November 2019). The Approved Mental Health Professional Workforce in the adult social care sector.
[142]Curtis, L. & Burns, A. (2020) Unit Costs of Health and Social Care 2020, Personal Social Services Research Unit, University of Kent, Canterbury. Unit Costs of Health and Social Care 2020 | PSSRU
[143] As above.
[144] As above.
[145] HM Treasury (31 March 2021) GDP deflators at market prices, and money GDP March 2021 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2021-quarterly-national-accounts

- In total, we estimate that additional AMHP support required would be around 30.3 hours (24 + 2 + 4.3) for each CTO.

20. For each ACD:

- Identification, initial signposting, referral and arrangement for follow up – estimated to be 0.25 hours.
- Information sessions in person, and two AMHPs are needed for each information session – the information session is estimated to last for an hour.
- Support for drafting ACD (in person or online) – estimated to be an hour.
- Meeting with service user, carer, professional to discuss ACD contents and confirm capacity of the service user- estimated to take an hour
- In total, we estimated that additional AMHP support required would be around 4.25 hours (0.25+2+1+1) for each ACD.
- Due to the mix of a community mental health clinical team, the tasks that AMHPs may take up while establishing an ACD can also be taken up by other team members e.g., nurses. The AMHPs to nurse ratio in the team is roughly 1:4. For that reason, we are assuming AMHPs will take up the above tasks for 20% of the ACDs made in the year, and that would result 0.85 hour of extra workload for AMHPs per ACD.

21. **Travel time.** To account for travel time, and in the absence of good evidence on the proportion of AMHPs who are placed locally or who need to travel, we are assuming that AMHPs would need to travel to meet 50% of the patients in a CTO. From these, we are assuming that[146,147]:

- 44% live in rural areas – these are the proportion of Local Authorities classified as Mainly Rural (rural including hub towns >=80%), Largely Rural (rural including hub towns 50-79%) and Urban with Significant Rural (rural including hub towns 26-49%)
- and that the remainder 56% live in urban areas – these are the proportion of Local Authorities classified as Urban with City and Town, Urban with Minor Conurbation and Urban with Major Conurbation.
- This produces an average travel time per visit of 1.4 hours.

22. Our **method** is briefly as follows:

- Additional working hours per CTO = number of CTOs multiplied by 30.3h;
- Additional working hours per ACD = number of ACDs multiplied by 0.85 hours;
- These additional hours allowed estimating extra FTE = Additional hours / standard working hours per year; ((Number of CTOs*30.3)+(Number of ACDs*0.85))/(37*52.14).

23. **Headcount.** To estimate training costs, we converted the estimated FTEs in year 1 (2023/24) into headcount by considering that:

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[146] Department for Environment, Food & Rural Affairs (21 June 2016). Department for Environment, Food & Rural Affairs. 2011 Rural-Urban Classification of Local Authorities and other geographies – Lookup for 2011 Rural Urban Classification of Local Authorities. Accessed at: https://www.gov.uk/government/statistics/2011-rural-urban-classification-of-local-authority-and-other-higher-level-geographies-for-statistical-purposes

[147] There are 6 urban/rural classifications, defined as follows:

- "major urban: districts with either 100,000 people or 50% of their population in urban areas with a population of more than 750,000
- large urban: districts with either 50,000 people or 50% of their population in one of 17 urban areas with a population between 250,000 and 750,000
- other urban: districts with fewer than 37,000 people or less than 26% of their population in rural settlements and larger market towns
- significant rural: districts with more than 37,000 people or more than 26% of their population in rural settlements and larger market towns
- rural-50: districts with at least 50% but less than 80% of their population in rural settlements and larger market towns
- rural-80: districts with at least 80% of their population in rural settlements and larger market towns"

Source: Office for National Statistics (no date). Rural/urban local authority (LA) classification (England). Accessed at: https://www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications/2001ruralurbanclassification/ruralurbanlocalauthoritylaclassificationengland

24. 25% of active AMHPs are estimated to have a single AMHP role whilst 75% are in a combined role (based on numbers of active AMHPs)[148];

25. As most AMHPs are social workers, we use our estimated rate for social workers: 90,000 social care FTE in LAS to 112,200 jobs – rate of conversion is 80%[149].

26. To estimate total headcount, we combined these two conditions, obtaining an estimated 149 AMHPs across single and combined roles[150] (see table below).

Table B.IV.1 AMHPs FTEs and converted Headcount from 2023/24 to 2032/33

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33
Additional AMHPs FTEs under Option 2	74	68	62	56	50	50	51	51	51	51
Sole role - headcount	37	34	31	28	25	25	25	25	25	25
Combination role - headcount	111	102	93	84	76	76	76	76	76	76
Total headcount	149	136	124	112	101	101	101	101	102	102

27. **Training unit costs.** The training cost per head is estimated at under £27,840 in 2020/21 prices, which includes:

    - average training cost around £3,700 for a 6-month period (based on average training costs from online professional adverts and confirmed by professionals);
    - post backfill (social worker salary, oncosts, and overheads) estimated at under £22,280 (6 months).

28. **Training costs.** We multiplied headcount by the costs of training per head to obtain overall training costs.

Sensitivity Analysis

29. The two assumptions tested are (see Risk and assumptions section for further detail):

    - additional working hours – the AMHPs model is mainly driven by assumptions on additional working hours, which were defined following discussions with professionals;
    - salary (including oncosts and overheads) estimates, which are derived from the assumption that all AMHPs are employed as adult social workers (around 95%[151] of the workforce are social workers); the salary is assumed to remain the same throughout the forecast.

[148] Department of Health and Social Care & Skills for Care (November 2019). The Approved Mental Health Professional Workforce in the adult social care sector (p.6).
[149] Skills for Care (October 2019). The state of the adult social care sector and workforce in England September 2019 (p. 30, table 3). Consultt: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx
[150] To demonstrate these calculations: (a) converting 81 FTEs into headcount (81*0.8) produces 101.25 headcount; (b) if 40% of these are single role AMHP, we obtain 40.5 headcount (unrounded); (c) these are supposed to account for 25% of the headcount, so extrapolating to 100% (40.5/0.25), we obtain an estimated total 162 headcount.
[151] Association of Directors of Adult Social Services & Benchmarking Network (April 2018). AMHPs, Mental Health Act Assessments & the Mental Health Social Care workforce: National Findings -England. Accessed at: nhsbn-and-adass-social-care-national-report.pdf

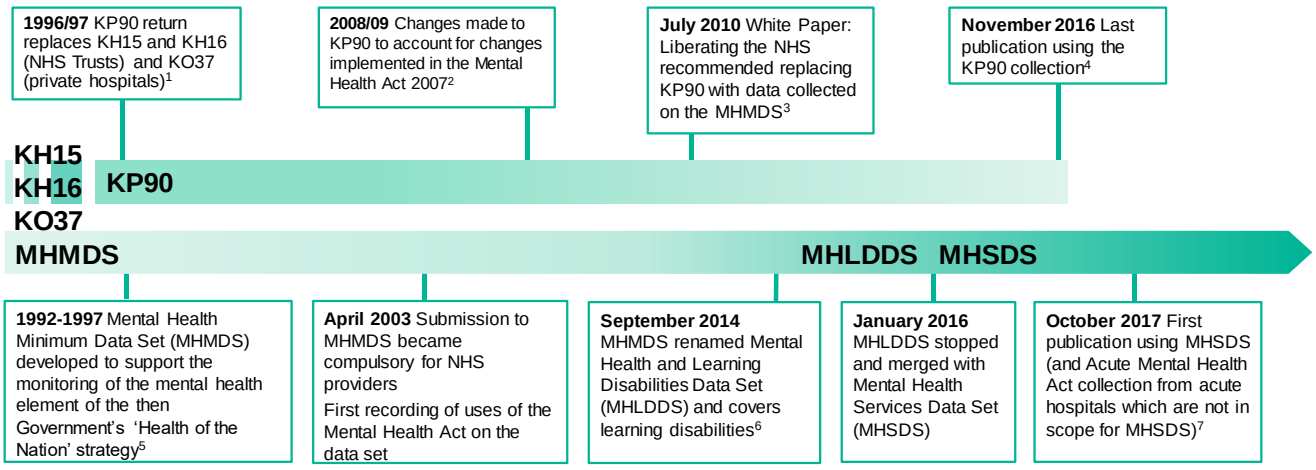
Annex H. Changes in data on the uses of the Mental Health Act

1. From 1 April 1987, statistics on formally detained patients admitted to NHS facilities and NHS patients using non NHS facilities under contractual arrangements were collected on the aggregate return KH15 on a financial year basis and on the return KH16 on changes in legal status[1]. Following a review of requirements for information on detained patients, a new return, KP90, was introduced for 1996/97. This return replaced returns KH15 and KH16, previously completed by NHS trusts, and KO37, completed by health authorities on behalf of private hospitals in their area[1].

2. The Secretary of State's Fundamental Review of Returns 2013 recommended that the KP90 collection would be retired once the same information could be produced from administrative sources, namely the Mental Health Services Data Set (MHSDS) and previous versions. These have been reporting data on detentions since 2003, alongside KP90. The MHSDS became the official data source for detentions under the MHA in 2016/17, and data from KP90 were last published in 2015/16[4,7].

3. The scope of the administrative data source has gradually increased from covering only NHS mental health services for adults, to including Independent Sector Providers in 2011 together with changing the format to permit analysis of individual uses of The Act, adding learning disability services in 2014 and, in the current MHSDS, introducing Children and Young People services and referral level data in January 2016. This means it now covers the majority of services where The Act is used[7].

The Mental Health Services Data Set became the official source of data for Mental Health Act Statistics in 2016/17 and is not comparable with previous data



1 NHS Digital (26 May 2006). Inpatients Formally Detained in Hospital under the Mental Health Act 1983 - England, 1994-1995 to 2004-2005. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment/inpatients-formally-detained-in-hospital-under-the-mental-health-act-1983-england-1994-1995-to-2004-2005

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