Title: Mental Health Act Draft Bill **IA No:** 9587 **RPC Reference No:** RPC-DHSC-5184(1) **Lead department or agency:** Department of Health & Social Care **Other departments or agencies:** Ministry of Justice	Impact Assessment (IA) **Date:** 16/06/2022 **Stage:** Final Stage – Pre-legislative Scrutiny **Source of intervention:** Domestic **Type of measure:** Other **Contact for enquiries:** MHBill@dhsc.gov.uk
Summary: Intervention and Options	**RPC Opinion:** Fit for purpose

Cost of Preferred (or more likely) Option (in 2022/23 prices)			
Total Net Present Social Value	**Business Net Present Value**	**Net cost to business per year**	**Business Impact Target Status:** NonQualifying provision
-£296 million	£24 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. A 2018 Independent Review of the MHA found that it was out of step with a modern-day mental health service: the patient's voice lost within processes that are out-of-date and can be uncaring; an unacceptable overrepresentation of people from black and minority ethnic groups amongst people detained; and people with learning disabilities and or autism facing particular disadvantage. This Impact Assessment (IA) accompanies a Draft Mental Health Bill, published ahead of pre-legislative scrutiny, which intends to update legislation. This forms part of a suite of reforms informed by a public consultation and recommendations of the Independent Review.

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

The main policy objectives of the Government reforms are to:

- modernise mental health legislation to give patients greater choice and autonomy over their care and treatment, and access to enhanced rights and support under the MHA;
- treat service users as individuals, making sure they are treated with dignity and respect, with a view to improving patients' experience;
- ensure that restriction is minimised and limiting the length of their detentions, for example giving patients earlier access to the Mental Health Tribunal (MHT) and to a Second Opinion Appointed Doctor (SOAD);
- improve existing and introduce new patient safeguards, such as granting informal patients access to an Independent Mental Health Advocate (IMHA); and
- reduce racial disparities under the MHA and promote equality.

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.
Option 2: Implement the proposals outlined in the Government's response to its consultation on the MHA reforms. The IA's main focus is on those requiring legislation to improve 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: 16/06/2022

Summary: Analysis & Evidence **Policy Option 1**

Description: Business as usual

FULL ECONOMIC ASSESSMENT

Price Base Year 22/23	**PV Base Year** 22/23	**Time Period Years** 20	**Net Benefit (Present Value (PV)) (£m)**		
			Low:	**High:**	**Best Estimate:**

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

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	**Total Benefit** (Present Value)
Low				
High				
Best Estimate				

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:	**Benefits:**	**Net:** 0	

Summary: Analysis & Evidence **Policy Option 2**

Description: Implementation of the Government proposed MHA reforms in the MHA draft Bill

FULL ECONOMIC ASSESSMENT

Price Base Year 22/23	PV Base Year 22/23	Time Period Years 20	Net Benefit (Present Value (PV)) (£m) (not including unquantified benefits)		
			Low: -£867 million	**High:** £453 million	**Best Estimate:** £296 million

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value; Inc
Low	£11 million	1	£48 million	**£763 million**
High	£11 million		£69 million	**£1,098 million**
Best Estimate	£11 million		£67 million	**£1,067 million**

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

The estimated total cost in Present Value of the MHA reforms (total cost and average cost per year) are:

- £436 million for the NHS (£2.0 billion with opportunity costs), an annualised average of £22 million per year;
- £446 million for Local Authorities, an annualised average of £22 million per year;
- £46 million for Second Opinion Appointed Doctors (SOADs), an annualised average of £2 million per year; and
- £139 million for the Justice system, an annualised average of £7 million per year
- The transition costs are estimated for Approved Clinicians' familiarisation with the MHA reforms.

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 and strengthening the detention criteria.

BENEFITS (£m)	Total Transition (Constant Price)	0 Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0		£14 million	**£219 million**
High	0		£77 million	**£1,204 million**
Best Estimate	0		£49 million	**£771 million**

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

We present quantified monetised benefits for reduced detentions following Advanced Choice Documents and new criteria for people with learning disabilities and autism, for reduced Community Treatment Orders (healthcare costs) and from saved tribunal cancellation fees. In the absence of quantitative evidence on the other benefits, we use a breakeven analysis to illustrate the benefits per patient detained required to offset the cost of Option 2. For the costs of the policy to be offset by these savings, we estimate that it would take either: a reduction of 0.56 days (1%) in the average length of a detention (the average of Sections 2 and 3; currently 54 days); a reduction from 15.7% to 14.8% in the number of people with repeated detentions, or a QALY increase of 0.006 for each detainee each year --equivalent to helping detainees live 4.1 days in perfect health (health-related quality of life score of 1) rather than in moderate health (score of 0.5).

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

The key non-monetised benefits pertain to the improved health outcomes experienced by patients due to improved safeguards and increased patient empowerment, a 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 (%)	3.5% 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 varied across best (lowest cost) and worst (highest cost) case scenarios. Key assumptions about the impact of reforms on workforce time requirements have also been identified in each of the cost models and varied in sensitivity analysis to approximate low and high estimates of the additional costs of Option 2.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:						Score for Business Impact Target (qualifying provisions only) £m:
Costs:	1.1	**Benefits:**	0	**Net:**	1.1	N/A

Contents

Note: Please refer to Annex A for any acronyms used.

Evidence Base

Problem under consideration and rationale for intervention

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 Independent Review[3] conducted by Professor Sir Simon Wessely identified that the current MHA is out of step with a modern-day mental health service and in significant need of reform to make it work better for everyone. The reforms the Review recommended were driven by the following problems: rising rates of detention; racial disparities in detentions and Community Treatment Orders; poor patient experience; and the particular disadvantages experienced by some people with a learning disability and autistic people . These are explained below.

3. In the years preceding the Independent Review, for example between 2006[4] and 2016[5] the number of detentions rose by over a third. The Care Quality Commission investigation published in January 2018[6] suggested that this increase may be due to a range of factors such as:

    - the 2007 reform of the MHA, which widened the definition of mental disorder and of treatment;
    - greater police awareness of mental health and more diversion from the Criminal Justice system;
    - changes in legal requirement for patients without capacity to consent to admission made it more likely that these patients would be assessed for detention under the MHA than in the past;
    - reduced availability of alternative community care and decrease in bed numbers;
    - population growth, including among groups that are more at relatively high risk of detention (for instance those experiencing social exclusion and untreated drug and alcohol misuse); and
    - improvements in data quality, which also prevented double counting of detentions when hospital transfers took place[7]. However, data from the last four years suggest that this trend may be changing, with estimated annual increases of around 2%[8].

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[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] NHS Digital (14 October 2009). Inpatients Formally Detained in Hospitals Under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment - 1998-1999 to 2008-2009. 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-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment-1998-1999-to-2008-2009

[5] NHS Digital (30 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

[6] Care Quality Commission (January 2018).Mental Health Act – The rise in the use of the MHA to detain people in England. Accessed at: Mental Health Act – The rise in the use of the MHA to detain people in England | Care Quality Commission (cqc.org.uk)

[7] Data published prior to 2016/17 were collected using an aggregate data collection (KP90), which did not allow for identifying transfers to another hospital and therefore, double counted some detentions; this is now recorded in the Mental Health Services Data Set (MHSDS), and so can be identified and excluded from the total number of detentions in the year – estimated at 15% in 2016/17 (see Annexes B.I and H).

[8] Mental Health Act Statistics, Annual Figures - NHS Digital

4. The Review considered that improvements in community mental health services and crisis care services could make a substantial contribution in tackling this increase. These improvements were planned under the NHS Long Term Plan (NHS LTP) and, before the COVID-19 pandemic, were expected to cover England by 2023/24[9]. Due to the impact of the pandemic, the NHS LTP delivery profiles are currently being reviewed. If NHS LTP plans are delivered, then we expect that some detentions will be prevented and that the overall costs will be lower than those estimated in this IA.

5. Regarding ethnic disparities, Black or Black British people are disproportionately likely to be detained under the MHA (over four times higher than that of the White British group) or be subject to Community Treatment Orders (over ten times the rate for the White group); have longer periods of detention and more repeated admissions[10], and are also more likely to be subject to police holding powers under the MHA[11].

6. In considering the need to improve patient's experience of detention under the MHA, evidence shows that patients' involvement in care and treatment and planning is patchy, and they are not always aware of their rights under the MHA. The CQC's 'Monitoring the MHA in 2020/21'[12] report suggests that patients still often lack guidance on their rights, with patient interviews suggesting that nearly half did not fully understand theirs. In 2020/21, during the COVID-19 pandemic, patient involvement in care and access to advocacy services was variable, with some good examples of good practice but with some services continuing to fail to explain patients' legal rights effectively[13]. In 2019/20, the CQC reported that they continued to note overall progress in services enabling patients' involvement in their care plans, and that care plans were showing *some* consideration of patients' views. The Independent Review identified that more needed to be done to proactively support patients to take part in care and treatment decisions and ensure their views were taken on board as far as possible.

7. Regarding people with a learning disability and autistic people, we have seen several high profile cases of poor care where a common theme was that detained inpatients were not receiving sufficiently therapeutic or reasonably adjusted care[14]. The use of the MHA to detain someone for treatment can lead to perpetuated detention and, while this could be true of other people detained under the MHA, the sensory needs of autistic people and people with a learning disability and reduced ability to self-advocate may exacerbate these risks[15].

8. There is also a large need for a sustained programme of investment to ensure that the MHA can be used as intended, as a response to a vulnerable person in crisis that will improve their mental health, rather than a last resort because services are unable to provide the continuous support that is required. These reforms are therefore designed to complement and build upon the existing investment in the Community Mental Health Framework[16]. Taken together, these reforms should reduce the need for detention under the Act and improve the experience of people experiencing mental illness.

9. This Impact Assessment (IA) focusses on analysing the costs and benefits associated with proposed legislative changes, particularly on improving safeguards in both the Health and Social Care system

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[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/

[10] In the latest data for 2020/21, all ethnic groups have higher rates of detention per 100,000 population than the White or White British group. Black or Black British detention rates are over four times higher than that of the White British group (at an age-gender standardised rate of 344 detentions per 100,000 population for Black or Black British, and 75 per 100,000 population for White groups. Age-gender standardised rates of CTOs use for the 'Black or Black British' group (78.9 per 100,000 population) were over ten times the rate for the White group (7.8 uses per 100,000 population) in 2020/21. Source: Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

[11] Care Quality Commission. Monitoring the Mental Health Act in 2020/21. Accessed at: https://www.cqc.org.uk/publications/major-reports/monitoring-mental-health-act-202021

[12] Care Quality Commission. Monitoring the Mental Health Act in 2020/21. Accessed at: https://www.cqc.org.uk/publications/major-reports/monitoring-mental-health-act-202021

[13] Care Quality Commission. Monitoring the Mental Health Act in 2020/21. Accessed at: https://www.cqc.org.uk/publications/major-reports/monitoring-mental-health-act-202021

[14] Recent cases include: Winterbourne View abuse scandal; Whorlton Hall abuse inquiry

[15] Independent review of the Mental Health Act: interim report - GOV.UK (www.gov.uk)

[16] NHS England » The community mental health framework for adults and older adults

and in the Justice system. It accompanies the draft Bill for Pre-legislative scrutiny (PLS)[17] and updates the previous IA[18] (published alongside the government response to its consultation on reform proposals, also referred to as White Paper in this IA[19,20]). The analysis reflects updated policies and the latest expectations for implementation timescales, and includes new analysis of potential distributional impacts.

10. In terms of the benefits of proposals, and using the work done by the Independent Review, we would expect that *"patients and service users should experience improved choice, less coercion and restriction of their liberties, care that is more consistently respectful, and meets their individual needs"* (p. 228)[21]. That is, patients should feel supported to share their wishes and preferences, that they have more control over their care and treatment, and that compulsory medical treatment is only used as a last resort when there is no alternative. 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 inpatient stay[22,23].

11. This IA details some quantitative evidence about potential benefits, for instance a reduction in detentions for those with an Advanced Choice Document (ACD), and research evidence on the positive benefits of improved patient experience. In the case of people detained under the MHA, this may lead to improved health outcomes, reduced lengths of a detention, and potentially patients and carers being able to return to work or other meaningful activities more quickly. 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 also 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)

[17] PLS allows for the detailed examination of a draft Bill by either the relevant Commons Departmental select committee, or an ad hoc joint committee of both Houses (House of Commons and House of Lords). It seeks to improve legislation by allowing thorough consultation and scrutiny of legislation while it is in a more easily amendable form and makes it easier to ensure that potential parliamentary objections and stakeholder view are elicited. This ultimately helps to smooth the Bill's passage in Parliament by reducing the need for amendments.

[18] This is the third IA on the MHA reforms. The first one accompanied the White Paper published in January 2021, which accepted the vast majority of the Review's recommendations and consulted on the impact and implementation of these recommendations; the second one accompanied the Government response to the consultation published in July 2021 – see sources in the footnotes below.

[19] 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)

[20] Reforming the Mental Health Act - GOV.UK (www.gov.uk)

[21] 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

[22] 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/)

[23] 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/

12. The Bill will extend and apply to England and Wales. Health policy is generally a devolved matter in Wales. The parts of the Bill that intersect with the Criminal Justice system will be handled by the Ministry of Justice (MoJ) and will be reserved, otherwise the changes to the Mental Health Act are devolved and will engage the Legislative Consent Motion process in Wales. The Welsh Government has already expressed support for the reforms as they apply to 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 (MHT) in England and not the Mental Health Review Tribunal for Wales (MHRTW)[24].

Policy objective

13. The main policy objectives of the proposals are to:

- modernise mental health legislation to give patients greater choice and autonomy over their care and treatment, and access to enhanced rights and support under the MHA;
- introduce new patient safeguards, such granting informal patients access to an Independent Mental Health Advocate;
- improve existing patient safeguards, such as giving patients earlier access to the Mental Health Tribunal (MHT) and to a Second Opinion Appointed Doctor (SOAD);
- reduce racial disparities under the MHA and promote equality; and
- ensure that patients receive a therapeutic benefit from detention and that they are treated with dignity and respect, with a view to improving patient experience and limiting the length of their detention.

Description of policy options

Option 1: Business As Usual

14. 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.

15. The NHS Long Term Plan[25] (NHS LTP) presented plans for improvements in mental health community care and crisis care in England, which should help to reduce detentions. These policies should be implemented independently of the Government proposals for the MHA and the effects were therefore considered under the BAU in previous IAs. However, due to the impact of the pandemic, the NHS LTP delivery profiles are being reviewed and that has not been finalised yet. Therefore the BAU option in this IA does not account for impact of changes to NHS LTP delivery, which implies that our BAU may be overestimating the number of detentions over the appraisal period and, consequently, overestimating the associated impacts. We will be revising the BAU option to take into account the reset of the NHS LTP for the final IA, which will accompany the MHA Bill when it is introduced to parliament.

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

[25] 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/

Option 2: Implementation of the draft Bill provisions

16. The draft MHA Bill represents Option 2 of this IA. The Bill will include provisions in the following areas, which are summarised below:

- Detention criteria – the thresholds against which decisions are made whether to detain a person, and whether to keep that person detained. These need to balance the interests of public protection and risk, with personal freedoms and autonomy. The previous revision of the Act, in 2007, focused on public protection; in the draft Bill we make amendments which ensure both that a person actually presents a genuine risk, and that detention is necessary to enable the patient to receive a therapeutic benefit.

- Learning disability and autism – the draft Bill proposes that we further limit the extent to which the Act can be applied to people with learning disabilities and autistic people , most notably by not permitting detentions under Section 3 where the patient in question does not have a co-occurring mental health condition that requires hospital treatment. The draft Bill does not make equivalent additional changes with regards to the treatment of people with these conditions who are sentenced to hospital stays by the courts i.e. because they have been detained after a criminal offence. This is to ensure that accused people and offenders whom the courts or the Secretary of State might currently divert to an inpatient setting are not forced into the Criminal Justice System, which is not able, or indeed intended, to cater for their needs.

- Patient choice and autonomy over their care and treatment – the proposals set out in the draft Bill will enhance the rights of patients to inform their care and treatment, both at the time of detention and in advance, in preparation for their possible detention under the MHA. Clinicians will be required to demonstrate how treatment has been tailored to meet the patient's individual needs and, as far as possible, their wishes and preferences, beliefs and values. Where a patient has refused medical treatment for mental disorder, it will be harder for clinicians to simply override these choices without compelling reasons and approval from a Second Opinion Appointed Doctor. Changes will be made so that patients get earlier access to the Second Opinion Appointed Doctor's service, which independently scrutinises the use of compulsory treatment. Additional safeguards will be introduced to ensure that urgent treatment is only used in more limited circumstances and only when absolutely appropriate. Patients who are considered to be 'apparently' consenting to treatment will receive greater oversight from the CQC to ensure that the necessary safeguards are in place.

- Statutory Care and Treatment Plans – the draft Bill proposes that all formal patients (excluding those under short term sections, like Section 4) receive a timely plan on their care and treatment and how they will be progressed towards discharge. We will seek to ensure, through regulations, that the plan provides a record of the reasons why continued detention is considered necessary, the patient's wishes and preferences, their beliefs and values and how care and treatment has been tailored to meet their individual needs, including protected characteristics, communication preferences, social, cultural, or spiritual needs. The patient should be supported by the Responsible Clinician (RC) to develop the plan. Where the patient is unable to, or does not wish to engage with the RC or clinical team, those who care for the patient's welfare, such as their Nominated Person (NP), should be consulted on the plan. Clinicians will be required to put the plan in place by day 7 of the person's detention and update it as and when required to reflect the patient's progress. Patients' plans should be subject to a regular audit by the hospital to ensure they are of sufficient quality and coverage.

- Community Treatment Orders (CTO) —the draft Bill proposes revisions to the criteria that must be met in order to subject someone to a CTO, which are in line with the revised detention criteria. To introduce greater scrutiny and ensure that a CTO is only used when absolutely appropriate, more professionals will be required to be involved at critical decision points, e.g. the

patient's community clinician, who will be responsible for the patient's care in the community once they are put on a CTO, will be required to state that the criteria for making the CTO have been met. They must also be consulted by the RC before extending a patient's CTO, recalling a patient to hospital to provide medical treatment, revoking the CTO to place the patient back on a hospital section, or discharging the patient from the CTO. They must also be consulted before an RC can vary or suspend conditions made as part of a CTO. There will also be greater clarification of the role of the Approved Mental Health Professional (AMHP) in the decision-making process.

- Improving patient representation and support – the draft Bill modernises the existing arrangement under which a family member is automatically appointed 'Nearest Relative' under the Act, and has powers to make decisions about a person's care. Instead, the Bill proposes that the patient should be free to choose their own 'Nominated Person', a role which will have increased powers under the reforms. The Bill also proposes changes to increase the uptake of independent advocates among formal patients and to extend eligibility to informal patients. This is to help make sure patients are supported people to understand and access their rights and participate in decisions about their care and treatment.

- Places of safety – the draft Bill proposes making the use of police cells unlawful for the detention of people detained under short term police powers under the MHA – as has been the case for under 18s since 2017. The Bill will also include legislative changes to end the use of prison as a place of safety for accused or convicted people in the Criminal Justice system who are awaiting assessment or treatment under the MHA.

- Transfers to hospital from prisons and Immigration Removal Centres (IRCs) – the draft Bill proposes the introduction of a statutory time-limit of 28-days for transfers from prisons and IRCs to mental health hospitals. This aims to create greater accountabilities for all agencies involved in the transfer process to meet the good-practice time-limit set-out in the NHSEI Transfer and Remission Guidance published in June 2021.

- The Mental Health Tribunal (MHT) – the role of the MHT is to act as the ultimate safeguard for a patient in detention. It forms part of HM Courts and Tribunals Service (HMCTS), and provides judicial oversight of detentions made under the MHA. The MHT 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). The draft Bill proposes increasing the frequency with which patients can make appeals on their detention, and will ensure that those who do not appeal themselves will nevertheless receive hearings.[26] The Tribunal will have a power to recommend that community services are provided, where this could facilitate a fast/smoother discharge and they will also be able to inform the conditions that apply to a patient's CTO. The draft Bill will also reduce the burden of hearings cancelled at the last minute due to Section 3 patients no longer meeting the criteria.

- Supervised Discharge – The draft Bill includes a new power to allow for patients detained through the courts, who are subject to special controls by the Secretary of State for Justice to protect the public from serious harm, to be discharged into the community with conditions which amount to a deprivation of liberty. This power will only be applicable under specific circumstances, when a patient is no longer therapeutically benefiting from hospital detention but continues to pose a level of risk which requires supervision. The key benefit is that the new power will provide a legal basis for the discharge of these patients; without this power it is likely that this small cohort of high-risk patients would remain detained in hospital. This means that patients can progress appropriately through their pathway of care while also managing the

[26] **Hearing -** The hearing is a meeting at which the tribunal panel considers evidence (either orally or paper based) and reaches a decision (where the decision may be to adjourn or to agree a final outcome). Source: Guide to Tribunal Statistics Quarterly - GOV.UK (www.gov.uk)

potential risks they may pose to themselves and others. Enabling the progression of these patients to community supervision, if appropriate, will result in these patients no longer requiring specialist inpatient care and treatment, which is more expensive, and should lead to improved health outcomes for these patients.

17. These legislative proposals are accompanied by a range of non-legislative actions which will also play a role in addressing the disparity in outcomes and detentions, enhancing patient voice, increasing transparency and scrutiny of decisions and improving patient's right to challenge. Whilst not within the scope of this IA's analysis which focuses primarily on the legislative changes, these actions include:

- Filling evidence gaps, particularly on tackling racial disparities – 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[27].

- Improvements in data collection – DHSC are working with NHSE/I to improve the validity and completeness of existing data collections, and where we might want to collect new data.

- Culturally appropriate advocacy (CAA) – DHSC have commissioned pilots to develop models for delivering CAA for people from ethnic minority backgrounds who access mental health services. The pilot providers have been testing models of CAA in inpatient and community settings, in four regions in England, since November 2021. The pilots have now been extended to the end of June 2022. Their evaluation will inform potential future pilots and the development of a framework for commissioning and delivering CAA.

- Cultural change – 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 informed by experience. To contribute to this, we are defining the scope of the Quality Improvement Programme (to support the mental health system addressing issues around quality, patient experience, leadership and culture) and developing the Patient and Carer Race Equality Framework (PCREF)[28]. This is a new organisational competency framework aiming at improving Black, Asian and minority ethnic patient and carer experiences of mental health services; and currently being co-produced with ethnic minority patients and carers, system leaders and academic experts. 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 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.

Cost Benefit Analysis

18. An IA was published to accompany the Government's Response to its consultation on reforming the MHA[29]. This IA updates the estimates for costs and benefits in response to further development of policies, including: changes to the frequency with which the SOAD service should review and potentially certify a patient's compulsory treatment; the rules around the urgent use of electroconvulsive therapy (ECT); the scope of Care and Treatment Plans (CTPs) and how they are quality assured; the powers of the MHT to inform the conditions surrounding a patient's CTO. The cost estimates also include training costs for AMHPs, IMHAs and SOADs. We are now working with system partners to understand the workforce requirements of the MHA Reforms and expect to include training

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

[28] NHS England » Advancing mental health equalities

[29] Reforming the Mental Health Act - GOV.UK (www.gov.uk)

costs for clinical staff in the final IA. It also includes cost estimates for the following policies and impacts, which were not included in the Government consultation IA:

- the changing MHA detention criteria may affect inpatients with a learning disability and/or autistic inpatients (LDA), and whilst it is not our intention to increase Guardianships, we considered this to be a potential alternative scenario for LDA inpatients, for analytical modelling purposes;
- administrative costs, previously only covering advanced choice documents (ACDs) and SOADs;
- Nominated Persons, which would bring additional costs to Approved Mental Health Professionals (AMHPs), Independent Mental Health Advocates (IMHAs) and admin staff; and
- expanded powers for the MHT, including having the power to grant leave from hospital and direct transfer to a different hospital, consideration of discharge from CTOs and the ability to order changes to the conditions of a CTO and having the power to discharge patients with conditions that restrict their freedom in the community.
- familiarisation costs - for Section 12 doctors, and we intend to develop these estimates to other professional groups.

19. We present the modelling assumptions and estimated costs throughout the following section and, where necessary, have highlighted the level of uncertainty involved and associated risks. The assumptions for the models were discussed and agreed with NHSEI, CQC and also with other stakeholders (e.g., MHT judiciary and HMCTS operational colleagues, providers of services, professional associations). When a policy is new and the impact is very uncertain, we make this explicit when presenting the modelling assumptions.

20. It is important that Government proposals relating to access to the MHT 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 a model estimating the impact of the Justice System proposals inform another which estimates the impacts on Clinical Teams.

21. In the previous IA for the Government consultation, all policies and legal powers were assumed to start in 2023/24. Following further implementation planning we are now considering a phased implementation (see Table 1) and we are using the illustrative scenario below for the purposes of this IA. We are assuming Royal Assent of the Bill[30] in 2023/24, with policies assumed to start from mid-2024/25 and with the final stages of implementation completing in 2030/31.

[30] Royal Assent - UK Parliament

Table 1. Estimated commencing dates for specific MHA powers

	Mid 2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
New detention criteria, including for people with LDA	Implementation starts						
Nominated Person	Implementation starts						
Auto referral of formal patients to IMHA services	Implementation starts						
Expansion of IMHAs to informal patients			Implementation starts				
Advance Choice Documents				Implementation starts			
Changes to SOAD role*				Implementation starts			
Changes to SOAD role - Urgent ECTs					Implementation starts		
Changes to CTOs					Implementation starts		
Compulsory CTPs					Implementation starts		
Changed frequency of tribunals							Implementation starts

* Includes costs from other professional groups such as clinical staff and IMHAs, who have a role in the interaction with the SOAD.

22. As the policy implementation is staggered over time, with the latest powers (for increased frequency of tribunals) potentially turned on in 2030/31, the economic appraisal period will go from mid 2024/25 to 2043/44, a period of 20 years, this allows for 13 years of full implementation of the MHA reforms from 2031/32. Option 1 (BAU i.e., not intervening) is the counterfactual, so the impacts of Option 2 – the reforms in the MHA Bill are assessed against this benchmark.

23. Presentation of costs. The tables for each policy set out rounded[31] figures in constant 2022/23 prices using the GDP deflator as set out in the March 2022 Economic and Fiscal Outlook[32]. Figures in tables may not sum exactly due to this rounding. All monetary values exclude VAT.

24. The summary tables for all monetised costs present discounted costs using a discount rate of 3.5% for all costs (see HM Treasury Green Book[33]).

25. Impact of the COVID-19 pandemic. The impact of the COVID-19 pandemic is taken into account in the forecast of receipts and CTOs over the appraisal period – see section below. The total numbers of MHT receipts[34] and hearings[35] 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 HMCTS 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. The average sitting day cost pre-pandemic includes travel and subsistence costs associated with attendance at a hearing, and the introduction of remote hearings during the pandemic would have reduced the sitting days costs significantly. Although the MHT will return to face-to-face hearings in the near future, the expectation is that it will be a mix of face to face and remote hearings, making it difficult to predict what the long-term impact might be on the costs.

[31] These figures are rounded to the nearest appropriate multiple based on the order of magnitude or degree of uncertainty, unless otherwise stated.

[32] Office for Budget Responsibility (23 March 2022) Economic and Fiscal Outlook. (Medium-term forecasts). Accessed at: https://obr.uk/efo/economic-and-fiscal-outlook-march-2022/

[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-govervent

[34] **Receipt -** Volumetric term covering the acceptance of a case by a HMCTS Tribunal. Source: Guide to Tribunal Statistics Quarterly - GOV.UK (www.gov.uk)

[35] **Hearing -** The hearing is a meeting at which the tribunal panel considers evidence (either orally or paper based) and reaches a decision (where the decision may be to adjourn or to agree a final outcome). Source: Guide to Tribunal Statistics Quarterly - GOV.UK (www.gov.uk)

Option 1: Business as Usual

26. **Detentions.** The number of business as usual (BAU) detentions under Option 1 informs estimates for the Health and Social Care workforce requirements for the additional recommended safeguards and for the volume of MHT activity.

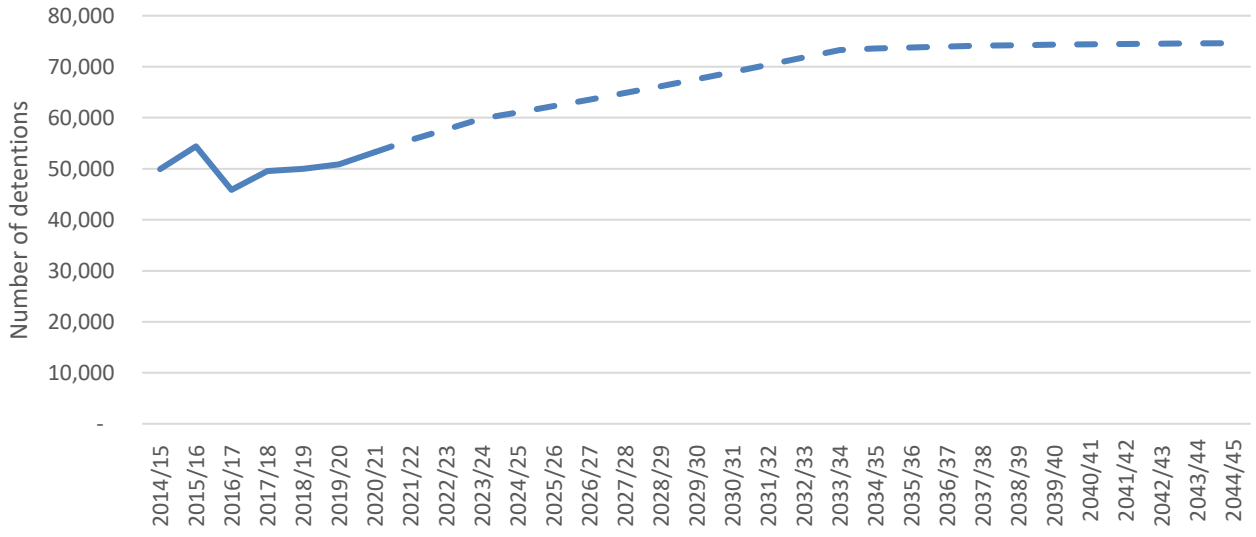
27. The BAU approach for detentions under the MHA assumes that:

- detentions under the MHA would increase by 4.5% in 2021/22 (the same annual percentage change as seen in 2020/21, based on NHS Digital (NHSD) estimates). Then, from 2022/23 to 2023/24, they increase by 3.7% (based on the average of the average annual percentage change in NHS Digital estimates from 2016/17 to 2019/20, the estimated percentage change in 2020/21 and the change forecasted for 2021/22). This assumes a moderate impact of the COVID-19 pandemic. From 2024/25 to 2033/34, detentions increase by 2.05% per year (based on the average percentage change of NHSD estimates from 2016/17 to 2019/20). Then from 2034/35 to 2043/44, we assume the annual growth of detentions grow in line with weighted demographic changes, assuming no policy improvements (see Annex B.I) – see Fig.1;

- this forecast is based on the most recent annual data from 2016/17, when the Mental Health Services Dataset (MHSDS) became the official dataset for the MHA and the previous data collection (KP90) was discontinued, and the number of detentions from these two datasets is not directly comparable (see Annex B.I)[36];

- we do not assume that this trajectory will decrease following improvements in mental health community care services and crisis services proposed within the NHS LTP[37], as the delivery profiles are being reviewed and are not yet finalised (see Annex B.I);

Figure 1. Number of Detentions - BAU Forecast



28. We also consider a best case and a worst case scenario in the sensitivity analysis (see Risks and assumptions section).

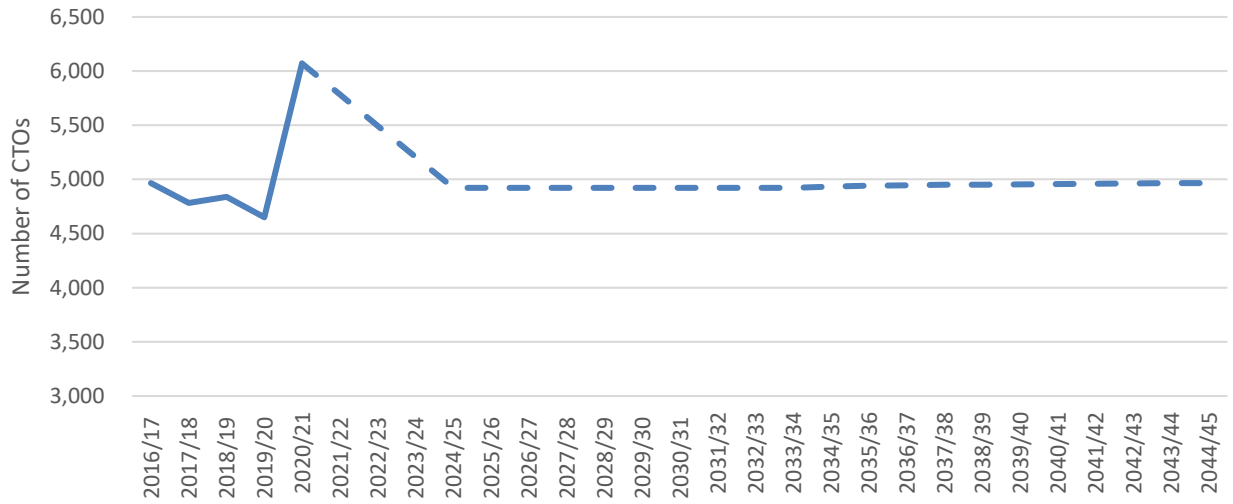
[36] Figures used for overall detention numbers may be slightly understated as MHSDS data is not thought to be complete, but coverage issues are most relevant to independent providers who constitute a small proportion of total detentions. See pages 11 to 16 of: Mental Health Act Statistics, Annual Figures: Background Data Quality Report, 2020-21

[37] 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/

29. **Community Treatment Orders (CTOs).** The annual number of CTOs from 2017/18 to 2019/20 has oscillated (likely due to data quality issues[38]) and it is not possible to identify an underlying trend in the total number of CTOs. The number of CTO uses in 2020/21 increased by 30.5%, which is significantly higher than any previous increase. As a cautionary approach, we are assuming that CTO numbers stay stable in a BAU scenario from 2024/25 to 2033/34, after a gradual reduction from the spike in 2020/21. Similarly with detentions, from 2034/35 to 2043/44, we assume the annual growth of CTOs grow in line with weighted demographic changes – see Fig. 2 (and Annex B.II).

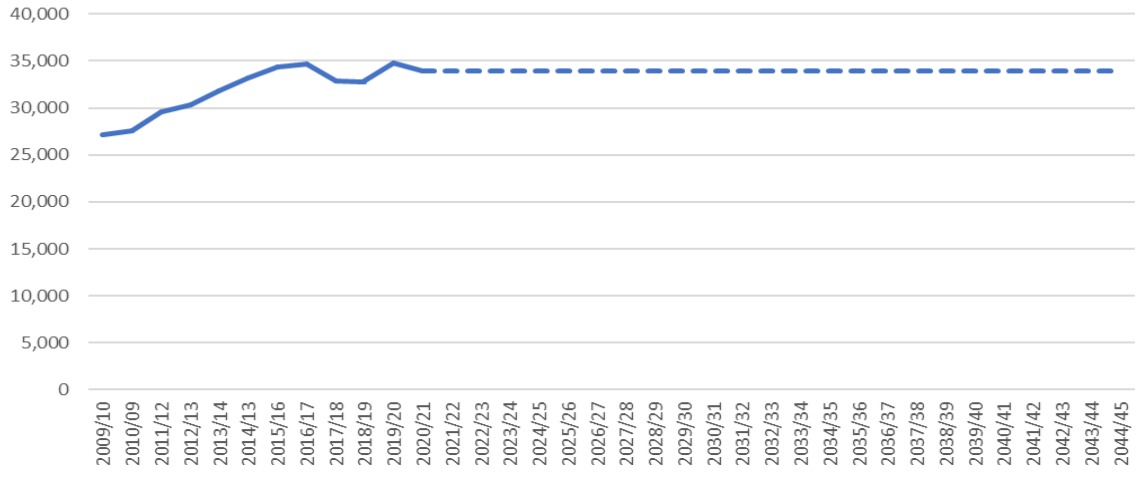
30. As with detentions, we also consider a high and low scenario in the sensitivity analysis (see Risks and assumptions section)

Figure 2. Number of CTOs - BAU Forecast



31. **Mental Health Tribunal (MHT) receipts.** We assume that the volume of MHT receipts will remain flat at 2020/21 levels in future years as seen in Fig. 3. Receipts have remained relatively steady since 2015/16 (at around 34,000 per year on average). The number of receipts is determined, at least in part, by the number of people detained under the Act but it has remained relatively static for the last 3 years. Further information is provided in annex D.

Figure 3. Number of MHT Receipts (applications and referrals)-BAU forecast



32. Health and Social Care workforce requirements. We also assume that all professional/workforce groups (Independent Mental Health Advocates, Approved Mental Health Professionals, Second

[38] See page 31 of: Monitoring_the_Mental_Health_Act_in_2018_to_2019_web.pdf

Opinion Appointed Doctors, Clinical staff) will keep their current roles and responsibilities when supporting the detentions processes.

Option 2: Implementation of proposed reforms

Monetised Costs

33. We present estimated additional costs for:

- The Health and Social Care (H&SC) system – we present additional costs in two ways:
  - Impacts disaggregated by the specific policies that cause them;
  - Impacts disaggregated by the professional groups in the Health and Social Care System, the additional demands of whom are the source of these costs. The following workforces will be expected to work together with patients to ensure they have access to the new safeguards: clinical teams, Approved Mental Health Professionals (AMHPs), Independent Mental Health Advocates (IMHAs), Second Opinion Appointed Doctors (SOADs), and NHS administrative staff;
- MHT activity in the Justice system- we present additional costs for the proposed changes to the MHT, as disaggregated by the specific policy areas of: automatic referrals, expanded powers and treatment choice.

Monetised Costs – Health and Social Care System

Costs by Health and Social Care policies

34. Overall additional costs for the Health and Social Care system (undiscounted real 2022/23 prices) are estimated at £1.43 billion over the 20-year appraisal period, an average of £71.6 million per year, and at an average of £85.7 million per year over the full implementation period from 2030/31 onward.

35. These estimated additional costs for the main health and social care policies are presented in the table below for the following aspects:

- Nominated person – this covers administrative costs for activities such as recording the NP, and any associated changes, in the patient's record, providing information to the NP (e.g. on the CTP) and consulting with them where necessary;
- Automatic referral of formal patients to IMHA services – this covers costs to IMHAs;
- Expansion of IMHAs to informal patients – this covers costs to IMHAs and Advance Choice Documents and includes costs for clinical staff, particularly RC and care coordinators, and also assumes that AMHPs can fulfil the care coordinator role in a smaller proportion of cases;
- Changes to SOAD roles, including their new role in deciding urgent ECTs;
- Changes to CTOs – these include costs to clinical teams and AMHPs;
- CTPs – includes costs to clinical teams, to administrative staff (particularly for the CTP audits) and to IMHAs;
- Changed frequency of tribunals – include support to more frequent tribunal for patients detained under the MHA and CTOs, which corresponds to additional costs to clinical staff, administrative staff and IMHAs;

- Changes to detention criteria for people with a learning disability and autistic people (LDA).
- Familiarisation costs – training for Approved Clinicians.

Table 2. Estimated <u>additional</u> monetised costs for the Health and Social Care system (£millions, 2022/23 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Nominated Person	1	1	1	1	1	1	1	1	1	1
Auto referral of formal patients to IMHA services	7	13	13	14	14	14	14	15	15	15
Expansion of IMHAs to informal patients	0	0	2	2	2	2	2	2	2	1
ACDs	0	0	0	6	6	6	6	6	7	7
SOAD role (including urgent ECT)	0	0	0	8	9	9	9	9	9	10
Changes to CTOs	0	0	0	0	19	14	13	12	10	10
CTPs	0	0	0	0	23	23	24	24	24	25
Tribunals frequency	0	0	0	0	0	0	17	13	14	14
Changes to detention criteria for people with LDA	1	2	1	1	1	1	1	1	1	1
Familiarisation costs	12	0	0	0	0	0	0	0	0	0
Total	**21**	**16**	**18**	**33**	**76**	**71**	**87**	**83**	**84**	**85**

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
NP	1	1	1	1	1	1	1	1	1	1	**22**
Auto referral of formal patients to IMHA services	15	15	15	15	15	15	16	16	16	16	**289**
Expansion of IMHAs to informal patients	1	1	1	1	1	1	1	1	1	1	**29**
ACDs	7	7	7	7	7	7	7	7	7	7	**113**
SOAD role (including urgent ECT)	10	10	10	10	10	10	10	10	10	10	**159**
Changes to CTOs	10	10	10	10	10	10	10	10	10	10	**184**
CTPs	25	25	25	25	25	25	25	25	25	25	**394**
Tribunals frequency	17	14	15	15	15	15	15	15	15	15	**210**
Changes to detention criteria for people with LDA	1	1	1	1	1	1	1	1	1	1	**21**
Familiarisation costs	0	0	0	0	0	0	0	0	0	0	**12**
Total	**87**	**85**	**86**	**86**	**86**	**86**	**86**	**86**	**86**	**86**	**1,433**

Costs by professional group – Independent Mental Health Advocates (IMHAs)

36. 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[39].

37. 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[40].

38. 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. The Government also proposes implementation of safeguards, which, despite not specifically aimed at the IMHA service, will result in additional responsibilities for IMHAs.

39. Following conversations with IMHAs professionals, we assume that these will be: supporting the patient to inform their CTP and their ACD[41]; supporting additional interaction with the SOAD and support for additional tribunals. We estimate that this will result in IMHAs workload increasing by around 6 hours per Section 3 detention, 6 hours per Section 2 detention, 12 hours per CTO and 2 hours for ACDs, 6 hours for informal patients that take up advocacy, and a further 6 hours due to increased interaction with SOADs and others (see Annex B.III for further details of the modelling).

40. Table 3 illustrates the spend for a central scenario over the twenty year period from 2024/25 (half year) to 2043/44, showing an overall estimated additional cost of around £571 million. The additional spend each year reaches around £31 million in 2028/29 increasing to around £33 million from 2034/35 onwards. Table 4 shows the estimated additional number of FTE IMHAs required each year.

41. In both Options 1 and 2, annual costs associated with IMHAs cover estimated salary, oncosts and overheads and capital of c. £53,000 (2022/23 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, 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 c. £1,600 (in 2022/23 prices), and to account for mixed roles and part time staff we estimated that each FTE is associated with 1.4 staff in headcount terms. For further details see Annex B.III.

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

[40] 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/

[41] In this IA we are assuming that no patient has advanced choice under BAU, which does not reflect accurately the current situation, and it means that costs under the policy may be overestimated.

Table 3. Estimated monetised costs for Independent Mental Health Advocates (£millions, 2022/23 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
BAU	9	19	19	19	20	20	21	21	21	22
Policy	16	32	35	38	51	51	52	53	53	54
Additional	7	13	16	19	31	30	32	32	32	32

*half year in 2024/25

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	22	22	22	22	22	22	22	22	22	22	**412**
Policy	55	55	55	55	55	55	55	55	55	55	**984**
Additional	33	33	33	33	33	33	33	33	33	33	**571**

Table 4. Estimated number of additional Independent Mental Health Advocates (FTEs; i.e. additional to BAU FTE in each year)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Additional	244	249	292	348	567	573	596	594	601	609

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44
Additional	616	612	616	616	617	617	618	618	618	619

Costs by professional group – Approved Mental Health Professionals (AMHPs)

42. 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 a humane and dignified way[42].

43. Under Option 2, it is expected that the workload for AMHPs will increase, with 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. Overall, AMHPs additional workload could increase by around 30 hours per CTO (see Annex B.IV for further details).

44. 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

[42] 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

obtained the number of additional FTEs required; then multiplied these by the estimated staff cost for AMHPs (including salary, oncosts[43], overhead[44] and capital[45]).

45. We use a simplified approach to estimate and profile associated training costs: comparing the number of additional FTEs required in one year to those of the previous year, and converting this difference into headcount. Some professionals work full time as an AMHP whilst others only work part-time and to account for this we estimated that for each FTE there is 1.4 headcount. We then multiplied the estimated headcount by the estimated training cost for each AMHP (including tuition fee and backfill costs). For further details see Annex B.IV.

46. Over the twenty year period from 2024/25 (half year) to 2043/44, additional total costs are estimated to be c.£100 million (undiscounted). The additional cost is expected to be at its highest at £12 million in 2028/29 under Option 2 due to training costs for additional AMHPs as the ACD and CTO polices are implemented (in 2027/28 and 2028/29 respectively). The additional cost decreases to £6 million by 2031/32 in line with the forecast decrease in CTOs over the period – see table below.

Table 5. Estimated additional monetised costs for Approved Mental Health Professionals (£millions, 2022/23 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
BAU	89	89	89	89	89	89	89	89	89	89
Policy	89	89	89	90	101	97	96	96	95	95
Additional	0	0	0	1	12	8	7	6	6	6

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	89	89	89	89	89	89	89	89	89	89	**1,785**
Policy	95	95	95	95	95	95	95	95	95	95	**1889**
Additional	6	6	6	6	6	6	6	6	6	6	**104**

47. From 2024/25 to 2028/29, an estimated 101 additional FTE staff would be required, with 91 of these placed in 2028/29 to meet the estimated increase in workload, but training new staff may in practice be spread over a longer period.

Table 6. Estimated number of additional Approved Mental Health Professionals (FTEs; i.e. additional to BAU FTE in each year)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Additional	3	3	3	10	101	93	85	78	70	70

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44
Additional	70	70	70	70	70	70	70	70	70	70

[43] Oncosts are essential associated costs such as salary oncosts which, for example, include the employer's national insurance contributions. Source: Unit Costs Report 2021 - Final version for publication.pdf (kent.ac.uk) (Glossary)

[44] Management and other non-care staff overheads include administration and estates staff. Non-staff overheads include costs to the provider for office, travel/transport and telephone, education and training, supplies and services (clinical and general), as well as utilities such as water, gas and electricity. Source: as above

[45] Capital overheads The cost of buildings, fixtures and fittings employed in the production of a service. Source: as above.

Costs by professional group – Second Opinion Appointed Doctors (SOADs)

48. 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, determined by the patient's clinical team, is appropriate. As part of this assessment, the SOAD should assess if due consideration has been given to the views and rights of the patient.

49. 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 or independent scrutiny, 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):

    - if the patient is refusing with capacity or treatment is in conflict with a valid advance decision or decision of a donee[46] or deputy or court, the SOAD must pre-approve that the treatment can be given before it can be administered compulsorily. This means that the SOAD could be requested from the first day of a patient's detention, rather than after 3 months of compulsory treatment;

    - if the patient lacks capacity to provide their valid consent, then the SOAD will be required to assess and potentially certify the patient's treatment at 2 months instead of 3 months (after treatment began);

    - if the patient requires urgent ECT and is refusing with capacity or treatment is in conflict with a valid advance decision, or decision of a donee or deputy or court, a SOAD will be required to pre-approve that the treatment can be given.

50. Patients that could be eligible for SOAD provision include those under Part II and Part III of the MHA. To estimate the number of detainees affected by the proposals we have taken the following approach:

51. For patients detained under Section 2 and Section 3 we have used length of stay data for 2020/21 from the MHA statistics published by NHS Digital[47]. This data does not provide complete length of stay information, but includes summary statistics of 25th, 50th and 75th percentiles of continuous detainee length of stay by section (which might be more than one detention period if there is no gap). Section 2 detainees would normally last no more than 28 days and so would not usually currently require a SOAD. Under the policy option, some of the Section 2 patients (those with capacity and refusing treatment) may also be eligible for a SOAD. For Section 2 detainees, 25% of had a length of stay of up to 10 days in 2020/21. We have used this as a lower cut off for Section 2 detainees and so estimate that up to 75% of Section 2 patients might be covered by SOAD provision under the proposed policy options. For Section 3 detainees, length of stay data suggests that current SOAD provision covers around 50% of Section 3 detainees. By extending the access to a SOAD to 0-3 months for patients refusing with capacity and 2-3 months for those lacking capacity, all Section 3 patients that refuse treatment with capacity would be covered (an additional 5% of detainees) along with an additional 16% of detainees that lack capacity.

52. 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, including SOAD fees, training and appraisal costs, management and support, travel and subsistence, and overheads.

[46] A donee is a person who is given a power of appointment

[47] Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

This provided an average unit cost per SOAD visit of around £411 (2022/23 prices), which has been applied to the forecast number of SOAD visits – see Annex B.V for further detail.

53. For patients requiring urgent ECT who are refusing with capacity or where treatment is in conflict with a valid advance decision, or decision of a donee or deputy or court, we have taken a similar approach as for other SOAD visits. However, this may underestimate the costs associated with an urgent response service, and estimates will be refined for the final IA.

54. The additional total costs (undiscounted) are summarised in Table 7 below. Over the twenty year period from 2024/25 (half year) to 2043/44, these are estimated at £71 million - around £4 million per year starting in 2027/28.

Table 7. Estimated additional monetised costs for SOADs (£millions, 2022/23 prices, undiscounted)

	2024/25*	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
BAU	3	7	7	7	7	7	7	8	8	8
Policy	3	7	7	11	11	11	11	12	12	12
Additional	0	0	0	4	4	4	4	4	4	4

*half year in 2024/25

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	8	8	8	8	8	8	8	8	8	8	**147**
Policy	12	12	12	12	12	12	12	12	12	12	**218**
Additional	4	4	4	4	4	4	4	4	4	4	**71**

55. SOAD activity usually complements other activities for the professionals involved, so FTE estimates were converted to headcount figures . 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 8. Estimated numbers of additional SOADs needed (headcount; i.e. additional to BAU headcount in each year)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Additional	-	-	-	80	88	89	90	91	92	94

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44
Additional	94	94	94	94	94	94	94	94	94	94

Costs by professional group – Clinical Teams

56. Clinical teams are formed of multiple disciplines, including responsible clinicians (RCs), occupational therapists and nurses, both in hospitals and the community. These professionals are expected to play an increased role in the care and treatment of formal patients, due to the additional safeguards the reformed Act will introduce, and to play a new role in supporting patients to prepare their Advance Choice Documents (ACDs) (see Annexes B.VI and B.VIII). Assumptions about additional workload were discussed and agreed with NHS England.

57. The additional costs are expected to arise in the following areas: CTP setup, contact with increased SOAD visits, applications and renewals of sections, and supporting patients to prepare ACDs. Clinical teams also need to support tribunal hearings, which will likely increase in the future relative to the BAU. The estimated monetised costs are summarised in the tables below; due to the phased implementation of the policies (see Table 1), cost profiles vary. The relevant policies and respective implementation start times are 2027/28 for ACDs, 2027/28 for changes to the SOAD service, 2028/29 for compulsory CTPs, 2028/29 for changes to CTOs, and 2030/31 for changed frequency of tribunals.

58. Under both Options 1 and 2 we calculated annual costs of MHT hearings separately for each healthcare profession. We multiplied the estimated time per hearing by the estimated staff cost (including salary, oncosts and overheads) and then summed over healthcare professions. For additional healthcare costs, annual costs were also calculated separately for each profession by multiplying extra time required per detainee by estimated staff cost (including salary, oncosts and overheads). Similarly, ACDs annual costs were assessed separately for each healthcare profession. For further details see Annexes B.VI and B.VIII. The figures presented indicate additional workload required by professional groups and not additional headcount.

59. Over the twenty year period from 2024/25 to 2043/44, costs are at estimated at £67 million for supporting additional MHT hearings and £548 million for healthcare settings. The total additional costs over the appraisal period is estimated at £615 million.

Table 9. Estimated <u>additional</u> monetised costs for clinical staff (£millions, 2022/23 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Tribunals frequency	0	0	0	0	0	0	7	4	4	4
Other policies (CTPS, ACDs, renewals, SOADs meetings)	0	1	1	8	26	26	34	34	34	35
Total	0	1	1	8	26	26	41	38	38	39

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Tribunals frequency	6	4	5	5	5	5	5	5	5	5	**67**
Other policies	35	35	35	35	35	35	35	35	35	35	**546**
Total	41	39	40	40	40	40	40	40	40	40	**613**

Notes:

- We only estimated additional healthcare setting costs (in both hospital- and community-based healthcare settings), as it was challenging to estimate and forecast BAU.
- Other policies cover CTPs, interaction with SOADs, section renewals, changes to CTOs and ACDs. The breakdown of cost by policy can be found in Table 2.

60. The estimated number of additional clinical staff in each year required across the 20 year period are presented in the table below:

Table 10. Estimated numbers of additional staff required (FTEs; i.e. additional to BAU FTE in each year)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Responsible Clinician	2	2	2	13	90	92	160	149	155	157
Nurse	6	5	5	16	17	17	46	33	36	35
Other clinical staff	0	0	0	12	13	13	13	13	13	14
Community Supervising Clinician	0	0	0	0	26	24	21	19	17	17
Additional Clinician	0	0	0	0	15	14	12	11	10	10
Occupational Therapist	6	5	5	5	5	4	4	4	4	4
Care Coordinator	0	0	0	0	0	0	29	16	19	18
Community Care Coordinator	0	0	0	38	39	40	40	41	42	43
Medical Consultant	0	0	0	12	12	12	12	13	13	13
Peer Supporter	0	0	0	12	12	12	12	13	13	13

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44
Responsible Clinician	166	157	161	161	161	161	161	161	161	161
Nurse	44	35	38	38	37	37	37	37	37	37
Other clinical staff	14	14	14	14	14	14	14	14	14	14
Community Supervising Clinician	17	17	17	17	17	17	17	17	17	17
Additional Clinician	10	10	10	10	10	10	10	10	10	10
Occupational Therapist	4	3	3	3	3	3	3	3	2	2
Care Coordinator	27	18	22	21	21	21	21	21	21	21
Community Care Coordinator	43	43	43	43	44	44	44	44	44	44
Medical Consultant	13	13	13	13	13	13	13	13	13	13
Peer Supporter	13	13	13	13	13	13	13	13	13	13

Costs by professional group – Costs for administrative staff in healthcare providers

61. Policies that could bring additional costs for administrative staff are the nominated person (NP; e.g. recording the NP in the patient's record, including potential changes to the patient's appointed NP, providing information to the NP, and consulting with them when necessary), ACDs, CTPs (particularly for CTP audits), and changes to the frequency with which patients can access the MHT. Assumptions about additional workload were discussed and most were agreed with some providers and will need to be refined alongside further development of the policy[48].

62. To estimate these additional administrative staff costs, we used assumptions on the extra time required for the additional tasks, then multiplied it by the number of detentions or tribunal hearings and by the average staff costs associated with each – for further detail, see annex B.VIII for ACDs and

[48] It is quite uncertain how the NP changes will be in practice and how much more additional administrative they would require. Due to this uncertainty, agreement on illustrative scenarios was more difficult and they would need to be refined.

annex B.VII for CTPs, NP and changes to tribunal frequency. Administrative costs associated with the SOAD work are included in the SOAD cost estimates described above.

63. The estimated additional monetised costs are summarised in the table below.

Table 11. Estimated monetised costs for administrative staff (£millions, 2022/23 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
BAU	2	2	2	2	2	2	2	2	2	2
Policy	3	3	3	3	5	5	5	5	6	6
Additional	1	1	1	1	3	3	3	3	3	3

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	2	2	2	2	2	2	2	2	2	2	**42**
Policy	6	6	6	6	6	6	6	6	6	6	**101**
Additional	4	4	4	4	4	4	4	4	4	4	**60**

64. Estimated numbers of additional administrative staff (FTEs) are given in the table below.

Table 12. Estimated numbers of additional administrative staff (FTEs; i.e. additional to BAU FTE in each year)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Total	16	16	17	20	37	37	41	40	41	41

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44
Total	42	41	42	42	42	42	42	42	42	42

Familiarisation costs

65. 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 policies, procedures and documentation. It is likely that extra training would be needed to prepare those organisations whose roles will directly change as a result of the reforms. 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 costs (see Sensitivity Analysis section).

66. To help facilitate the planned changes, we have considered that clinicians will need additional familiarisation training to bring them up to a working knowledge. We would expect that this training would then be part of their normal refresher training and are assuming that the bulk of these transitional costs would take place in 2024/25, before the first MHA powers are turned on. We present below initial familiarisation cost estimates for Section 12 clinicians, which include approved clinicians[49] (mental health professionals approved to make decisions under the MHA - all responsible clinicians must be approved clinicians). We will seek to provide further estimates as needed in the final IA.

[49] The British Psychological Society. Approved Clinician frequently asked questions. (2017). Accessed at: Approved Clinician FAQ - June 2017.pdf (bps.org.uk)

67. In 2020/21 there were c9,900 Section 12 doctors on the Mental Health Act Approval register[50] run by DHSC[51]. We estimate this could rise to around 10,700 by 2024/25 by assuming that this increase is in line with an average of modelled increases in detentions and changes over 10 years in number of NHS Psychiatrists[52]. Familiarisation training would take 1 day, costing £225 in 2022/23 prices per clinician[53], which gives an estimated one-off estimated cost of £2.4 million. We have also estimated costs to cover a clinicians' time and back fill using a consultant psychiatrist cost of £452 per day in 2022/23 prices (annual salary of £93,099)[54], which gives an estimated cost of £9.6 million. The overall cost is estimated at around £12 million.

Monetised Costs – Justice System

68. The monetised costs for the Justice system relate to changes that affect the Mental Health Jurisdiction of the First-tier Tribunal – also known as the Mental Health Tribunal or MHT. The Government proposals aim to broaden the rights and liberties of users of mental health services, thus expanding the use of the MHT and so incurring extra cost.

69. The estimated implementation time for the proposed changes to the MHT is 2030/31. The relevant appraisal period for MHT reforms in this IA spans 14 years, from 2031/32 to 2043/44. This allows us to cover 10 years of full implementation of the MHT reforms, within a 20-year appraisal from the start of DHSC's policies in 2023/24.

70. Estimates were made using a forecast of the number of receipts/hearings and a hearing days per sitting day ratio of 1.36, multiplied by the average sitting day costs for an MHT. The average sitting day cost of the MHT used in this IA was £2,262 in 2019/20 – this cost consists of staff costs, judicial salaries, estate costs and any other associated costs. The average sitting day cost is assumed to remain constant in real terms – i.e., change in line with the annual UK GDP deflator throughout the appraisal period. The monetised proposals have been broken down by their impact on the MHT and associated legal aid costs. Further details on the analytical approach can be found in Annex C.

71. 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. Presented below is the central scenario, with further detail found in the sensitivity analysis section.

72. In total, the proposals would amount to an estimated additional cost of £223 million (undiscounted) for the Justice system over our 14-year appraisal period (14 years since these costs start in 2030/31 due to phased implementation as set out in Table 1). As shown in Table 13 below, the largest cost driver is automatic referrals. Further details of each of the individual policy areas and their associated additional costs are explored in further detail below.

73. Estimated additional costs for the main Justice system impacts, including legal aid, are presented in tables 13 and 14 below for the following proposals:

    - Automatic referrals to the MHT – proposals relating to those detained or receiving treatment under the MHA having cases referred automatically to the MHT at specific points in time.

    - Treatment choices - a proposal regarding the review of a statutory Care and Treatment Plan (CTP) at the MHT hearing.

[50] Mental Health Act Register Database, DHSC, NHS Section 12 Doctor Database : Security (mharegisters.nhs.uk)

[51] Stevens et al,(2020), The availability of section 12 doctors for Mental Health Act assessments: Interview perceptions and analysis of the national MHA Approvals Register Database. Accessed at: The availability of section 12 doctors for Mental Health Act assessments: Interview perceptions and analysis of the national MHA Approvals Register Database - Research Portal, King's College, London (kcl.ac.uk)

[52] NHS Digital 2020, https://digital.nhs.uk/data-and-information/publications/statistical/nhsworkforce-statistics/april-2020

[53] Royal College of Psychiatrist refresher training of Section 12(2) Registration https://www.rcpsych.ac.uk/events/conferences/s12ACtraining/registration-section-12-refresher

[54] Unit Costs of Health and Social Care 2020 (pssru.ac.uk) Table 14.

- Expanded powers of the MHT – proposals regarding new powers for the MHT surrounding rights to discharge patients and review CTOs.

Table 13. Total estimated additional monetised costs for the Mental Health Tribunal, including legal aid, central scenario (£millions, 2022/23 prices, undiscounted and rounded to nearest £1m)

	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
BAU	36	36	36	35	35	35	35
Policy	57	50	51	50	54	50	51
Additional	21	14	15	15	18	15	16

	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	34	34	34	34	33	33	33	**484**
Policy	50	50	49	49	49	48	48	**706**
Additional	16	16	16	15	15	15	15	**223**

Table 14. Total estimated additional monetised costs for the Mental Health Tribunal, including legal aid, by proposal type, central scenario (£millions, 2022/23 prices, undiscounted and rounded to nearest £1m)

	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Automatic Referrals	17	11	12	11	15	11	12
Treatment choice	3	3	3	3	3	3	3
Expanded Powers	1	1	1	1	1	1	1
Total	**21**	**14**	**15**	**15**	**18**	**15**	**16**

	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Automatic Referrals	12	12	12	12	11	11	11	**171**
Treatment choice	3	3	3	3	3	3	3	**43**
Expanded Powers	1	1	1	1	1	1	1	**11**
Total	**16**	**16**	**16**	**16**	**15**	**15**	**15**	**223**

Automatic Referrals

74. The Government proposes that patients who are either detained or receiving treatment under the MHA and have not made an application to the MHT will have their case automatically referred at specified periods during their detention or treatment. The automatic referral proposals impact distinct patient groups (e.g., some proposals only impact part III patients).

75. Part III patients under 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 MHRT 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.

76. To avoid overestimating MHT activity in light of discharges by an individual’s RC that often occur prior to the hearings taking place, we used MHT hearing volumes instead of receipt volumes in most 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, using MHT receipts was more appropriate to calculate legal aid costs. Further detail on the methodology for automatic referrals can be found in Annex D.

77. 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.

78. The Government intends to take forward the following proposals:

- Having an automatic referral to the MHT at 3 months, 12 months and annually after the start of the detention. This interacts with the proposal to reduce initial maximum detention periods and both are applicable to part II patients. The estimated total additional costs including legal aid of the proposals over our 14-year appraisal period is £28 million (undiscounted), assuming that the proposal results in a 100% increase in referrals.

- 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. The estimated total additional costs including legal aid of this proposal over the appraisal period is £84 million (undiscounted), based on an estimated 37% increase in applications to the MHT.

- Part III patients will have an automatic referral once every 12 months. This proposal has the largest estimated additional cost, including legal aid at £110m (undiscounted) due to the central assumption of an increase in receipts of 325%.

- There are two proposals relating to 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. Whilst this should result in increased referrals to the MHT for each patient subject to a CTO, the intention of the reforms is to bring down the overall volume of CTOs, therefore actually resulting in fewer referrals to the MHT. Using DHSC's assumed central scenario of a gradual 40% decrease in the annual number of CTOs, there is an estimated avoided cost of £85m (undiscounted) over the 14-year appraisal period. The proposed 40% reduction is not assumed to occur until 2032/33; until that point there is a gradual decline over the previous 5 years in the number of CTOs as a result of implementing the policy to revise the criteria for CTOs in 2028/29.

- Automatic referrals for people on conditional discharge after 24 months and at regular intervals of 4 years after that for those who have not applied directly. The estimated total additional costs including legal aid of this proposal over the 14-year appraisal period is £33m (undiscounted). As this is a new policy there is no current BAU.

79. Automatic referrals are the key cost driver of the MHA reforms on the Justice system with an estimated additional cost of £171m (undiscounted) over the 14-year appraisal period, as seen below in the table below.

Table 15. Estimated monetised costs, including legal aid, from implementing the automatic referral recommendations (£millions, 2022/23 prices, undiscounted and rounded to the nearest £1m)

	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
BAU	34	34	34	34	33	33	33
Policy	52	45	46	45	48	44	45
Additional	17	11	12	11	15	11	12

	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	33	32	32	32	32	31	31	**458**
Policy	45	44	44	43	43	43	42	**629**
Additional	12	12	12	12	11	11	11	**171**

Detention Criteria

80. The Independent Review stipulates 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 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

81. The Government proposes to allow the MHT to review the patient's CTP where concerns have been expressed.

82. 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 an MHT hearing, as existing patient plans already include reports to MHTs. Costs have therefore not been estimated for this subset of hearings. The analysis has focused on the following assumptions, which have been agreed with HMCTS:

    - Hearings relating to applications for discharge (excluding Section 2) are likely to increase in year 1 (2030/31) by a central assumption of 40 minutes per hearing, resulting in fewer hearings on average being heard per sitting day.

    - The hearing volumes for each policy scenario uses 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. The original hearings per sitting day ratio is 1.36 but with an additional 40 minutes per hearing this lowers the hearings per sitting day to 1.15 under the central scenario.

83. The estimated additional costs associated with the proposed legal changes to treatment choices are presented in the table below. There is a zero BAU because this element is entirely new. The estimated impact of the proposed changes to treatment choices over the 14-year appraisal period is put at £43 million.

Table 16. Estimated <u>additional</u> costs of increased treatment choices on the Mental Health Tribunal (£millions, 2022/23 prices, undiscounted and rounded to the nearest £1m)

	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Additional	3	3	3	3	3	3	3

	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Additional	3	3	3	3	3	3	3	**43**

Expanded Powers

84. The Government proposes to expand the powers of the MHT through three reforms for which costs have been estimated. The total estimated additional cost including legal aid of these policies over our appraisal period is £11m.

85. The Government accepted in principle the Review's recommendation to give the MHT the power, during an application for discharge, to grant leave from hospital and transfer to a different hospital (currently it has the power to make recommendations) and extend the MHT's power to direct the provision of aftercare services. After further consideration, it has been decided that these powers should remain as recommendations. We do propose that the MHT should have the power, during an application for discharge of non-restricted patients, to recommend that the relevant aftercare bodies

make plans for the provision of aftercare services for the patient where this is necessary to facilitate discharge at a future date. By conferring this power on to the MHT, it is considered that this will strengthen the MHT's role in reviewing a patient's detention and where necessary ensure earlier consideration is given to what services could be put in place for the patient.

86. The costs associated with this policy relate to the extra 2 hours of hearing time per case which would be required. Assuming that there are 10 cases which would be heard per year, this would require an additional four sitting days per year for the MHT. The additional estimated cost for these 4 days a year is around £0.2m over the appraisal period.

87. The Government wants to ensure the conditions attached to CTOs are proportionate. As such, it is proposed that the MHT should have the power to review the conditions attached to the CTO and recommend that the RC reconsider the conditions specified in a CTO in line with Section 17B(2) criteria when dealing with an application or reference by or on behalf of a community patient.

88. The position taken in the White Paper was that the MHT would only have the power to recommend that the RC reconsider those conditions that would not impact on the patient's clinical treatment, in order to avoid the MHT having a role in clinical decision making. However, having considered this further, we have concluded that in practice it will often be difficult to distinguish between 'clinical' and 'non-clinical' conditions and therefore we think the power to recommend should apply to all CTO conditions.

89. This will again result in an estimate of additional judicial time of one hour per case for an additional 851 receipts, resulting in 170 extra sitting days for the MHT per year, assuming there are 5 hours per sitting day. This corresponds to an additional cost estimated at around £6 million over the appraisal period.

90. For a very distinct group of restricted patients it is proposed that the MHT should have the power to discharge with conditions that restrict their freedom in the community, potentially with a new set of safeguards. These patients would be those for whom the MHA is no longer providing therapeutic benefit by detention in hospital, but who pose such a significant risk to others they would need continuous supervision to be managed safely in the community.

91. The current policy position is that a review should take place at 12 months after discharge, and then every two years. The patient can apply to the MHT between 6-12 months following discharge. The Secretary of State for Justice also holds a discretionary power to refer a patient to the MHT for review, following application by the patient or their representative.

92. The result is that there will be a stock of patients reviewed by the MHT after 12 months and then every 2 years, as well as small numbers of new patients each year. Data on this cohort are extremely limited, although the size is expected to be small. The modelling has used an indicative estimate of an initial stock of 220 individuals with an extra 10 per year; only half of stock patients will be reviewed in 2031/32 and half in the following year. This results in extra sitting days per year for the MHT therefore incurring extra costs, but it is estimated that these are minimal compared to the total additional costs for the Justice system. As this is a new policy there is no BAU. The estimated additional cost is therefore around £5 million.

Table 17. Estimated additional costs of expanded powers on the Mental Health Tribunal (£millions, 2022/23 prices, undiscounted and rounded to the nearest £0.1m)

	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
BAU	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Policy	2.2	2.2	2.2	2.3	2.3	2.3	2.3
Additional	0.7	0.7	0.8	0.8	0.8	0.8	0.8

	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	1.5	1.5	1.5	1.5	1.5	1.5	1.5	**21**
Policy	2.3	2.3	2.4	2.4	2.4	2.4	2.4	**32**
Additional	0.8	0.8	0.9	0.9	0.9	0.9	0.9	**11**

Legal Aid Impact

93. Legal aid impacts have been provisionally estimated for all of the Government proposals, where possible. 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.

94. Most of the preparation work for an MHT hearing, for which providers can claim a preparation level fee, will be done more than 10 days in advance of the hearing date. Therefore, we do not expect the proposal, which aims to reduce the burden of MHT cancelled at the last minute, would have much impact on the legal aid claim total. With regard to the proposal that would allow the MHT to review the patients CTP, there is no expected impact on receipt volumes, so it has not been possible to estimate the potential legal aid costs associated with this recommendation. However, it is possible that 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.

95. For the proposals relating to Automatic Referrals, 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.

96. 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 in reality. As such, the estimated total legal aid costs may reflect an upper bound of public sector costs, but a fairer estimate of the overall economic cost. Additionally, the BAU scenario is modelled for each proposal 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.

97. The table below shows the total estimated cost for legal aid that 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. Over the 14-year appraisal period it is estimated that the proposals could result in an additional legal aid cost of £67 million.

Table 18. Estimated monetised costs for legal aid from increased receipts and hearings in the Mental Health Tribunal system, central scenario (£millions, 2022/23 prices, undiscounted and rounded to the nearest £m)

	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
BAU	12	12	12	12	11	11	11
Policy	20	17	17	16	17	16	16
Additional	7	5	5	5	6	5	5

	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
BAU	11	10	10	10	10	9	9	**151**
Policy	15	15	15	14	14	14	13	**218**
Additional	5	5	4	4	4	4	4	**67**

Non-Monetised Costs

Non-Monetised Costs – Health and Social Care System

Advance Choice Documents (ACDs)

98. 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 costs. These have not been captured in this IA.

Learning Disabilities and Autism

99. The Government proposes 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 there is a substantial risk of significant harm to self or others (as for all detentions). The assessment process under Section 2 should seek to find the cause of this distressed behaviour and if a mental health condition is identified as the cause 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).

100. 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) (to become Integrated Care Boards (ICBs) as a result of the Health and Care Act 2022) commissioners to ensure an adequate supply of community services specifically for people with a learning disability 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. These costs are challenging to quantify and are not included in this IA as there are existing programmes in place to expand community services. We do not currently know whether the new duties in the MHA will cost more than the resource provided through the NHS Long Term Plan, hence why this is not quantified here. 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.

Places of safety

101. The implementation requirements for removing police stations as a place of safety are likely to be small, since only 132 people were held in stations under Section 136 across England and Wales in 2020/21[55]. We know that some areas use police stations as a place of safety more than others, and their use can be driven by local circumstances – for example, local protocols and ways of working or the availability of health based places of safety, which may require capital investment to address in some cases. DHSC will work with NHSEI, the Home Office and NPCC to identify and address specific local operational challenges currently leading to the use of police stations as a place of safety. This ongoing work will help to inform what extra help is required, at a local level, to ensure the system is sufficiently equipped to meet the demand that may have previously been met by police cells. We have not yet been able to monetise this potential cost as it will be heavily driven by local circumstances. However, as figures from 2020/21 show that from a total of around 30,800 uses of places of safety

[55] Home Office (14 December 2021). Detentions under the Mental Health Act (1983) data tables, police powers and procedures, year ending 31 March 2021

following a Section 136 detention in England a police station was used 112 times, we do not envisage the scale of this cost to be significant[56].

Training costs for clinical staff and workforce planning

102. 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.

103. DHSC is working with system partners to understand the workforce requirements of the Mental Health Act Reforms, which will provide the foundation for planning the phased approach to implementation of the reforms. The monetised costs for clinical staff included in this IA include the cost of providing more clinical capacity based on workload (see Table 10 for FTE figures). This additional workload will likely be satisfied both by workers already in the system and new recruits. This IA has not monetised the additional cost associated with the training required to support this expansion in the workforce. The expansion of the MHA workforce is dependent on delivering the existent workforce expansion through the Long Term Plan.

Additional CQC costs

104. The MHA reforms will place an additional costs on the CQC including for instance provision of SOAD service to respond to urgent ECT. Some of these costs have been estimated in the current IA based on current SOAD provision (around 8% of additional costs to SOAD provision). However, there will be additional costs including administrative and management support to enable appropriate SOAD provision in urgent cases, which are being assessed by the CQC and not be included in this IA.

Non-Monetised Costs – Justice System

Expanded Powers

105. 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 and overruling a Nearest Relative (Nominated Person)

106. The Government has considered whether the County Court's power to displace a NR 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. Taking into account the wider reforms and impacts on the MHT, we propose that the power to fully displace a NP should remain in the County Court. In addition, we propose that the RC should have the power to temporarily 'block' the NP (through a barring order) if the NP appeals Section 3 admission, or objects to a CTO or ordering a patients discharge, but the patient is considered dangerous to themselves or others. This is in-keeping with the existing approach set out in Section 25 of the Act, which enables the RC to bar the use of the NR's power to discharge the patient.

107. The MHT will only be involved if the NP is barred and they later decide to use their right to apply to the tribunal (as is the case where the NR receives a barring order). In this way, the NP will still be able to retain their position and inform the patient's care and treatment, except for in the most extreme or serious circumstances e.g. where they pose a safeguarding risk to the patient, in which case the application can be made to the County Court to displace the NP.

[56] Home Office, Detentions under the Mental Health Act. Police Powers and Procedures, 2020/21. Accessed here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1040066/detentions-under-the-mental-health-act-1983-_police-powers-and-procedures-year-ending-31-March-2021.xlsx

108. We do not expect there will be a significant number of subsequent applications to the MHT by the NP, but we require further data in order to form appropriate assumptions.

Additional training for panel members

109. The Government agreed in principle in its White Paper that training should be developed for MHT panel members in specialisms including children and young people, forensic psychiatry, learning disability, autism, and older people.

110. 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.

Length of detention

111. The Government proposed that where a person has been subject to detention under Section 3 within the last twelve months, an application for detention under Section 2 should only be made where there has been a material change in the person's circumstances. In addition, the Government proposed that the Code of Practice should make it clear that Section 3, rather than a Section 2, should be used when a person has been already subject to Section 2 within the last twelve months. Finally, the Government has proposed that the detention stages and timelines should be reformed so that they are less restrictive through extending the right of appeal for Section 2 beyond the first 14 days. These proposals have not been modelled in this iteration of the IA as there is currently insufficient data to model the monetary impact on the tribunal.

Ending the use of prison as a place of safety

112. The Bill will include legislative changes to end the use of prison as a place of safety for accused or convicted people in the Criminal Justice system who are awaiting assessment or treatment under the MHA.

113. Under Part III of the MHA, a court may send an accused or convicted person to hospital for an assessment or treatment where they have concerns about their mental health. If the hospital cannot immediately receive the person, the court may direct them to a place of safety in the interim (for a maximum of 7-28 days). In this context, for adults, a place of safety means any police station, prison or remand centre, or any hospital whose managers are willing temporarily to receive the person.

114. Similarly, people can be remanded to prison under the 'own protection' clause of the Bail Act (1976), which is sometimes used in cases where there is concern over mental health and is also often referred to as prison being used as a place of safety. Schedule 1 of the Bail Act states that the defendant need not be granted bail if the court is satisfied that they should be kept in custody for their own protection or, for a child or young person, for their own welfare. MoJ is undertaking an internal review of the use of the power to remand for 'own protection' under the Bail Act. This work will need careful consideration before a final decision is made on whether to amend legislation to avoid any harm coming to vulnerable defendants.

115. There are multiple scenarios in which a prison could be used as a place of safety under the MHA so it is critical that we fully understand how, when and why this is happening before we can be sure of safely ending its use entirely.

116. Because of a lack of centralised recorded data, it is difficult to establish how frequently any of these scenarios are occurring. The MoJ, DHSC, Her Majesty's Prison and Probation Service (HMPPS), HMCTS, NHS England and NHS Improvement have established a cross-government working group to identify and analyse relevant data sources and case examples. Although data on this issue are limited, anecdotal evidence suggests the power is rarely used.

117. 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 or in psychiatric intensive care units in the community) would be greater by an equal amount.

Transfers to hospital from prisons and Immigration Removal Centres

118. In the White Paper, the Government has committed to introducing a new statutory time limit of 28-days for transfers from prisons and IRCs to mental health hospitals. We intend to deliver on this commitment and introduce a statutory time-limit to create greater accountability for all agencies involved in the transfer process to meet the good-practice time-limit set-out in NHS England and NHS Improvement's Transfer and Remission Guidance published in June 2021[57].

119. We remain mindful that enshrining the time limit in statute could result in unintended consequences if not carefully managed. 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. Furthermore, we wish to avoid patients being transferred to a distant hospital far from their existing support networks when more local provision is unavailable in order to comply with a time limit on transfers. 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.

120. We also recognise that the costs of taking this proposal forward 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. NHS England and NHS Improvement have commenced collecting data against the new timeframe of 28 days from April 2021, but as this is not yet considered reliable data, we have no understanding of the proportion of transfers currently happening within 28 days.

121. A 2020/21 HM Inspectorate of Prisons report gives some anecdotal evidence, finding that some prisoners due for transfer under the MHA had to wait for unacceptably long periods of time, with one prisoner waiting 266 days for transfer. However, other prisons reported no delays for transfers, and it is hard to determine the overall potential risk of not meeting the new guidelines. There are difficulties in costing this proposed policy as implementing the statutory transfer time would not necessarily bring about additional cost, that is, the assumption is these transfers would happen anyway but under the proposed changes in a timelier manner. Without these data it is not possible to ascertain what the current cost of these transfers are, and it would be difficult to make assumptions on the potential unintended consequences without further understanding the current situation.

122. Despite these potential costs and risks, we are confident that the introduction of a 28-day statutory time-limit is an effective means of tackling delays to transfers and creating greater accountability for the health and justice agencies involved in the transfer process as set out in the NHS England and NHS Improvement's guidance. In line with the White Paper's position, the time limit will only be made statutory once necessary operational improvements have been made to enable safe delivery of this change.

Detention Criteria

123. The Review recommended that the criteria for detention under the MHA should be strengthened. This would require that treatment is available which would benefit the patient, and which cannot be delivered without detention, rather than solely to service public protection. It would also require there

[57] NHS England » Guidance for the transfer and remission of adult prisoners and immigration removal centre detainees under the Mental Health Act 1983

to be a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person without treatment.

124. These changes to the detention criteria could mean that fewer people will meet the criteria for detention under Part III of the MHA. This may result in more people remaining in prison when they may previously have been transferred to hospital. Whilst this reduced demand for secure hospital places may result in lower costs to the Healthcare system, it will simply be a transfer of demand to the Justice system in relation to the prison population. Strengthening the detention criteria may also have the consequence that those who would previously have been diverted from custody by courts may instead serve a custodial sentence. This change to the detention criteria has not been costed in this iteration of the IA due to the difficulty of estimating the potential numbers affected.

Summary of Costs

125. The estimated costs of the policy interventions under Option 2 have been summarised in the table below. They have been split into costs relating to the NHS, Local Authorities, SOADs (under the responsibility of CQC) and the Justice System. They are first presented at 2022/23 prices and then discounted[58] and presented in a similar table for ease of comparison – see tables below.

126. Overall additional undiscounted costs for these three areas are estimated at £1,658 million for the 20-year period, an average of £83 million per year. Due to the phased implementation nature of the proposals, these costs are not evenly split over the 20 years starting from 2024/25 when the necessary legislation is assumed to be in place.

Table 19. Summary of total additional costs (£millions, 2022/23 prices, undiscounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35
NHS	13	2	2	9	29	29	44	41	42	42	44
Local Authority	7	14	16	20	43	38	39	38	38	38	39
SOADs	0	0	0	4	4	4	4	4	4	4	4
Justice System	0	0	0	0	0	0	21	15	15	15	19
Total	**21**	**16**	**18**	**33**	**76**	**71**	**108**	**98**	**99**	**100**	**106**

	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total	Average
NHS	42	43	43	43	43	43	43	43	43	**683**	**34**
Local Authority	39	39	39	39	39	39	39	39	39	**679**	**34**
SOADs	4	4	4	4	4	4	4	4	4	**71**	**4**
Justice System	15	16	16	16	16	16	15	15	15	**225**	**11**
Total	**100**	**102**	**102**	**102**	**102**	**102**	**101**	**101**	**101**	**1,658**	**83**

Note: Costs may not add up exactly due to rounding

127. For each area, overall undiscounted costs for the appraisal period are:

- Additional NHS (clinical and administrative staff) costs are estimated at £683 million, an average of £34 million per year;

[58] 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

- Additional Local Authorities (IMHAs and AMHPs) costs are estimated at £679 million, an average of £34 million per year;
- Additional SOAD costs are estimated at £71 million, an average of £4 million per year;
- Additional Justice system (tribunal procedure, automatic referrals inc. legal aid, treatment choice, detention criteria and expanded powers) costs are estimated at £225 million, an average of £11 million per year.

Discounted costs

128. The summary tables for all monetised costs below show Present Value (PV) cost estimates[59] (in 2022/23 prices) for the NHS, SOADs (CQC), Local Authorities and the Justice system, which overall are put at £1.07 billion for the appraisal period, an average of £68 million per year.

Table 20. Summary of total additional costs (£millions, 2022/23 prices, discounted)

	2024/25	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**
NHS (without opportunity costs)	13	2	2	7	24	23	34	30	29	29	29
Local Authority	7	12	14	17	35	30	30	28	27	26	26
SOADs	0	0	0	3	3	3	3	3	3	3	3
Justice System (including legal aid)	0	0	0	0	0	0	16	11	11	10	12
Total (without opportunity costs)	19	14	16	27	62	56	82	72	70	68	70

	2035/36	**2036/37**	**2037/38**	**2038/39**	**2039/40**	**2040/41**	**2041/42**	**2042/43**	**2043/44**	**Total**	**Annualised costs[60]**
NHS (w/o opport. costs)	27	27	26	25	24	23	22	22	21	**436**	**28**
Local Authority	25	24	23	22	22	21	20	19	19	**446**	**28**
SOADs	3	3	3	2	2	2	2	2	2	**46**	**3**
Justice System (incl. legal aid)	9	10	10	9	9	8	8	8	7	**139**	**9**
Total (w/o opport. costs)	64	63	61	59	57	55	53	51	49	**1,067**	**68**

[59] Present Value (PV) refers to the sum of the future costs of the policy in the 20-year appraisal period that have been discounted by the social time preference rate, at 3.5%, to bring them to today's value.

[60] Applying Department for Business, Energy & Industrial Strategy's Business Impact Target Assessment Calculator (13 May 2013) to undiscounted costs: Impact assessment calculator - GOV.UK (www.gov.uk). We did not use a simple average – as discounted costs decrease over time, the average would get lower for longer appraisal periods and would be, therefore, biased. The annualised costs estimates the *equivalent* annual real impact cost which, if it were constant across the appraisal period and then discounted and summed, would give the same NPV as the one estimated for the policy. We used annuity rates based on discounting rates of 3.5%.

129. For each area, the estimated total cost in Present Value terms estimated for the appraisal period are:

- £436 million for the NHS, an annualised average of £28 million per year;
- £446 million for Local Authorities, an annualised average of £28 million per year;
- £46 million for SOADs, an annualised average of £3 million per year; and
- £139 million for the Justice system, an annualised average of £9 million per year.

NHS and other healthcare resources opportunity costs

130. 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[61]. QALYs account for impacts on length of life (longevity) and health-related quality of life (QoL), where 1 QALY is equivalent to 1 additional year of life in full health or 2 years of life at half of full health.

131. In DHSC, it is considered that an additional QALY (valued by society at £70,000) can be purchased for £15,000[62]. Where proposed health spending redirects resources from alternative use in the NHS, the opportunity cost of spending is 4.7 times the financial cost (£70,000 divided by £15,000 ≈ 4.7).

132. If funding for these policies were met from within existing NHS resources, this would potentially create an opportunity cost of £4.7 for every £1 of diverted resources. To estimate the impact were this to be the case, in the table below we have uplifted estimated NHS clinical and administrative staff costs by multiplying them by a factor of 4.7. These healthcare opportunity costs were not applied in cost estimates presented above and are not included in the NPV reported on the summary sheets of this IA.

Table 21. Summary of total additional NHS costs with and without opportunity costs (£millions, 2022/23 prices, discounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35
NHS (without opport. costs)	13	2	2	7	24	23	34	30	29	29	29
NHS (with opport. costs)	59	7	7	35	110	105	156	140	138	134	136

	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
NHS (w/o opport. costs)	27	27	26	25	24	23	22	22	21	**436**
NHS (with opport costs)	126	124	120	116	112	108	104	101	97	**2,036**

[61] For a full explanation of the QALY cost/ benefit methodology, please see Annex E.

[62] 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

Benefits

133. In our approach to estimating benefits, we distinguish between:

- benefits (cost savings) to the Health & Social Care system, such as reducing the number and the length of detentions, and to the Justice system; and
- improved health outcomes, and a better and more dignified experience of treatment under the MHA, for patients and carers – the primary aim of the proposals.

134. 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 Healthcare system or via tribunals within the Justice system. We are not able to quantify the benefits attached to these proposals at this point.

135. A systematic review of published research studies showed that improvements in patient experience are associated with improved use of resources such as length of stay, readmissions and primary care use, and defended that patient experience is positively associated with clinical effectiveness and patient safety, and should be one of the central pillars of quality in healthcare[63] (see section on non-monetised benefits below). However, 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 Healthcare 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).

136. With regard to the Justice system, one aspect of the 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. There is also an avoided cost associated with automatic referrals for those on CTO's (recommendations 61+64). The overall reform package will cause a significant decline in the annual volume of CTOs and thus result in an avoided cost, this is explained in more detail in the monetised benefits section.

Monetised benefits

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

137. 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[64,65]. 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[66]. While the evidence does not show that crisis planning interventions reduce the risk of voluntary admissions, it does not suggest that voluntary admissions will be higher for

[63] 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/

[64] 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 June; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

[65] 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

[66] 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 June; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

those who engage in crisis planning[67]. 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).

138. There are also potential benefits pertaining to the wellbeing and health impact of an avoidable detention. Both the Independent Review[68] and the CQC annual reports on their monitoring of the uses of the MHA[69] have found that many patients are still not involved in the decisions involving their care, are not treated with dignity and respect, and are detained in low quality physical spaces. Many have spoken about their concerns or complaints, and about the trauma detention and treatment has caused them. Avoiding detentions, and instead receiving more beneficial voluntary treatment, would also imply avoiding deterioration in quality of life and longer term social impacts, which we do not monetise here.

139. To estimate the monetised benefits associated with savings to the Health and Social Care system, we calculated the number of compulsory admissions under the MHA prevented due to an ACD and multiplied that by the estimated total cost of a detention. There are two types compulsory admissions that could be avoided: i) the repeated detention avoided within the 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 from the sum of cost of length of stay and the average cost of detention including clinical costs, AMHP, SOAD and IMHA costs, and Justice system costs (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[70] and deflated to £6,032 in 2022/23 prices) from the costs of avoided detentions. The healthcare costs for people with Serious Mental Illness are likely to vary across clinical and socioeconomic characteristics. However, in the absence of robust evidence on this variation, we use 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 as a proxy for the cost of alternative healthcare services for those not in detention.

140. As this monetised benefit is dependent on the number of compulsory admissions prevented, which is strongly influenced by the uptake of ACDs and the impact of ACDs on preventing detentions, we have conducted sensitivity analysis around these variables. We have also estimated high and low monetised 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.

141. Monetised benefits (discounted) over the appraisal period are estimated at £747 million (ranging from £209 million to £1,165 million) – see table below.

[67] 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 June; 5(4): e53; published online 2019 Jun 13. doi: 10.1192/bjo.2019.28

[68] 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

[69] Monitoring the Mental Health Act | Care Quality Commission (cqc.org.uk)

[70] Ride, J., Kasteridis, P., Gutacker, N., 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)

Table 22. Estimated monetised benefits following Advance Choice Documents (ACDs) (£millions, 2022/23 prices, discounted at 3.5%)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Central scenario (40% ACD uptake rate and 25% detention prevention rate)										
Number of detentions prevented	0	0	0	2,105	2,149	2,193	2,238	2,284	2,331	2,378
Benefits	0	0	0	52	51	50	50	49	48	48
High monetised benefits scenario (40% ACD uptake rate and 39% detention prevention rate)										
Number of detentions prevented	0	0	0	3,284	3,352	3,421	3,491	3,562	3,636	3,710
Benefits	0	0	0	81	80	78	77	76	75	74
Low monetised benefits scenario (40% ACD uptake rate and 7% detention prevention rate)										
Number of detentions prevented	0	0	0	590	602	614	627	639	653	666
Benefits	0	0	0	14	14	14	14	14	13	13

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Central scenario (40% ACD uptake rate and 25% detention prevention rate)											
Number of detentions prevented	2,387	2,395	2,401	2,406	2,409	2,412	2,415	2,417	2,419	2,421	**39,758**
Benefits	46	45	43	42	41	39	38	37	35	34	747
High scenario (40% ACD uptake rate and 39% detention prevention rate)											
Number of detentions prevented	3,724	3,736	3,745	3,753	3,759	3,763	3,767	3,770	3,773	3,776	**62,022**
Benefits	72	70	67	65	63	61	59	57	55	53	1,165
Low scenario (40% ACD uptake rate and 7% detention prevention rate)											
Number of detentions prevented	668	671	672	674	675	675	676	677	677	678	**11,132**
Benefits	13	13	12	12	11	11	11	10	10	10	209

Health and Social Care System - Reduction in detentions for people with LDA

142. The changes to detention criteria for people with LDA will result in monetised benefits, as fewer LDA inpatients means lower costs in inpatient settings. The NHS Benchmarking Network Mental Health Dashboard reports the mean cost of LDA inpatient care per 10 beds. We used the GDP deflator to convert this figure to 2022/23 prices and divided by 10 to estimate the average cost per bed. We multiplied this by the assumed reduction in LDA inpatient beds. This produced the total estimated cost for that number of LDA inpatient beds as the total monetised benefits for the policy change, at £7.2m (discounted) over the appraisal period. To account for the policy change starting in mid-2024/25, we halved all costs in year 1. We have also estimated high and low monetised benefits scenarios using for a range of 10% to 100% uptake in Guardianships.

Table 23: Estimated monetised benefits following changes to detention criteria for people with LDA (£millions, 2022/23 prices, discounted at 3.5%)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Central scenario (50% uptake in Guardianships)										
Reduction in LDA inpatient beds due to additional Guardianships	81	77	74	71	68	65	62	59	57	54
Monetised benefits	0.4	0.7	0.6	0.6	0.5	0.5	0.5	0.4	0.4	0.4
High scenario (100% uptake in Guardianships)										
Reduction in LDA inpatient beds due to additional Guardianships	161	154	148	141	135	129	124	118	113	108
Monetised benefits	0.7	1.3	1.2	1.1	1.1	1.0	0.9	0.8	0.8	0.7
Low scenario (10% uptake in Guardianships)										
Reduction in LDA inpatient beds due to additional Guardianships	16	15	15	14	14	13	12	12	11	11
Monetised benefits	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Central scenario (50% uptake in Guardianships)											
Reduction in inpatient beds	52	49	47	45	43	41	40	38	36	35	**1,093**
Monetised benefits	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.2	**7.2**
High scenario (100% uptake in Guardianships)											
Reduction in inpatient beds	103	99	95	91	87	83	79	76	72	69	**2,185**
Monetised benefits	0.7	0.6	0.6	0.5	0.5	0.4	0.4	0.4	0.4	0.3	**14.5**
Low scenario (10% uptake in Guardianships)											
Reduction in inpatient beds	10	10	9	9	9	8	8	8	7	7	**219**
Monetised benefits	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	**1.4**

Health and Social Care System – Reduction in CTOs following changes in CTO criteria

143. The use of CTOs is expected to reduce following the changes in the CTO criteria. We assume that CTOs will decrease gradually by around 40% (using expectations in the Independent Review) over a five-year period from 2028/29 – see Annex B.II.

144. Monetised benefits over the appraisal period for the reduction in CTOs are estimated at £15 million (ranging from £8 million to £23 million) – see table below.

Table 24. Estimated monetised benefits following reduction in CTOs (£millions, 2022/23 prices, discounted at 3.5%)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Central scenario (40% reduction)										
Number of CTOs reduced by	0	0	0	0	394	788	1,181	1,575	1,969	1,969
Benefits	0	0	0	0	0.3	0.5	0.8	1.0	1.2	1.2
High cost scenario (20% reduction)										
Number of CTOs reduced by	0	0	0	0	197	394	591	788	984	984
Low Benefits	0	0	0	0	0.1	0.3	0.4	0.5	0.6	0.6
Low cost scenario (60% reduction										
Number of CTOs reduced by	0	0	0	0	591	1,181	1,772	2,363	2,953	2,953
High Benefits	0	0	0	0	0.4	0.8	1.2	1.5	1.9	1.8

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Central scenario (40% reduction)											
Number of CTOs reduced by	1,973	1,977	1,979	1,980	1,981	1,982	1,982	1,983	1,985	1,986	27,683
Benefits	1.2	1.1	1.1	1.0	1.0	1.0	0.9	0.9	0.9	0.9	**15**
High cost scenario (20% reduction)											
Number of CTOs reduced by	987	988	989	990	990	991	991	992	992	993	13,842
Low Benefits	0.6	0.6	0.5	0.5	0.5	0.5	0.5	0.5	0.4	0.4	**8**
Low cost scenario (60% reduction											
Number of CTOs reduced by	2,960	2,965	2,968	2,970	2,971	2,973	2,974	2,975	2,977	2,979	41,525
High Benefits	1.7	1.7	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.3	**23**

Monetised Benefits - Justice System

Detention Criteria

145. The Government has accepted a proposal to reduce the burden of MHT hearings cancelled at the last minute, which is deemed to mean within 48 hours. Before considering the impact of this recommendation on cancellation fees (due to assembling a panel that then does not sit), it is worth noting that:

- It may not always be possible to certify exactly 10 days before a hearing, as this proposal would require, 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 alternative

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%.

146. The overall impact of this proposal is an avoided cost from the reduction in cancellation fees, which can be claimed by the MHT's panel members. This has been estimated to be £1.3 million (discounted) over our appraisal period. 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 reducing MHT cancellations (£millions, 2022/23 prices, discounted at 3.5%, rounded to the nearest £0.1m)

	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Additional	0.1	0.1	0.1	0.1	0.1	0.1	0.1

	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Additional	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1.3**

Non-monetised Benefits

147. **For the individual.** Evidence shows that involving patients in decisions about their treatment under involuntary mental health treatment is associated with improved outcomes such as 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[71]. 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 primary and secondary care resource (such as hospitalisations, readmissions and primary care visits)[72]

148. The proposed changes to the MHA aim at improving patient's voice and experience, and it is expected that these will bring significant beneficial impacts on wellbeing and health for patients who are detained under the MHA. 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.

149. 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. This latter point can be supported by the findings of the Independent Review[73], which describe the very negative patient experience associated with being detained for many patients. As mentioned above, there is evidence that

[71] 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)

[72] 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/

[73] 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

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

150. Strengthening patient involvement in their own care and treatment is intended to improve experiences of the MHA and provide dignity to those detained under it. These are important outcomes, but they are not easily monetised. The extent to which the changes outlined throughout this IA will affect patient dignity is uncertain, and the value attributed to it is subjective and likely variable across patients. Whilst there are methods to quantify a change in life satisfaction, the relationship between enhanced patient experience and life satisfaction is not well evidenced.

151. If a patient refuses the chosen medical treatment, while it will be harder for the clinician to simply overrule the patient, it may still result in treatment being administered. The responsible clinician will be required to demonstrate that either there is no other alternative available, or that they have considered alternatives with the patient and/or those close to the patient, but the patient has not consented to them. However, before treatment can be administered against a patient's consent, a SOAD is required to approve the necessary treatment and to ensure the clinician has taken all the necessary steps. Therefore, while patient engagement with treatment planning may not always align with preferences, it is the greater transparency in the overall decision-making process and the stricter criteria for actioning against preferences, which we think will contribute towards increased patient satisfaction. To support greater dignity and respect of patients, any reasons for deviating from their stated preferences will be explained by the clinical team.

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.

153. **For the Health & Social Care system.** Benefits associated with improving health outcomes covered above will also have an impact on the Health & Social Care system. 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[74,75].

154. With respect to how patient experience benefits could translate into economic benefits, the NICE Guidance Development Group[76] 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). We are aware of this evidence gap will seek to address it as part of monitoring and evaluating the reforms (see section Monitoring and Evaluation).

155. 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

[74] 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

[75] 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

[76] 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)

elsewhere in the Healthcare system and generate further direct health benefits in the form of QALYs elsewhere. 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.

156. **New MHA detention criteria.** 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 treatment is available, which would benefit the individual, and which cannot be delivered without detention. 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 serious harm may be caused to the health or safety of the patient or another person.

157. 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 benefits in this IA.

158. **ACDs.** International and national evidence[77] 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[78]. 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[79]. The collaborative approach of ACDs stimulate communication between health professionals and service users, which may aid in improving therapeutic relationships[80].

159. **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[81,82] and reports made by the CQC[83,84] have highlighted that the inpatient setting can 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 fail to meet their sensory and communication needs. This can lead to a deterioration in their condition. The CQC's thematic review[85] states that sensory overload can result in severe distress, which can be displayed as challenging behaviour. In other words, even if an

[77] 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

[78] 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

[79] 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

[80] 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

[81] 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)

[82] 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)

[83] 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)

[84] 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)

[85] As above.

individual meets the detention criteria, it is possible that detention does not meet their specific needs. Inappropriate and/or non-therapeutic detentions of people with a learning disability and autistic people risk excessive use of restrictive practices and poor quality care. The Government's proposals aim to limit the scope for detention of individuals with a learning disability and autistic people under the Act unless they have a co-occurring, treatable mental health condition, and to mitigate against inappropriate detentions by improving community alternatives to avoid needs escalating and prevent crises,. 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.

160. **For the Justice system.** 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 ending the use of prison as a place of safety) would also contribute to efficiency gains in other parts of the Justice system of England and Wales.

161. 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.

162. In terms of Justice system impacts, prisoners awaiting transfer to secure hospitals and those remanded to prison with severe 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 ending the use of prison 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.

163. There would also be benefits in reducing the emotional and psychological impact on prison officers of managing the behaviour of individuals who are severely unwell for prolonged periods, as they are not trained to provide the support these prisoners may require. This 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.

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

165. 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[86] [87] [88]. 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

[86] 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

[87] 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

[88] 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

conditions are associated with lower levels of productivity[89]. 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.

166. There is evidence demonstrating that mental health problems have negative impacts on an individual's family, peers, employers, and wider society[90]. 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[91,92]. 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.

167. 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 (18 to 64), which accounted for 77% of all detentions in 2020/21[93]. 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.

Summary of Quantified Benefits and Breakeven Analysis

168. The benefits associated with the proposed policy Option 2 are likely to be significant. However, due to the absence of quantitative evidence for the impacts on patients, as explained above, we were only able to monetise cost savings from a reduction in detentions following ACDs and new criteria for people with LDA, from reduction in CTOs leading to less healthcare and automatic referrals costs, and from tribunal cancellation fees in the Justice system – see table below. They are estimated at £771 million over the appraisal period in a central scenario (£1 million in the Justice System and £770 million in the Health and Social Care system), with overall benefit estimates ranging from £219 million to £1,204 million.

[89] 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/

[90] 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

[93] Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

Table 26. Summary of total monetised benefits for the Justice and Health &Social Care systems (£millions, 2022/23 prices, discounted)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Central scenario										
Justice	0	0	0	0	0	0	0.1	0.1	0.1	0.1
H&SC	0.7	0.7	0.6	52	52	51	51	50	50	49
Total	0.7	0.7	0.6	52	52	51	51	50	50	49
High Benefits scenario										
Justice	0	0	0	0	0	0	0.1	0.1	0.1	0.1
H&SC	1.5	1.3	1.2	82	81	80	79	79	78	77
Total	1.5	1.3	1.2	82	81	80	80	79	78	77
Low Benefits scenario										
Justice	0	0	0	0	0	0	0.1	0.1	0.1	0.1
H&SC	0.1	0.1	0.1	15	15	14	14	14	14	14
Total	0.1	0.1	0.1	15	15	14	14	14	14	14

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Central scenario											
Justice	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
H&SC	48	46	45	43	42	40	39	38	37	35	**770**
Total	48	46	45	43	42	40	39	38	37	35	**771**
High Benefits scenario											
Justice	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
H&SC	74	72	70	67	65	63	61	59	57	55	**1,203**
Total	74	72	70	68	65	63	61	59	57	55	**1,204**
Low Benefits scenario											
Justice	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1**
H&SC	14	13	13	12	12	12	11	11	10	10	**218**
Total	14	13	13	12	12	12	11	11	10	10	**219**

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

Breakeven analysis

169. To complement this approach, we estimate how large non-monetised benefits would need to be in order for the net costs of the policy to be fully offset. We illustrate this using the following exemplars: i) reductions in length of stay for detainees; ii) reductions in readmissions and iii) improved quality of life. Annex F provides further details on these.

170. We first estimate the base clinical cost of a period spent in detention (by multiplying the estimated number of detentions by the median length of stay and by the national average unit cost per bed day using NHS Reference costs[94]), and add on the further costs associated with detentions assessed in this IA (e.g. NHS and non-NHS staff workloads), in both our BAU and policy scenarios. These totals are divided by the number of detentions to give an indication of the average cost per detention to the Health and Social Care and Justice systems with and without the introduction of additional safeguards by the proposed reforms (see annex B.I).

171. Looking at simple averages of these estimated real annual unit costs per detention across the appraisal period suggests that the reforms increase them from £33,000 to £34,200 (an increase of around £1,200). However, reforms are introduced gradually and these costs include various transitory and implementation effects. A fairer indication of the longer term impact is that on average in the years from 2031/32, the real cost per detention calculated in this way increases by £1,400, or by 4.2%.

172. It is anticipated that some of the additional costs associated with making a given detention of a given length a more costly process for the Health and Social Care system and the Justice system will be offset by greater patient empowerment following from the additional safeguards, which will lead to a reduction in the number of detentions and CTOs that happen in the first place. The benefits (or cost

[94] NHS England and NHS Improvement (June 2021). 2019/20 National Cost Collection data – National schedule of NHS costs (tab PLMHPS – PLICS Mental Health Provider Spells). Accessed at: NHS England » National Cost Collection for the NHS

savings) for the Health and Social Care system and the Justice system are included in the NPV calculated in this IA, but the following describes how far other benefits would have to arise in order to fully offset the remaining net costs. In a central scenario, these net costs average £23 million per year in real terms across the appraisal period (or £20 million in annualised terms, incorporating discounting).

173. **Reduced length of stay.** The current average length of a detention is estimated to be around 54 days (for the average of Sections 2 and 3 detentions)[95]. The proposals may help to deinstitutionalise patients who previously were subjected to long-term detentions but would now have better access to appeals and more effective care treatment plans, potentially bringing a higher chance of earlier discharge. Focusing on the clinical costs associated with a period in detention discussed above (which constitute the majority of costs), these would have to reduce by 1% across the appraisal period in order to offset the net costs of the reforms, ignoring associated benefits to patients which have not been monetised. Assuming such costs are proportional to lengths of stay, we estimate that this would be equivalent to a 0.56 days reduction in all detainees' lengths of stay.

174. **Repeated detentions.** Similarly, improved patient safeguards and involvement in decision making could also lead to more suitable treatment and improved treatment adherence and, in turn, a reduction in the number of people with repeated detentions. On average, from 2017/18 to 2020/21, around 15.7% of people were detained more than once in a year – around 7,000 people in 2020/21[96]. Dividing the additional annual net policy cost by the estimated cost of a detention in each year under the policy scenario suggests, on average, that they would have to reduce by around 610 per year on average during the appraisal period. Assuming that, in the absence of intervention, the proportion of detainees with repeated detentions would remain constant at around 15.7% for the appraisal period, we estimate that this would need to fall to 14.8% throughout the period for the net costs of the policy to be completely offset by the savings gained from a reduction in the number of repeat detentions (ignoring associated benefits to patients which have not been monetised).

175. **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 caused by 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 £70,000[97] to work out the number of quality-adjusted life years (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.

176. It is estimated that each detainee would need to be associated with a health improvement as a result of reform of circa 0.006 QALYs for the costs of the policy to be offset i.e. around 2 days (0.006*365 days = 2.0 days)[98].That would be equivalent to helping someone live for an extra 2 days in perfect health (i.e. health-related quality of life (HRQoL) of 1), or, live for 4.1 days in a state of perfect health rather than in moderate health (if that were equivalent to a HRQoL of 0.5)[99].

[95] NHS Digital (26 October 2021). Mental Health Act Statistics, Annual Figures 2020/21. Accessed at: Mental Health Act Statistics, Annual Figures 2020-21 - NHS Digital

[96] NHS Digital (26 October 2021). Mental Health Act Statistics, Annual Figures 2020/21. Accessed at: Mental Health Act Statistics, Annual Figures 2020-21 - NHS Digital

[97] DHSC has updated the social value of a QALY to £70,000 (2021/22 prices).

[98] 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 0.006 QALYs for the costs of the policy to be offset, i.e., the person would need to experience perfect health for around 2 days in the year following treatment (0.006*365 days = 2.03 days).

[99] There are various scales available to quantify HRQoL e.g. EQ-5D (euroqol.org), Mental Health Quality of Life Questionnaire - iMTA.

Risks and Assumptions

177. This section explores how sensitive the estimated total discounted costs over the appraisal period (i.e. the Net Present Value, NPV[100]) 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.

178. Due to the uncertainties involved with economic appraisal, and not being clear at this stage to what extent some of Government's proposals already represent best practice in some organisations, sensitivity analysis has been conducted with respect to the proposed MHA reforms in the draft Bill.

179. **Health and Social Care System.** There are the following main groups of uncertainties:

- the magnitude of the future number of people detained or under CTOs, either in response to wider trends, or the impact of the proposed reforms;
- how much additional time from the health and social care workforce will be required to deliver the additional safeguards and how much current work will be re-adjusted or in line with the reforms.

180. We present in the table below the key assumptions in each model for the central scenario and for alternative scenarios. 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 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.

[100] 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

Model	Assumption	Central scenario	Low PV scenario	High PV scenario
Volumes				
Baseline trajectories for detention numbers	Growth factor	Moderate to no impact of COVID-19: for 2022/23 and 2023/24, 3.7% increase per year[101]; from 2024/25 - 2.05% increase per year[102]	Slight to no impact of COVID-19: for 2022/23 and 2023/24, 2.54% increase per year[103]; from 2024/25 - 2.05% increase per year[104]	Moderate to slight impact of COVID-19: for 2022/23 and 2023/24, 3.7% increase per year[105]; from 2024/25 - 2.54% increase per year[106]
Policy impact of detentions	Growth factor	Moderate to no impact of COVID-19: for 2022/23 and 2023/24, 3.7% increase per year[107]; from 2024/25 - 2.05% increase per year[108]	Slight to no impact of COVID-19: for 2022/23 and 2023/24, 2.54% increase per year[109]; from 2024/25 - 2.05% increase per year[110]	Moderate to slight impact of COVID-19: for 2022/23 and 2023/24, 3.7% increase per year[111]; from 2024/25 - 2.54% increase per year[112]
Baseline trajectories for CTOs	CTOs are assumed to reduce gradually from 2028/29 with a gradual change over 5 years until 2032/33	40% decrease over 5 years	60% decrease over 5 years	20% decrease over 5 years
Policy impact on CTOs	CTOs are assumed to reduce gradually from 2028/29 with a gradual change over 5 years until 2032/33	40% decrease over 5 years	60% decrease over 5 years	20% decrease over 5 years
Workload				
IMHAs	IMHA uptake	85%	70%	95%
AMHPs	Additional workload due to the proposals	Central estimates	-20%	+20%
SOADs	Rate of SOAD visits per Detainee type (Refusal, Incapable, ECT, CTO)	Central estimates	-20%	+20%
Clinical teams	Additional workload	Central estimates	-20%	+20%
Administrative staff	Additional workload	Central estimates	-20%	+20%

[101] Average of the annual percentage change in the number of detentions before COVID-19: 2016/17 to 2019-20 (2.05%), the percentage change in 2020/21 in relation to 2019/20 (4.5%) and the forecasted change in 2021/22 (4.5%)

[102] Average percentage change before COVID-19, 2016/17 to 2019/20.

[103] Average percentage change including COVID-19 period, 2016/17 to 2020/21.

[104] Average percentage change before COVID-19, 2016/17 to 2019/20

[105] Average of the annual percentage change in the number of detentions before COVID-19: 2016/17 to 2019-20 (2.05%), the percentage change in 2020/21 in relation to 2019/20 (4.5%) and the forecasted change in 2021/22 (4.5%)

[106] Average percentage change including COVID-19 period, 2016/17 to 2020/21.

[107] Average of the annual percentage change in the number of detentions before COVID-19: 2016/17 to 2019-20 (2.05%), the percentage change in 2020/21 in relation to 2019/20 (4.5%) and the forecasted change in 2021/22 (4.5%)

[108] Average percentage change before COVID-19, 2016/17 to 2019/20.

[109] Average percentage change including COVID-19 period, 2016/17 to 2020/21.

[110] Average percentage change before COVID-19, 2016/17 to 2019/20

[111] Average of the annual percentage change in the number of detentions before COVID-19: 2016/17 to 2019-20 (2.05%), the percentage change in 2020/21 in relation to 2019/20 (4.5%) and the forecasted change in 2021/22 (4.5%)

[112] Average percentage change including COVID-19 period, 2016/17 to 2020/21.

182. **Justice system.** 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:

- Detention periods: expected increase in Section 3 applications of between 25% and 50%, the central scenario employs the midpoint of 37%.
- 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;
- 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%, and the central scenario employs the midpoint of 33%.
- 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;
- On 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.
- 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.
- No sensitivity analysis has been conducted on the expanded powers policies which have been newly modelled in this iteration on the IA. This is due to estimates for the assumptions being provided and the costs for these recommendations being very minimal in comparison to the other proposed recommendations.

Summary of Sensitivity Analysis

183. Using the scenarios presented earlier (see above for PV and Benefits section for high and low benefits scenarios), the impact of varying our assumptions on the cost and benefit estimates are in the table below. As described above, benefits depend on the assumed impact of reforms on the numbers of detentions and CTOs. The costs are particularly sensitive to uncertainty surrounding the costs to the Justice system and in workload for clinical teams:

- In the Justice system, the total additional discounted cost could range between £242 million less to £82 million more over the appraisal period (£137 million as the central estimate). This corresponds to, respectively, a decrease of 23% and an increase of 8% in the overall discounted costs (present value).
- For Clinical teams, a change of 20% in additional hours could lead to a change in total costs by around plus or minus £78 million (7% of discounted costs). Illustrative changes in other costs could have up to around 3% change in discounted costs (up to £40m) – see table below.

Table 28. Impact of varying assumptions on the Net Present Value (NPV) in relation to the central scenario (2022/23 prices, discounted)[113]

Assumption	Scenario	Modelled total NPV	Impact on NPV relative to central scenario (-£296m)
Central NPV		**-£296m**	
Baseline detentions	Central Scenario (3.7% increase to 2023/24 then by 2.05%)		
	Low cost Scenario (2.54% increase to 2023/24 then 2.05%)	-278	+18
	High cost Scenario (3.7% increase to 2023/24 then 2.54%)	-331	-35
Policy impact on detentions (ACDs)	Central benefit scenario (ACD has a 25% reduction rate)		
	High benefit scenario (ACD has a 39% reduction rate)	122	+418
	Low benefit scenario (ACD had a 7% reduction rate)	-834	-538
Policy impact on detentions (LDA)	Central benefit scenario (50% uptake in guardianships)		
	High benefit scenario (100% uptake in guardianships)	-289	+8
	Low benefit scenario (10% uptake in guardianships%)	-302	-6
Policy impact on CTOs	Central Scenario: -40%		
	Low costs Scenario: -60%	-262	+35
	High costs Scenario: -20%	-331	-35
IMHA policy workload impacts	Central - opt in uptake 85%		
	High cost - uptake 95%	-316	-19
	Low cost - uptake 70%	-267	29
AMHPs policy workload impacts	Central: Additional Workload		
	High cost - plus 20%	-310	-14
	Low cost - minus 20%	-283	+14
SOAD policy workload impacts	Central - Rate of SOAD visits per Detainee type		
	High cost - plus 20%	-306	-9
	Low cost - minus 20%	-287	+9
Clinical teams workload impacts			
	High cost - plus 20%	-374	-78
	Low cost - minus 20%	-219	+78
Administrative staff workload impacts			
	High cost - plus 20%	-304	-7
	Low cost - minus 20%	-289	+7

[113] Analysis has been carried out to indicate how much costs and benefits are likely to change when key assumptions change and what is the overall impact on costs and NPV. This analysis does not consider possible second order effects of variation, for example where changes to the costs of new processes has impacts on the cost per detention, or an increase in the baseline detentions rate increases the benefits achieved. We expect the overall impact of these to be small, as new processes are only a small element of the overall cost of detentions and the variation between detention rate scenarios is small.

Assumption	Scenario	Modelled total NPV	Impact on NPV relative to central scenario (-£296m)
Justice costs			
	High costs	-379	-82
	Low costs	-55	+242

184. **Net Present Value (NPV)**. Using the estimated high and low costs and benefits described above for the proposed policies, we have combined these to provide low and high estimates of the NPV. The analysis suggests that all the optimistic assumptions (high benefit minus low costs) could cause the total estimated net present value of Option 2 to rise to £453 million. The pessimistic assumptions (low benefit minus high cost) could cause the NPV to fall to around -£867 million. In all cases, these NPVs, by definition, do not include benefits for health and experience of the MHA for patients.

Summary and preferred option

185. Overall, Option 2 is considered to be the preferred option as the implementation of the Government proposals is expected to modernise the MHA and make it fit for purpose. In particular, 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 policy objectives that the reforms aim to achieve.

186. Over the 20 year time horizon, the estimated net benefit are estimated to be -£296 million in 2022/23 prices and in Present Value terms. This pertains to monetised benefits estimated at £771 million minus costs (excluding health opportunity costs) estimated at £1,067 million. Whilst only a narrow range of benefits has been monetised, 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.

Direct cost to Business – Private Sector Costs

187. These reforms may have direct impacts on the private sector, including charities, in three main ways:

a) Some provision in the Health and Social Care system, both for treatment and the work of non-clinical professional groups responsible for delivering obligations under the MHA, is delivered by private organisations who are contracted to do so by the NHS or local authorities. These reforms are expected to increase the demand for this provision, which is costed in this IA; but, on the basis that this is delivered on behalf of public authorities, such impacts are not defined as direct regulatory business costs under the Better Regulation Framework;

b) A proportion, expected to be small, of treatment that takes place under the MHA or is affected by these reforms' provisions is incurred in private sector establishments and privately funded by or for patients. Costs affecting this treatment is taken here to be within scope of 'regulatory costs' under the Better Regulation Framework;

c) Private legal firms and solicitors will provide representation to patients as part of MHA processes. The legal aid costs of this are included in the costs estimated in this IA, but as explained below, this is also not within scope of regulatory costs under the Better Regulation Framework.

Health and Social Care System

188. Taking a cautious approach, this analysis focuses on direct costs, as the benefits are considered to be difficult to allocate to private businesses directly. A reduction in detentions by ACDs will likely be felt mostly by NHS-funded services.

189. 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 and administrative staff employed either in the NHS or in the independent sector. That is, clinical staff (see section on costs for clinical teams) and administrative costs in health care providers are the main areas where the private sector could potentially incur costs from changes in the MHA.

190. 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.

191. 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[114].

192. The overall average additional cost of clinical staff and administrative staff has been estimated at around £30 million per year over the appraisal period and at £38 million per year for the full implementation period (2022/23 prices) for all detained patients, that is, including public and private funding for patients in the public and independent sector.

193. To estimate the costs related to private funding and independent sector supply (cost category ‘b’ above), we applied the 2.9% market share to the overall estimated cost in each year and that gives an estimate of around £1 million per year over the period. Annex H provides more detail of this methodology.

194. To estimate the equivalent annual net direct cost to business (EANDCB) for assessment under the Better Regulation Framework for comparison against other regulatory provisions, these costs are expressed in 2019 prices and discounted back to 2020 to give an estimate of £1.1 million per year.

[114] Source: Laing & Buisson (2021). UK Healthcare Market Review, 33rd Ed. London (p.71)

Table 29. Estimated additional monetised costs for the private sector (£millions, undiscounted at 2022/23 prices and EANDCB)

	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34
Undiscounted										
Clinical staff	0.5	0.8	0.8	8	26	26	34	34	34	35
Admin staff	1	1	1	1	3	3	3	3	3	3
Total	1	2	2	9	29	29	38	37	37	38
Assuming 2.9% of these costs are for the independent sector/ private patients										
2022/23 prices	0.04	0.1	0.1	0.3	1.0	1.0	1.3	1.3	1.4	1.4
EANDCB										

	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	Total
Undiscounted											
Clinical staff	35	35	35	35	35	35	35	35	35	35	**546**
Admin staff	4	4	4	4	4	4	4	4	4	4	**60**
Total	38	38	38	38	38	38	38	38	38	38	**606**
Assuming 2.9% of these costs are for the independent sector/ private patients											
2022/23 prices	1.4	1.5	1.5	1.5	1.6	1.6	1.7	1.7	1.7	1.8	**24**
EANDCB											1.1

Justice System

195. Increased MHT activity is expected to increase the demand for legal services delivered by the private sector. However, as legal firms/solicitors are usually paid for this type of work by Legal Aid, this has not been presented as a direct cost to business and this aspect of the reforms do not constitute a regulatory provision within scope of the Small Business, Enterprise and Employment Act 2015[115]. In other words, the private sector impacts for the Justice system are considered not to have direct cost to business.

Impact on small and micro businesses

196. The MHA Bill applies to all organisations providing services required by the application of the MHA. Private sector impacts are expected to be most relevant for independent healthcare providers and advocacy services provided by the business/charity sector. It is expected that small and micro businesses play a more significant role in the latter.

Independent healthcare providers

197. We do not expect that there are a significant number of independent healthcare providers affected by the reforms that qualify as small or micro-business. The latest 2021 Laing & Buisson Healthcare Market Review[116] reports the number of mental health private hospitals (2018) and beds (2019). The major 8 providers have a range of beds from around 100 to under 7,000; smaller providers number 44 and have 2,455 beds, an average of 56 each. There may still be some providers within this group that classify as small or micro businesses but it has not been possible to estimate how many.

198. Most costs associated with these reforms are likely to be proportionate to patient numbers and, as described above, funded via contracts with the NHS or local authorities. It is possible that one-off transition costs would represent fixed costs that small providers would find harder to absorb under

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

[116] Laing & Buisson (2021). Healthcare Market Review, 33nd Ed. London (see p. 6.3, page 70).

ongoing funding arrangements. Familiarisation costs for clinicians have been estimated at £12m (see above) but, as described in the previous section, most of these costs will be experienced by the public sector, and of the remainder only a small proportion will be in respect of privately-funded provision.

Providers of advocacy services

199. In the absence of readily available information on the size of providers of advocacy services, we held a workshop with providers of advocacy services to collect their views on the impact of the reforms in their organisations. Participants suggested that, consistent with the analysis in this IA, the reforms will bring an increase in demand for advocacy services, but it was hard to predict the precise scale of this demand. However, changes in the MHA were not seen as providing additional burdens (in net financial terms) to the organisations.

200. The size of providers of advocacy services is thought to vary substantially. The smallest will be micro-providers that just provide IMHAs to a small LA. The largest provide IMHA services alongside other types of advocacy to multiple LAs across multiple regions, and the view of participants was that the reforms would not have a differential impact on organisations with different sizes.

201. Most advocacy providers have a multi-advocacy model, i.e. they deliver multiple advocacy services in addition to IMHAs (e.g. Care Act Advocacy, Community Advocacy, Health Complaints Advocacy, Independent Mental Capacity Advocacy (IMCA), Independent Mental Health Advocacy (IMHA) and Self-Advocacy). The way IMHAs services are commissioned and funded by local authorities, and the amount of funding provided, also varies across commissioners – contracts can be for a certain number of hours of advocacy provision (not only Independent Advocacy), or block contracts, and fewer contracts are based on the number of people detained/needs assessment, which providers think is the preferred option. Funding is based on meeting the requirement for statutory advocacy provision, and that for IMHA over other advocacy provision tends not to be ring-fenced in delivery arrangements and providers have to prioritise between the different types of advocacy. This means that, generally, whilst advocacy providers may not face financial risk from varying demand for MHA-related advocacy, effective provision of advocacy depends on whether it is adequately funded by public authorities.

Distributional and wider impacts

202. The Independent Review of the MHA heard concerns around the disparity of access to, and experience of, mental health services for different disadvantaged groups, including LGBTQ+, ethnic minority communities, people with learning disabilities or autistic people, and asylum seekers and refugees. This can influence the likelihood of detention in the first place, given varying access to and success of alternatives, as well as experiences when subject to the Act. Broadly, it is anticipated that improved involvement of patients in treatment decisions (before or after the potential need for detention arises) could improve patient satisfaction and adherence with treatment, and lead to improved health outcomes[117,118], in the face of the specific needs for such disadvantaged groups.

203. The following sections provide more detail on distributional implications where data are available on variation in application of the Act: for racial disparities, age and gender, learning disabilities and autism, deprivation, and geographical variation. Statistical comparisons are derived mainly from MHA annual statistics[119]. Due to gaps in coverage of these data, total detention numbers and rates presented will understate the true picture nationally and small differences in figures should be treated with caution, but broad comparisons of relative rates for different groups remain valid[120].

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[117] 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/)

[118] 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/

[119] Mental Health Act Statistics, Annual Figures - NHS Digital

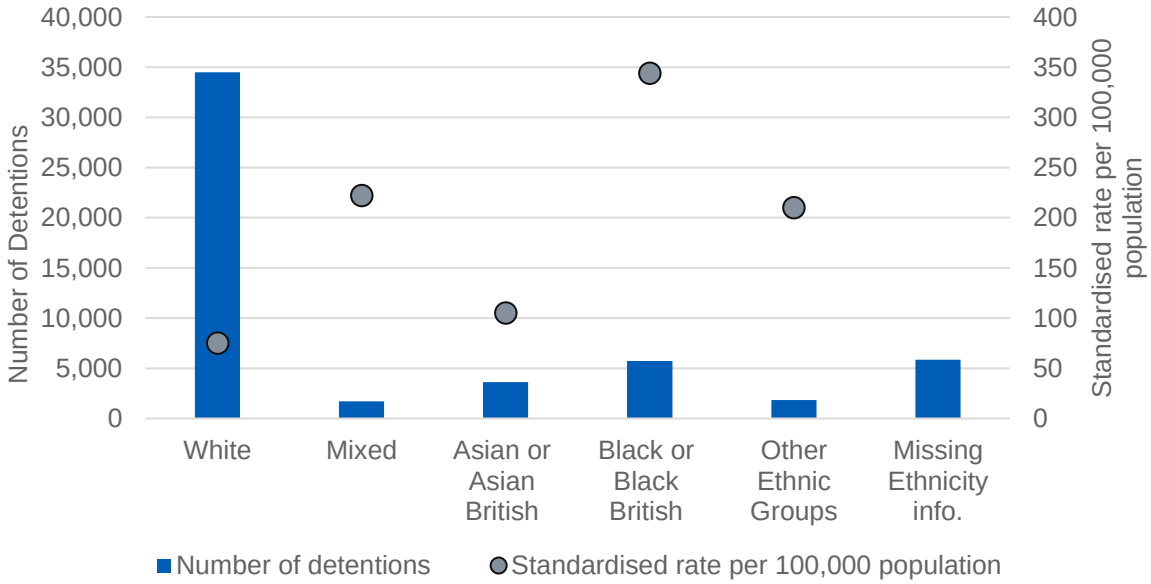
[120] Mental Health Act Statistics, Annual Figures: Background Data Quality Report, England 2020-21.

Racial disparities

204. There is a well-established correlation between ethnicity and diagnosis of psychoses such as schizophrenia and major depression, and strong evidence that severe mental health conditions are particularly elevated for people from black ethnic backgrounds[121]. People from South Asian, non-British white and mixed ethnicity groups are also at increased risk[122]. The rapid review of evidence on Ethnic Inequalities in Healthcare, undertaken for the NHS Race and Health Observatory, identified research evidence of barriers among ethnic minority groups to seeking and accessing treatment for common mental disorders, linked to a distrust of health care providers and fear of being discriminated against. Evidence from qualitative research suggests that the lack of appropriate interpreting services acted as a deterrent to seeking help. It also identified large and persisting gaps in access to secondary treatment for severe mental illness as well as worse recovery outcomes. People from black Caribbean, black African and black British backgrounds with severe mental illness experience higher rates of contact with the police and Criminal Justice system (both as victims and as offenders)[123].

205. This context is reflected in ethnic minority groups' experiences under the MHA. In 2020/21[124], as illustrated in the figure below, all ethnic groups had higher rates of detention per 100,000 population than the White or White British group, similar to previous years. Around two thirds (65%) of detentions were amongst White or White British people, while a quarter (24%) of detentions were amongst ethnic minority people[125]. Those of black African and Caribbean heritage are particularly likely to be subject to compulsory powers under the MHA, whether in hospital or in the community: Black or Black British standardised detention rates (343.5 per 100,000 population) were over four times higher than that of the White British group (74.7 per 100,000 population)[126].

Fig.4: Recorded detentions under the MHA: number and standardised rate, England, by ethnicity, 2020/21[127]



[121] For example: Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. - NHS Digital

[122] Halvorsrud, K, Nazroo, J, Otis, M, Brown Hajdukova, E & Bhui, K 2019, 'Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses', Social psychiatry and psychiatric epidemiology, vol. 54, no. 11, pp. 1311-1323. (Viewed on 4 February 2022)

[123] Kapadia D, and others (2022) 'Ethnic inequalities in healthcare: a rapid review of the evidence', NHS Race and Health Observatory.

[124] NHS Digital Mental Health Act Statistics, Annual Figures 2020/21 accessed here: Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

[125] NHS Digital Mental Health Act Statistics, Annual Figures 2020/21: Table 1c. 11% of detentions did not have ethnicity information recorded.

[126] NHS Digital Mental Health Act Statistics, Annual Figures 2020/21: Table 1c. 'Standardised rate' refers to the number of detentions for each ethnic group adjusted for differing age-gender structures across groups, giving a more like-for-like comparison considering the importance of these demographic factors for detention rates across the whole population.

[127] NHS Digital Mental Health Act Statistics, Annual Figures 2020/21: Table 1c

206. As explained in the benefits section, research findings suggest that involving patients in their treatment decisions could improve patient satisfaction and adherence with treatment, and lead to improved health outcomes. As ethnic minorities are disproportionately likely to be subject to the MHA, it is to be expected that these benefits will disproportionately accrue to these groups if they are affected by the reforms in similar ways to others. The patients statutory care and treatment plan must set out why detention is considered appropriate or why the use of force or compulsory treatment is justified, and it is shared with the patient and others involved in their care. This therefore provides the patient with more opportunities to appeal their detention at the MHT. The CTP is also to be reviewed and scrutinised during the MHT process. The MHT has the power to discharge or recommend changes to the restrictions placed on a patient. Increased transparency and scrutiny of decisions will improve the patients right to challenge and should therefore result in less disparity of treatment across groups by reducing the scope for biases to contribute towards treatment choices.

207. The Review heard that mental health services are often inappropriate for minority groups as they are not equipped to understand their needs, beliefs, backgrounds or culture to be able to provide required care and support. This can prevent people accessing the services they need to prevent crisis and detention. A lack of understanding or even a basic appreciation of different religious and spiritual beliefs can negatively impact an individual's experience of assessment and detention under the MHA.

208. Advanced decision making and care and treatment planning will help to ensure that patients are supported to express their wishes, preferences, beliefs and values and that these are followed as far as possible by the clinical team in charge of their care.

209. Further, whilst implementation of the legislation will not be systematically varied across ethnic groups, it is possible that the non-monetised benefits described above will be particularly relevant to and valued by ethnic minorities, because these groups appear to suffer disparities in care once detained and the reforms are specifically designed to provide safeguards against unequal or unfair treatment. Black or black British people have longer periods of detention and more repeated admissions[128], and are also more likely to be subject to police holding powers under the MHA[129]. The standardised rate of Community Treatment Orders per 100,00 population is 10 times higher for Black or Black British (78.9 per 100,000 population) than for White or White British people (7.8 per 100,000 population)[130]. To some extent this reflects higher overall detention rates, but the number of CTOs as a proportion of overall detention numbers is higher for Mixed (16%), Asian or Asian British (15%), Black or Black British (22%), and Other Ethnicity (15%) people compared with White people (10%)[131].

210. The Independent Review of the MHA asserted that a lack of dignity and trust that patients will be treated fairly inspires fear, discouraging early engagement with services[132]. In response, the reforms intend to strengthen patient voice, make treatment choices more tailored to individual circumstances, and provide safeguards to ensure decisions are made with patient needs and preferences at their heart. It is therefore possible that ethnic minority groups who are assessed and/or detained under the

[128] In the latest data for 2020/21, all ethnic groups have higher rates of detention per 100,000 population than the White or White British group. Black or Black British detention rates are over four times higher than that of the White British group (at an age-gender standardised rate of 344 detentions per 100,000 population for Black or Black British, and 75 per 100,000 population for White groups. Age-gender standardised rates of CTOs use for the 'Black or Black British' group (78.9 per 100,000 population) were over ten times the rate for the White group (7.8 uses per 100,000 population) in 2020/21. Source: Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

[129] Care Quality Commission. Monitoring the Mental Health Act in 2020/21. Accessed at: https://www.cqc.org.uk/publications/major-reports/monitoring-mental-health-act-202021

[130] NHS Digital Mental Health Act Statistics, Annual Figures 2020/21: Table 3c.

[131] NHS Digital Mental Health Act Statistics, Annual Figures 2020/21: Table 1c, Table 3c. To give CTO:overall detention ratios, crude CTO rates per 100,000 population from Table 3c are divided by crude detention rates (which include CTOs) per 100,000 from Table 1c.

[132] 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

Act will disproportionately benefit from an improvement in treatment and engagement with it before and during detention, although there is a lack of direct evidence on this potential impact.

211. Specifically, studies from the United States and United Kingdom have shown that Advanced Choice Documents may be most effective among service users of black ethnicity compared to those of other ethnic backgrounds. ACDs resulted in black service users being more likely to have an increased sense of autonomy[133] and including them was more likely to be cost-effective for this group[134] compared to those of other ethnic backgrounds.

212. These measures are complemented by specific interventions aimed at reducing ethnic disparities. Whilst not within scope of costs and benefits assessed in this Impact Assessment, for context these are as follows:

- The need to ensure that culturally-appropriate advocacy is provided consistently for people of all ethnic backgrounds has been recognised in the Independent Review of the MHA, in particular for individuals of black African and Caribbean descent and heritage. The Government is now piloting improved culturally appropriate advocacy services, so that people from ethnic minority backgrounds can be supported by people who understand their needs.

- 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. NHS England and NHS Improvement published its first Advancing Mental Health Equalities Strategy in October 2020[135], aiming to bridge gaps for communities faring worse than others with regards to mental health services and tackle inequalities for Black, Asian, minority ethnic and other minority communities. As a core part of the strategy, NHS England and NHS Improvement is developing the Patient and Carers Race Equality Framework (PCREF). The PCREF will motivate and support Trusts and their workforce to engage with Black, Asian and minority ethnic communities to better understand how they fare against their core organisational competencies, how they can best meet local needs in a more culturally sensitive way and enable trust-wide improvement in race equality for patients and carers and increase organisational accountability to making improvements. Support from our four Pilot trusts and in partnership with their local voluntary sector partners in engaging with their local ethnic minority community has helped to identify 6 national organisational competencies, which will help to improve the outcomes and experiences of Black, Asian and minority ethnic communities. NHS England and NHS Improvement will capture learning to date and provide information to Pilot trusts on how to ready themselves for the eventual roll-out of the PCREF as they test implementation of the PCREF throughout 2022/23.

- The Review identified gaps in the evidence around the use of the MHA and made a number of recommendations on the need for research to inform future policy. In 2020/21, the National Institute for Health Research Policy Research Programme (NIHR PRP), on behalf of DHSC, funded four research projects to explore 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.

- NHS England and NHS Improvement is working with local mental health systems to embed equality indicators to improve their local data on access, experience and outcomes for Black, Asian and minority ethnic communities. Broadening the data available and improving data quality

[133] 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.

[134] 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

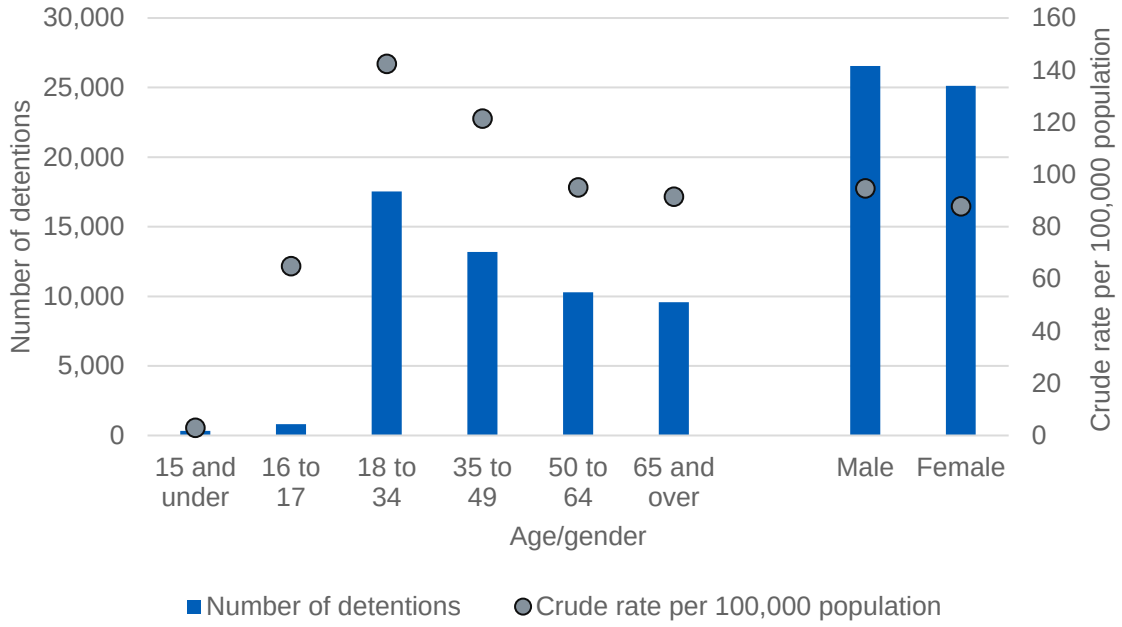
[135] https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/

are intended to advance equalities in mental health – facilitating better performance monitoring, understanding of current disparities and designing appropriate service improvements.

Age and gender

213. As illustrated in the figure below, detention rates in 2020/21 were slightly higher for males (94.8 per 100,000 population) than females (87.9 per 100,000). In terms of age, detentions for those under 16 are extremely rare, whilst those aged 16 to 17 also have relatively low rates, at 64.9 per 100,000 in 2020/21. Among adults, detention rates are highest among 18 to 34-year-olds (142.5 per 100,000) and lowest for those 65 and over (91.6 per 100,000). Although detention rates are slightly higher for males than females, in 2020/21, a higher proportion of females were detained more than once (17.6 percent compared to 15.3 percent of males). These reforms are not intended to be applied differently across these groups, but these data suggest that young adults, of both genders, may be expected to be disproportionately affected by the changes.

Fig.5: Recorded detentions under the MHA: number and standardised rate, England, by age and gender, 2020/21[136]



Learning disabilities and autism

214. The Independent Review of the MHA heard that those with a learning disability or autism (LDA) were at particular risk of not having their specific needs understood or taken into account in detention and treatment decisions. It also identified that people with a learning disability and autistic people are more likely to be detained within inpatient settings without treatment that provides therapeutic benefit[137].

215. Since the Assuring Transformation data collection started in 2015, data have shown that around 90% of LDA inpatients are subject to the MHA. In February 2022, there were 1,875 (91.9% of 2,040) LDA inpatients detained under the Act in England[138]. Comparing this to the wider population of inpatients, in December 2021, there were 15,647 (64.9% of 24,124) people in mental health hospital services detained under the Act in England[139]. It has been shown that the prevalence of mental health

[136] NHS Digital Mental Health Act Statistics, Annual Figures 2020/21: Table 1b.

[137] DHSC. Consultation Outcome Reforming the Mental Health Act. (2021). Accessed at: Reforming the Mental Health Act - GOV.UK (www.gov.uk)

[138] NHSD. Learning Disability Service Statistics, Assuring Transformation. (2021). Accessible at: Learning disability services monthly statistics from Assuring Transformation dataset: Data tables - NHS Digital

[139] NHS Digital. Mental Health Services Monthly Statistics. (2021). Accessed at: Mental Health Services Monthly Statistics - NHS Digital.

conditions in people with a learning disability, autistic people , and people with a learning disability and autism is higher than in the general population[140,141,142].

216. In addition to measures that aim to strengthen patients' voice and involvement in decisions more generally, the reforms aim to specifically limit the scope to detain people with a learning disability and autistic people under the Act where there is not clearly a mental health condition that justifies the application of it. This is intended to reduce reliance on inpatient services for people with a learning disability and autistic people through development of community-based support.

Deprivation

217. Socio-economic status has a well-established association with wellbeing and mental health[143]. Research has found that economic disadvantage increases the risk of common mental disorders[144] and severe mental illness[145],[146] alike, and that these impacts can be seen from childhood[147]. Data from the Improving Access to Psychological Therapies initiative (IAPT)[148] shows that people living in the most deprived areas of England are more likely to be referred to IAPT services than those from the least deprived areas. However, the data also shows that people from the most deprived populations are less likely to use such services and less likely to have recovered by the end of treatment compared to those living in the least deprived areas. An analysis of mental health service data found similar patterns in 2014[149]. An evidence review commissioned for the Independent Review of the MHA found that those reliant on social benefits were subject to an increased risk of detention[150].

218. These patterns are reflected similarly in comparisons of detention rates under the MHA across areas ranked according to the Index of Multiple Deprivation (IMD)[151], a measure of living conditions for people living in a given area based on indicators of income, employment, health deprivation and disability, education and skills training, crime, barriers to housing and services, and living environment. As can be seen in the figure below, detentions in the most deprived areas had the highest rates of detention, more than three and a half times higher than the rate in the least deprived areas.

[140] Cooper SA, Smiley E, Morrison J, Williamson A, Allan L. Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. T*he British journal of psychiatry*. 190, 27-35 (2007).

[141] Lever, A.G., Geurts, H.M. Psychiatric Co-occurring Symptoms and Disorders in Young, Middle-Aged, and Older Adults with Autism Spectrum Disorder. *Journal of Autism Developmental Disorders.* 46, 1916–1930 (2016).

[142] Simonoff, Emily & Pickles, Andrew & Charman, Tony & Chandler, Susie & Loucas, Tom & Baird, Gillian. Psychiatric Disorders in Children with Autism Spectrum Disorders: Prevalence, Comorbidity, and Associated Factors in a Population-Derived Sample. *Journal of the American Academy of Child and Adolescent Psychiatry*. 47, 921-9 (2008).

[143] World Health Organization. (2014). Social determinants of mental health. World Health Organization.

[144] Patel V, Lund C, Hatheril S, Plagerson S, Corrigall J, Funk M, et al. Mental disorders: equity and social determinants. In: Blas E, Kurup AS, editors. Equity, social determinants and public health programmes. Geneva: World Health Organization; 2010.

[145] McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

[146] NHS Digital (16 December 2015). *Health Survey for England, 2014.* Accessed at: http://content.digital.nhs.uk/catalogue/PUB19295

[147] Gutman and others 'Children of the new century: mental health findings from the Millenium Cohort Study' (2015) Centre for Mental health and UCL. 'Mental health of children and young people in England' (2017) NHS Digital

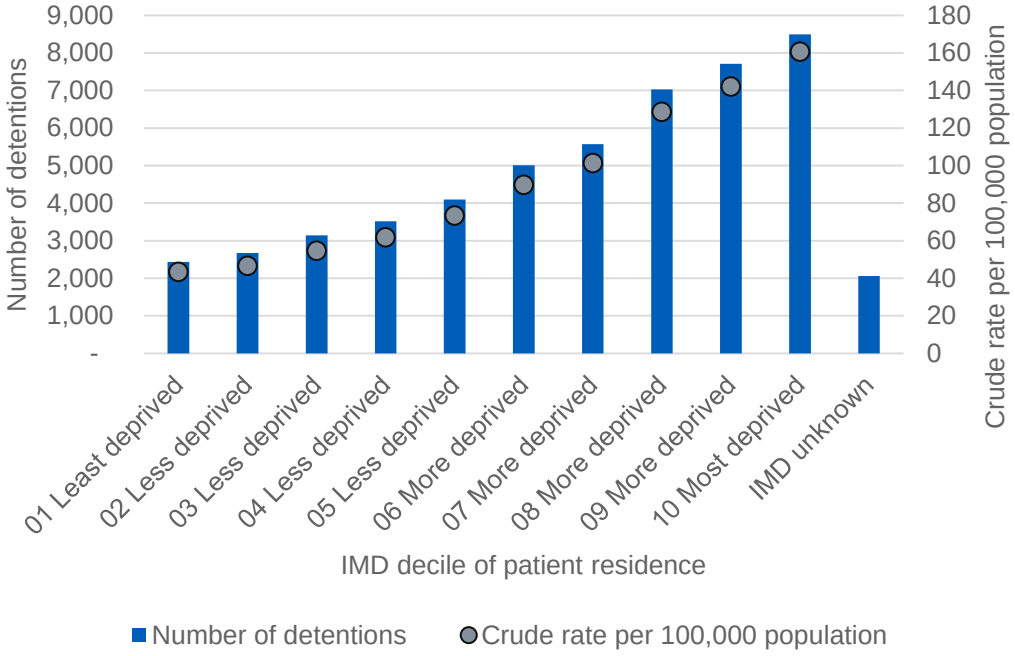
[148] Office of Health Improvement and Disparities, Public Health profiles, Common Mental Disorders 2022.

[149] Delgadillo J, Farnfield A, North A. Social inequalities in the demand, supply and utilisation of psychological treatment. Couns Psychother Res. 2018

[150] Susan Walker, Euan Mackay,Phoebe Barnett, Luke Sheridan Rains, Monica Leverton,Christian Dalton-Locke, Kylee Trevillion, Brynmor Lloyd-Evans, Sonia Johnson (2019), 'Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis', Lancet Psychiatry 2019, 6, 1039–53.

[151] English indices of deprivation 2019 - GOV.UK (www.gov.uk)

Fig.6 Recorded detentions under the MHA: number and standardised rate, England, by IMD decile of patient residence, 2020/21



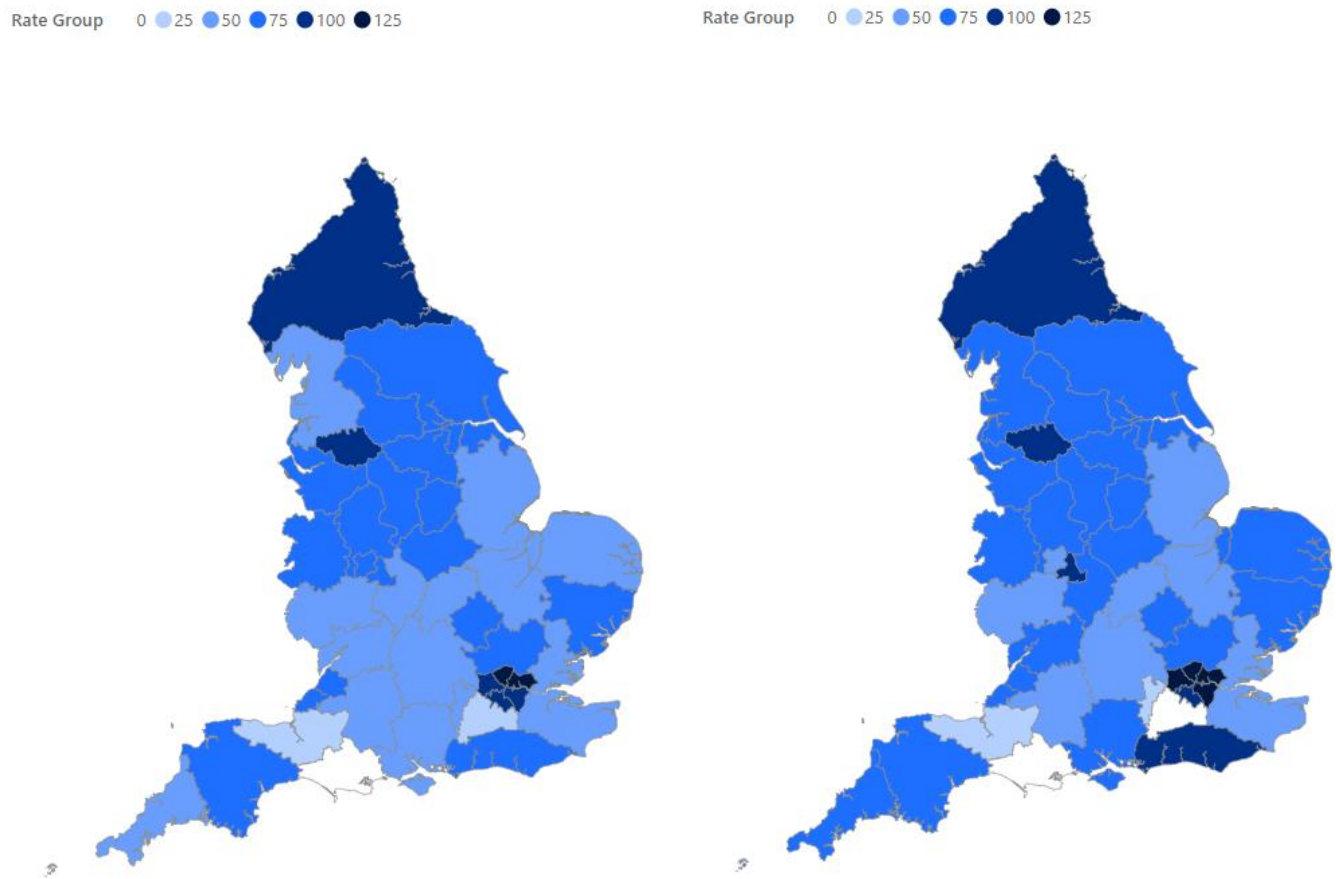
219. These reforms are not intended to be applied differently across individuals or areas subject to differing socio-economic circumstances, but it is to be expected that economically disadvantaged people, and those living in more deprived areas, will be disproportionately affected by the changes as a result of them being more likely to be at risk of requiring treatment under the Act in the first place.

Geographical variation

220. As illustrated in the figure below, showing recorded detention rates in 2019/20 and 2020/21, there tends to be significant variation in the number of detentions across England's Sustainability and Transformation Partnership (STP)[152] areas relative to their resident populations. Rates vary year to year in a given area, but, over the last two years of recorded data, the highest rate of detentions (of 100 or more per 100,000 population) have been seen in the cities of London, Manchester, Birmingham, and also on the south east coast and the far north of England. Most STP areas showing rates of less than 50 per 100,000 population have been in the south east and east midlands.

[152] STPs is where local NHS organisations and Local Authorities draw up shared proposals to improve health and care in the areas they serve (Sustainability and Transformation Partnership (datadictionary.nhs.uk). In some areas STPs have evolved to become Integrated Care Systems, a form of even closer collaboration between these organisations (NHS England » What are integrated care systems?)

Fig.7: Crude rate of detention under the MHA per 100,000 population: England, by Sustainability and Transformation Partnership (STP) area, 2019/20 and 2020/21[153]



221. At a finer level of geography, a suitable classification of rurality is available from the Office for National Statistics for most, but not all, Clinical Commissioning Group (CCG) areas[154]. Among those, it has been estimated that in 2020/21 the crude rate of detention per 100,000 population was 103 across 'Predominantly Urban' areas, 63 across 'Urban with Significant Rural' areas, and 66 across 'Predominantly Rural' areas. This is consistent with research suggesting a higher prevalence of severe mental illness in urban areas, although this overlaps significantly with the effects of deprivation[155].

222. This suggests that, generally, the impacts of these reforms may be felt disproportionately in more urban parts of the country. However, it is by no means the case that rural areas invariably have low pressures on mental health services or low rates of detentions.

Monitoring and Evaluation

223. We are developing a monitoring and evaluation strategy for the MHA reforms. This will include commissioning independent process and impact evaluations for the reforms, which we expect to take

[153] NHS Digital (2021), 'Recorded use of the Mental Health Act: crude rates per 100,000 population power BI dashboard'. Accessed 30/03/2022.

[154] Office for National Statistics (2016) 'Rural Urban Classification (2011) of CCGs including population in England'. 105 of 135 CCGs in NHS Digital's 'Mental Health Act Statistics, Annual Figures 2020-21' publication have a matching classification available, but this only represents 55% of the population.

[155] Lee, S. C., DelPozo-Banos, M., Lloyd, K., Jones, I., Walters, J. T., Owen, M. J., O'Donovan, M. and John, A. (2020), 'Area deprivation, urbanicity, severe mental illness and social drift - A population-based linkage study using routinely collected primary and secondary care data. Schizophrenia research', 220, p. 130–140.

place in stages over the implementation period of the Act. We would then expect impact assessments to be completed later as outcomes take time to emerge.

224. We have already began work on commissioning process evaluation of the reforms we plan to introduce in 2024/25 (changes to detention criteria, nominated persons and independent mental health advocates). We are also working to commission independent evaluation for pilots and phased rollout of other measures.

225. We are also exploring what data we will need ahead of implementation, to ensure that sufficient baseline information is available to identify impacts. This work includes looking to commission feasibility studies for how we can collect systematic data on patient and carer experiences.

226. We are also considering how we monitor inequalities, including race, disabilities and socioeconomic factors. We will work with stakeholders to make sure the data is available to monitor these issues. We are also carrying out workshops with stakeholders to develop a theory of change to map out how the MHA reforms will reduce racial disparities under the Act. This will be used to develop criteria to monitor and evaluate the impact of the reforms on reducing racial disparities.

Annexes

Annex A. List of acronyms

ACD – Advance Choice Document

ADASS – Association of Directors of Adult Social Services

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

CYP – Children and young people

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

LDA – Learning disability and/or autism

LGA – Local Government Association

MHA - Mental Health Act 1983

MHCS – Mental Health Casework Section

MHRTW – Mental Health Review Tribunal for Wales

MHSDS – Mental Health Services Data Set, NHS Digital

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

NPV – Net Present Value

OT – Occupational therapist

PCREF - Patient and Carer Race Equality Framework

PV – Present Value

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. Forecasting the baseline number of detentions under the Mental Health Act and estimating their average cost

Background and proposed policy change

1. The purpose of this model was to estimate changes in number of detentions under the MHA and the average cost of a detention. 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). The number of detentions under the MHA anticipated in future years will directly affect the cost and benefit estimates of implementing the policy under the MHA Bill (Option 2).

2. The BAU approach assumes that detentions under the MHA would increase by 4.5% in 2021/22, the same estimated annual increase as seen in 2020/21. Detentions would then increase by 3.7% in 2022/23 and 2023/24, then by 2.05% per year from 2024/25 to 2033/34. Then from 2034/35 detentions will grow in line with weighted demographic changes.

Summary of model

3. Purpose: To estimate the number and cost of detentions during the policy period for BAU.

4. Main outputs:
   - Number of detentions
   - Estimated cost of a length of stay (i.e., excluding MHA assessments)

5. Main data sources: Mental Health Services Data Set (MHSDS)[156] and MHA Statistics[157], from 2016/2017 to 2020/21.

6. 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 2020/21 are based on a subset of providers providing good quality data in 2015/16 (KP90) (see Annex H for change in data collection method)
   - There are only 5 years of MHSDS data, with an undercount of detentions in the first two years

Model Assumptions

7. Main assumptions – Option 1 (BAU)
   - The initial annual detentions is estimated at 53,000 detentions, based on 2020/21 MHSDS data.
   - The estimated annual increase in detentions from 2019/20 to 2020/21 is assumed to be 4.5% - 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. Although the estimate in the annual report is only based a small set of 24 providers, we do not view this as an undercount as it does not significantly differ from the actual percentage change in the number of detentions from 2019/20 to 2020/21 (4.6%). This 4.5%

[156] Mental Health Services Data Set (MHSDS) annual data Mental Health Bulletin - NHS Digital
[157] Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

increase in detentions under the Act over this period is likely a result of the impacts of COVID-19. The CQC 2019/20 report on their monitoring of the MHA identified COVID-19 pressures in the mental health system[158]. CQC anticipates that with fewer beds and limited community support delivered through remote contact, there would be significant unmet need during lockdown, and they expect that this unmet need would increase the risk of coercive pathways into mental health care, including detentions under the MHA. Based on this and conversations with professionals, we assume that the number of detentions in 2021/22 will still show the impact of the pandemic. We therefore assume detentions will continue to grow at an annual rate of 4.5% in 2021/22. ,

- Then from 2022/23 onwards, as services continue to rebuild their capability after the pandemic and reflect this through improved patient experiences, we assume that the lasting impact of COVID-19 on the number of detentions will gradually diminish. We assume a moderate impact of COVID-19 will remain from 2022/23 to 2023/24, growing at an annual increase of 3.7% - this is the average of the estimated change included in the annual MHSDS reports before the pandemic (2016/17 to 2019/20) (2.05%), the estimated change in 2020/21 (4.5%) and the forecasted change in 2021/22 (4.5%). Although the forecast assumes a diminishing impact of Covid, the approach is still relatively pessimistic in the growth rate of detentions and so may overestimate the overall number of detentions.

- From 2024/25 to 2033/34, we assume that the annual increase in detentions revert back to 2.05%, the average estimated change reported, pre-pandemic (2016/17 to 2019/20).

- Due to the length of the appraisal period used and the difficulty in accurately forecasting detentions so far into the future, from 2034/35onwards, that is, for the last 10 years of the 20-year appraisal period, we assume detentions will grow in line with weighted demographic changes. This uses the projected population percentage change by age group (average of 0.20% across the ten years)[159], together with the average proportion of detentions by age group, from 2016/17 to 2020/21.

8. Main assumptions – Option 2 (Policy).

    - The forecasted number of detentions will remain the same under the policy option. A 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 the estimated number of reduced detentions following ACDs in each year (see Annex B.VII for detail).

Cost of Length of Stay

9. Cost of length of stay (not including MHA related activities)

    - The cost of the length of stay in hospital was calculated by multiplying the unit cost per bed day (£524)[160] by the average of the median length of stay of detentions subject to Section 2 and 3 (54 days)[161]. The cost was then inflated to £571 in 2022/23 prices using the GDP deflator. Multiplying the cost and the average length of stay estimates the cost of the length of stay in a hospital during a detention in 2022/23 prices at £31,000.

[158] Care Quality Commission (2020). Monitoring the Mental Health Act in 2019/20. Accessed at: https://www.cqc.org.uk/sites/default/files/20201127_mhareport1920_report.pdf

[159] Office for National Statistics (12 January 2022). 2020-based Interim National Population Projections. Accessed at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/z3zippedpopulationprojectionsdatafilesengland

[160] https://www.england.nhs.uk/wp-content/uploads/2021/06/2_National_schedule_of_NHS_costs_FY19_20_V2.xlsx

[161] Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

Data sources and baseline

10. Data published prior to 2016/17 were collected using the KP90 data collection, which was an aggregate data collection[162] (see Annex H). The 2016/17 MHA Statistics publication[163] 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[164] (which are not in scope for MHSDS[165]).

11. In most of our analysis, we use MHSDS data because 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 5 data points (2016/17 - 2020/21) from MHSDS and the data quality from MHSDS has improved over the years and become more reliable.

Data caveats

12. 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.

13. 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.
    - Data for individual providers are also incomplete, particularly for independent sector providers and acute trusts.

Option 1. BAU Model

14. This model is intended to project the number of detentions under the counterfactual. To do this we have estimated an initial number of annual 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 monetised benefits from ACDs and breakeven analysis of costs/benefits.

15. Detention baseline forecast:
    - The initial annual number of detentions is assumed to be the latest published annual number of detentions in 2020/21 MHSDS data[166], which is 53,239.
    - This baseline was projected forward using the growth rate assumption.

16. Growth rate – to account for the impact of COVID-19 in the growth rate used to forecast detentions, we split the appraisal period into smaller timeframes. We expect the impact of the pandemic to have a

[162] 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

[163] 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

[164] 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

[165] 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

[166] NHS Digital (26 October 2021). Mental Health Act Statistics, Annual Figures 2020/21. Accessed at: Mental Health Act Statistics, Annual Figures 2020-21 - NHS Digital

continued impact on detentions in the immediate short run then forecast the annual growth rate of detentions to revert back to pre-pandemic levels from 2024/25.

- 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 2020/21) 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 have submitted good quality data in 2015/16 (KP90) and continue to do so since the switch to MHSDS. We used these estimates until 2020/21, excluding 2019/20 – see explanation below.

- The number of providers included in the subset has been falling and were only 24 in both 2019/20 and 2020/21– see table BI.1 below. This is a limited number of providers so, to avoid underestimating the annual increase in detentions we have taken a more pessimistic approach. For the change from 2018/19 to 2019/20, we used the change in the number of detentions as published, rather than the estimated change based on a small number of providers as this may bias the average yearly change in detentions to lower values– see table below. We take this action for the 2019/20 data given the significant difference between estimates using the subset of providers and the published figure. However, given the little difference in the estimates for 2020/21, we continue to use the estimated increase as published by the reports due to a limited concern of underestimating the annual increase in detentions in this particular year.

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

	2016/17	2017/18	2018/19	2019/20	2020/21	Average
Reported number of detentions	45,864	49,551	49,881	50,893	53,239	
Percentage increase calculated from reported detentions				1.81%	4.61%	
Estimated annual increase based on high data quality subset of providers published by NHSD	2%	2.4%	2%	0.8%	4.5%	
Number of providers included in the subset of providers for NHSD estimates	35	33	28	24	24	
Percentage increase used in model	2%	2.4%	2%	1.81%	4.5%	2.54%

17. The Care Quality Commission (CQC) 2019/20[167] report on monitoring the MHA identified COVID-19 pressures in the mental health system. The CQC noted that, whilst recognising that services rose to the challenges of lockdowns and the additional burdens that this placed on patients and staff, the experience of hastened hospital discharges meant that some patients were released from detention with unsafe or incomplete care plans. Also, with fewer beds and limited community support delivered through remote contact, there will have been significant unmet need during lockdown. These are all factors which may increase the risk of coercive pathways into mental health care, including detention under the MHA. Additional factors leading to a proportionate increase in the use of MHA detention at a time of reduced hospital admissions include increased demand experienced by some services for MHA assessments, routine checks on the wellbeing of people who use mental health services re-routed from community teams to AMHP services for MHA assessments and pressures from the

[167] 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)

unavailability of beds having consequences for patients who were not able to access impatient care. These findings are in line with the estimated 4.5% rise in detentions under the MHA in 2020/21.

18. Reduction in detentions following improvements in services. The Independent Review expected that if its recommendations were accepted then detentions under the MHA would decrease. It acknowledged 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)[168]. It also acknowledged 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.

19. Their consultation/collection of evidence on what could reduce detentions is summarised by the recommendations below (p.109)[169]:
    - 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."

20. The first recommendation above on improved crisis and community services is being taken forward as part of addressed by the NHS LTP[170], and further detailed in the NHS Mental Health Implementation Plan 2019/20 – 2023/24[171], published in July 2019. Due to the impact of the pandemic, the NHS LTP delivery profiles are being reviewed and are not yet finalised, therefore the impact of these improvements in detentions are not included in this IA. The Independent Review also recommended 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 detentions in the near future in a way that we are able to include them in our estimates of the reduction in detentions.

Option 2. Policy option

21. Under the policy (Option 2), the initial number of detentions is expected to the same as in BAU (Option 1).

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

22. The average cost of a length of stay was calculated by multiplying an estimated mean unit cost per bed day[172] (£524) by the average length of stay of a detention (54 days, calculation described below). The cost was then inflated to 2022/23 prices using a GDP deflator. The cost of length of stay in 2022/23 prices is estimated at around £31,000. This estimate was used in the breakeven analysis of costs/benefits.

23. **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

[168] 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

[169] As above.

[170] NHS England (January 2019). The NHS Long Term Plan. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[171] 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/

[172] NHS England and NHS Improvement (June 2021). 2019/20 National Cost Collection data – National schedule of NHS costs (tab PLMHPS – PLICS Mental Health Provider Spells). Accessed at: NHS England » National Cost Collection for the NHS

Section 2 and 3 as our estimate for average length of stay. In 2020/21[173] the median length of stay was 20 days for Section 2 detentions and 87 days for Section 3 detentions, and their average is 54 days.

24. **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:
    - 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.

25. **Estimating costs.** The number of days was multiplied by the cost of a bed day, which gives an estimated costs of £30,550 (2022/23 prices) for an average cost length of stay.

[173] NHS Digital (26 October 2021). Mental Health Act Statistics, Annual Figures 2020/21. Accessed at: Mental Health Act Statistics, Annual Figures 2020/21 - NHS Digital

B.II. Estimating the number of Community Treatment Orders (CTOs)

Background and proposed policy change

1. The use of Community Treatment Orders (CTOs) is expected to reduce following the changes in the CTO criteria.

2. We assume that, after 5 years of gradual implementation of the change in criteria for CTOs in the MHA reforms, CTOs will decrease by around 40% (instead of the 50% expected reduction).

3. The baseline scenario for the number of CTOs is included in the business as usual (BAU) option. Proposed policy options on reducing CTOs under the MHA can be compared against the BAU Option 1 to estimate additional costs and cost savings, staff requirements, etc. and benefits associated with these options.

Summary of model

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

5. Main outputs: Number of CTOs, workforce costs relating to CTOs (includes consultants and care co-ordinators) and potential cost savings from the reduction of CTOs.

6. Main data source: MHSDS data from 2017/18 to 2020/21. Note: MHSDS data from 2016/17 has a known downward bias and derived rates and is dropped from the estimation[174][175].

7. Data caveats: See section on detentions above.

Model Assumptions

8. Main assumptions – Option 1 (BAU):

   - Start date of policy is assumed to be 2028/29, once legislation is expected to be in place.

   - The BAU forecast assumes the number of CTOs will remain constant from 2024/25 based on the average number of CTOs from MHSDS when excluding the COVID-19 pandemic (2017/18 to 2019/20) and including it (2017/18 to 2020/21). As the uses of CTOs increased by 30.5% from 2019/20 to 2020/21, likely due to the effects of the pandemic, we assume the uses of CTOs will gradually fall over the coming years before remaining constant from 2024/25 to 2033/34. From 2034/35 onwards we assume the use of CTOs grow in line with the weighted demographic changes.

	2017/18	2018/19	2019/20	2020/21	Average
Excluding COVID-19	4,784	4,840	4,650		4,758
Including COVID-19	4,784	4,840	4,650	6,070	5,086
Average, BAU forecast					4,922

   - 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.

[174] 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.

[175] 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

- We assume all patients require time with a consultant and only half of patients require time with a care coordinator.

- Hourly costs for responsible clinicians and care coordinators are estimated to be £123 and £36 (in 2020/21 prices, £127 and £38 when inflated to 2022/23 prices).

9. Main assumptions – Option 2 (Policy):

    - CTOs are assumed to reduce gradually by 40% from 2028/29 with a gradual change over 5 years until 2032/33. From here, this lower number will remain constant until 2034/35, after which CTOs are assumed to grows in line with weighted demographic changes. The transition to demographic projections is consistent with the forecast of detentions and is used given the uncertainty around accurately forecasting so far into the future.

    - Contact time with clinical staff uses the same contact time as in the BAU option.

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

Option 1. BAU Model

10. The number of CTOs[176] has been fluctuating in previous years with no obvious trend. After consulting NHSD and NHSEI, we decided to have a flat CTO forecast, from 2024/25 instead of using the average percentage increase of MHSDS or the average percentage increase from 2010/11 to 2020/21. We first assume a phased decrease in the number of CTOs before reaching our flat forecast to account for the recent, sizeable spike in the uses of CTOs, likely due to COVID-19. We assume COVID-19 will continue to have a temporary, lasting effect on the uses of CTOs.

11. 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 £123.46 (in 2020/21 prices) or £127.16 (in 2022/23 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 £36.42 (in 2020/21 prices) or £37.51 per hour (in 2022/23 prices)[177]. All costs were inflated to 2022/23 prices using a GDP deflator[178].

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

13. 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

14. We assume that the start date of the policy is 2028/29 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

[176] 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

[177] Jones, K. & Burns, A. (2021) Unit Costs of Health and Social Care 2021, Personal Social Services Research Unit, University of Kent, Canterbury. Accessed at: Unit Costs of Health and Social Care 2021 | PSSRU

[178] Office for Budget Responsibility (23 March 2022). Economic and fiscal outlook. Accessed at: Economic and fiscal outlook - March 2021 - Office for Budget Responsibility (obr.uk)

Annex B.VI.

15. Under the policy (Option 2), we have assumed a 40% reduction in the number of CTOs taking place gradually over 5 years from 2028/29 until 2032/33 and the number of CTOs will remain flat after 2032/33 until 2034/35, from which forecasts are expected to grow in line with weighted population changes, as in the BAU forecast but from the lower policy baseline.

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

Background and proposed policy change

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. 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. The Government also proposes implementation of safeguards, which, despite not specifically aimed at the IMHA service, will result in additional responsibilities for IMHAs: supporting the patient to inform their CTP and their ACD; supporting additional interaction with the SOAD and support for additional tribunals.

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

Summary of model

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

4. 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.

5. Main data sources:

   - Detention and CTO scenario forecasts sourced from other models in this impact assessment.
   - Conditionally Discharged Restricted Patients forecasts are aligned with the MoJ model.
   - Advocacy providers for information on uptake, caseload, salary and potential additional workload.
   - IMHA costs of Guardianships added in to summary costs from the DHSC Guardianship model.

6. Main assumptions – Option 1 (BAU)

   - Current levels of advocacy uptake are 50%[179].
   - IMHA staff costs (salary, oncosts and overheads) are estimated at £53,161 per year, and costs to train new IMHAs are £1,635 at 2022/23 prices. These figures were estimated from online job adverts, using a base salary of £27,250 in 2022/23 prices.
   - An advocate has a caseload of 100 people per year (see explanation below). [180]
   - Conditionally discharged restricted patients figures are based on estimates from MoJ forecast modelling.
   - Sections 57 and 58A treatment and ECT in under 18s remain constant at 5 and 1 cases per year.

7. Main assumptions – Option 2 (Policy)

[179] Newbigging, K. (September 2021). Rapid appraisal of the uptake of Independent Mental Health Advocacy Services – Report for the Department of Health and Social Care. Unpublished.

[180] 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

- Advocacy opt-in is assumed to expand to 85% for those currently entitled to an IMHA and to 50% uptake for informal mental health inpatients.
- The staff costs (salary, oncosts and overheads) and cost of training an IMHA remain the same.
- An IMHA's caseload increases by 6 hours per CTP (6 hours for Section 2 detainees, 6 hours for Section 3 detainees), 6 hours per SOAD interaction, 12 hours per CTO case, 6 hours per tribunal and 2 hours per ACD.
- The forecast for conditionally discharged restricted patients is aligned with MoJ modelling.
- BAU forecasts are maintained for serious mental health surgery, and ECT in under 18s.
- Mental Health inpatient numbers are assumed constant at 2016/17 levels, and voluntary patients are assumed to be the difference between inpatients and detainees.

8. The policy model consists of two main parts.

- Opt-in: This part considers expanding BAU uptake from 50% to 85% opt-in and divides by the additional numbers of cases by the average IMHA caseload (described below) to determine the number of IMHAs needed.
- Additional Workload: This part calculates the additional workload expected due to additional IMHA input (see details below) in terms of overall additional hours. This is then divided by the average number of working hours per year (accounting for holidays, sickness and training) based on PSSRU figures to determine the additional number of IMHAs needed.

Eligibility

9. Under the current MHA, those who are eligible[181] to use IMHA services are:

- 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
- People in supervised Community Treatment Orders (CTOs)
- Conditionally discharged restricted patients
- People subject to guardianship under the Act
- Informal patients 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)
- People under 18 and being considered for electro-convulsive therapy

[181] 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/

10. Offender Management statistics[182] show that the population of restricted patients currently conditionally discharged from hospital increased by an average of 4% per year between 2014 and 2018. The number of restricted patients currently conditionally discharged from hospital will be impacted by a number of proposals including those relating to automatic referrals. The forecast numbers for these patients are aligned with the modelling outputs from the MoJ model with no change between BAU and post implementation.

11. Public data on Guardianship under the MHA were obtained from NHS Digital (NHSD)[183], with annual figures available up until the year 2020/21. Estimates from 2021/22 onwards use the mean annual decrease of 51 Guardianship cases seen between 2003/04 and 2020/21. Costs associated with IMHA support for Guardianships are added in from the Guardianship model.

12. 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.

13. We estimated the number of ECT in England in people under 18 years of age from available data as follows: the number of courses of ECT in England in 2016/17 was estimated at 2,153[184]; which we divided by the rate of ECT courses per patient for the UK and Ireland (1.08) . However, only 0.1% of ECT patients are under 18 (giving an estimate of 2 patients), and 52% are informal. We therefore assume that only 1 patient is captured in this cohort and this is the same in BAU and the policy scenario.

14. 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).

15. Data from NHSD[185] indicate that the number of mental health inpatients over recent years has been fairly consistent. We therefore assume that the number of mental health inpatients remains fixed at 2016/17 levels of around 101,600. We assume that maximum number of voluntary patients are equal to the difference between total inpatients and detentions.

Additional Workload

16. 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 (preparation, meeting and travel)	6
CTPs for Section 2 detainees (preparation, meeting and travel)	6
Contact with SOAD	6
CTOs (preparation, meeting and travel to application and renewal)	12
Additional Tribunal	6
ACDs - 1 to 1 session with service user	1
Support of drafting ACD	1
Informal patients (at 50% uptake)	6

[182] 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

[183] NHS Digital. Guardianship under the Mental Health Act 1983, England – 2018-19, 2019-20 & 2020-21. (2021). Accessible here.

[184] 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

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

Caseload

17. 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[186]. Based on this, an annual caseload of 100 is assumed (25 cases every three months = 100 in 12 months).

18. We assume a FTE IMHA works 1,513 hours per year (using a Social Worker as a proxy, see PSSU table 11.1)[187]. This takes into account 29 days of annual leave and statutory holidays, 10 days other study/training and 8.5 days sick leave.

19. The training cost per IMHA was estimated to be £1,635 (in 2022/23 prices) and to account for mixed roles and part time staff we estimated that for each FTE there is 1.4 headcount[188]

    Sensitivity Analysis – see Risk and assumptions, sensitivity analysis section.

[186] 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

[187] Unit Costs Report 2021 - Final version for publication.pdf (kent.ac.uk) Table 11.1

[188] Newbigging, K., et al. (2012) Right to be heard Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England uclan.pdf (firah.org)

B.IV. Estimating the impact on Approved Mental Health Professionals (AMHPs)

Background and proposed policy change

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). 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) and Guardianships.

2. One key impact we expect on the AMHP workforce is an increase in workload resulting from needing to perform more frequent assessments for CTOs. However, despite an expected increase in workload per CTO, we expect the AMHP workforce needed to reduce due to the forecast decreases in CTOs. AMHP workforce is also expected to increase in their workload in supporting a variety of tasks for setting up an ACD.

3. For Option 1 (BAU), we assume that the current number of AMHPs would remain– 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.

4. 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

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

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

7. Main data sources: CTO and ACD model data flow through to this model. Costs of guardianships are added in from the DHSC Guardianship model (see Annexe B.IX).

8. Main assumptions – Option 1 (BAU):

    - Uses figure of 140,000 assessments a year[189].
    - Number of assessments assumed to be flat across the policy period.

9. Main assumptions – Option 2 (Policy):

    - Start date of policy is assumed to be the year MHA legislation changes should be in place – 2027/28 for ACDs and 2028/29 for CTOs.
    - Workload increases by 30.3 hours per CTO.
    - Workload increases by 0.85 hours per ACD (as we assume that AMHPs could cover around 20% of ACDs in each year, the remaining 80% would be covered by other professionals).

[189] 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

Option 1. BAU Model

10. Number of assessments. These are assumed at 140,000 assessments a year[190], and to be flat across the policy period.

11. Salary, oncosts, overheads and capital. From a base salary of £38,800[191] in 2019/20 prices then adding oncosts, overheads and capital (assumed at 49% of total costs) in line with the proportion of these costs in the salary of a social worker in adult services (PSSRU unit)[192] giving £75,695 costs (2019/20 prices)[193] inflating this to £82,506 (2022/23 prices),[194].

12. Full Time Equivalents (FTEs). The number of FTE AMHPs was estimated to be around 1,244. 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 (1,513)[195] to estimate the number of FTE AMHPs in England. The number of working hours in a year takes into account 29 days of annual leave and statutory holidays, 10 days other study/training and 8.5 days sick leave.

13. Costs. To obtain overall costs, the estimated number of FTEs is then multiplied up by the average salary of an AMHP including on-costs, overheads and capital, £82,506 (2022/23 prices).

Option 2. Policy Model

14. Salary, oncosts and overheads for professionals during training. Around 95% of AMHPs are social workers[196]. We have used the annual salary for a social worker as a proxy for the salary of the professional training as an AMHP, based on estimates from the PSSRU report on Unit Costs of Health and Social Care 2020/21, the – this is £35,710 in 2020/21 prices[197]. We also estimated oncosts based on published costs for social worker in adult services[198]. Oncosts were estimated to be £10,136, which gives a total cost of £45,863 (in 2020/21 prices). Next, we assumed training time is six months and an average AMPH course costs c£3,700 giving a total training cost of £26,923 (in 2020/21 prices). Finally, total costs were inflated to 2022/23 prices giving £27,724 in 2022/23 prices using a GDP deflator[199].

15. 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.

16. For each CTO:

    - Two additional assessments at 6 and 12 months into CTO – each estimated to be 12 hours (2 * 12 hours)

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[190] As above.

[191] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Social-work/Approved-Mental-Health-Professional-workforce.aspx

[192] Unit Costs Report 2021 - Final version for publication.pdf (kent.ac.uk) Table 11.1

[193] Department of Health and Social Care & Skills for Care (November 2019). The Approved Mental Health Professional Workforce in the adult social care sector.

[194] 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

[195] Unit Costs Report 2021 - Final version for publication.pdf (kent.ac.uk) Table 11.1

[196] AMHP Skills for care survey.(2019/20) https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Social-work/Approved-Mental-Health-Professional-workforce.aspx

[197] As above.

[198] As above.

[199] October 2021 Economic and fiscal outlook: Economy supplementary tables, Table 1.7 https://obr.uk/efo/economic-and-fiscal-outlook-october-2021/

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

17. 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.

18. For Guardianships:

Guardianship costs are estimated separately (see Guardianship model, annexe B.IX) and costs for AMHPs are added into the overall AMHP costs.

19. 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[200,201]:

- 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%)

[200] 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

[201] 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

- 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 (allowing 2 hours for urban and 4 hours for rural travel, with 50% of visits needing travel and 56% being urban, 44% rural).

20. 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;

    - From these calculations, we can estimate extra FTE = Additional hours / standard working hours per year; ((Number of CTOs*30.3)+(Number of ACDs*0.85))/(1513.3).

21. Headcount. To estimate headcount we have converted FTE to headcount using a scaling of 1.4 based on information on the proportion of full time equivalent posts and numbers of staff in post. This is used to calculate the numbers of AMHP staff needed to train.

22. Overall costs**.** Total costs for AMHPs combine the overall FTE costs for ACDs and CTOs, and the costs of training additional staff. AMHP costs associated with guardianships are added in to the total cost for AMHPs.

Sensitivity Analysis – see Risk and assumptions, sensitivity analysis section.

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

Background and proposed policy change

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 without capacity to 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 from first day of detention, at the request of the patient or their representative, if a patient with capacity is receiving treatment that they have refused.

3. When urgent ECT is needed and the patient is refusing treatment, the approved clinician (AC) should secure approval from a SOAD within 48 hours that the treatment can be given.

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:

   - The main model input is the forecast number of Section 2 and 3 detentions drawn from the DHSC Detentions model. The model also draws on the estimated number of CTOs from the DHSC CTO model, and the numbers of Part III patients detained in hospital[202.]

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

   - NHS Digital (NHSD) MHA data: Number of days detained under the MHA per single-provider hospital spell, 2020/21.[203]

6. Main assumptions:

   - Breakdown of SOAD visits: 79% of SOAD visits are to review medication – (of these 11% for refusals and 89% for those lacking capacity). 12% of SOAD visits are in relation to ECT and 9% for CTOs. This is based on average proportions of the numbers of SOAD visits reported by CQC 2016/17-2020/21 except 2019/20 which did not provide sufficient detail due to focus on COVID-19.

   - Rates of SOAD Visits per Detainee: These were calculated based on the number of SOAD visits divided by the estimated number of eligible detainees. Estimated rates were 0.08 visits for refusals per Section 3 Detainee, 0,72 visits for those lacking capacity, 0.06 visits for ECT and 0.26 visits for CTO averaging rates across 2018/19 to 2020/21. The model assumes the same proportions in future years.

   - Length of Stay (LOS): 49.5% of Section 3 detainees have a stay of 3 months or more. 18.3% have stays between 2 months and 3 months, and 32.2% have stays between 0 months and 2 months. The model assumes the same proportions in future years.

   - Cost of a SOAD Visit: Each SOAD visit is assumed to cost £411 in 2022/23 prices.

[202] Offender management statistics https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2020

[203] Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital

- Caseload: A SOAD conducts a mean of 109 visits per year.
- 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 additional shadowing involving attending two visits with a more experienced SOAD. SOADs also undergo mandatory refresher training each year.

Option 1 (BAU) Model eligible detainees:

7. The BAU model estimates the number of SOAD visits, number of SOADs and costs, based on the modelled number of people for those currently eligible Section 3 detainees and CTOs from the DHSC models. BAU covers Section 3 detainees who have lengths of stay longer than 3 months, Part III patients detained in hospital; CTOs and ECTs:

- detainees eligible under BAU include:
    - Section 3 Detainees refusing medication (length of stay beyond 3 months)
    - Section 3 Detainees lacking capacity (length of stay beyond 3 months)
    - Section 3 Detainees receiving ECT (any length of stay)
    - Part III detainees retained in hospital, assumed a similar profile to Section 3 length of stay.
    - Those on CTOs (any length)

Option 2 (Policy) Model eligible detainees:

8. The policy scenario 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 first day of detention; Section 2 detainees refusing with capacity (we have excluded very short length of stays using the first 25% of LOS (10 days); those lacking capacity from 2 months; Part III patients detained in hospital; reduced CTO numbers from the CTO model; there is no change in routine modelled ECT numbers; but we have included initial estimates for Urgent ECT.

- detainees eligible after implementation of proposals include:
    - Section 3 Detainees refusing medication (from first day of detention)
    - Section 3 Detainees lacking capacity (length of stay beyond 2 months)
    - Section 2 Detainees (we have used 75% of Section 2 detainees, excluding those in the first 25% of length of stay (10 days in 2020/21)
    - Section 3 Detainees receiving ECT (any length of stay) including urgent ECT
    - Part III detainees retained in hospital, assumed a similar profile to Section 3 length of stay.
    - Those on CTOs (any length)

9. SOAD costs and estimated numbers under the Scenario are compared to the BAU.

Option 1. BAU Model

10. 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.

11. The BAU usage of SOADs for Section 3 detainees is modelled as follows:

Number of SOAD visits *equals*:

Refusals: Estimate Number of Section 3 detentions (and Part III detainees in hospital) with lengths of stay longer than 3 months multiplied by rate of refusal visits per detainee *plus*

Lacking Capacity: Estimate Number of Section 3 detentions (and Part III detainees in hospital) with lengths of stay longer than 3 months multiplied by rate of lacking capacity visits per detainee *plus*

CTOs: Estimate Number of CTOs multiplied by rate of CTO visits per CTO *plus*

ECT: Estimate Number of Section 3 (and Part III detainees in hospital) 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

12. The percentage of people detained for different lengths of stay has been calculated using published 2020/21 NHSD MHA data on length of stay. This only includes 25th,50th,75th percentiles of length of stay by detention section. We have used these to calculate the proportions of detainees 0-2 months, 2-3 months and greater than 3 months. This is used to estimate the number of SOAD visits as explained in the box above.

13. 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*
<31 days	15.3%
>=31 days to <61 days	16.9%
>=61 days to <91 days	18.3%
>=91 days	49.5%

*Proportions may not sum due to rounding

Rates of SOAD Visits

14. The average proportion of SOAD visits for each type of SOAD visit was calculated from available CQC data across 2016/17-2020/21 except 2019/20 which did not provide sufficient detail due to focus on COVID-19. Approximately 79% of SOAD visits are to review medication – (of these 11% for refusals and 89% for those lacking capacity). 12% of SOAD visits are in relation to ECT and 9% for CTOs.

15. 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	0.06
CTO	0.26
Medication Review - Refusals	0.08
Medication Review – Lacking Capacity	0.72
Urgent ECT	0.01

SOAD Caseload

16. 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

17. 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 when detention starts for those capable but refusing medication, and from 2 months for those who lack capacity to provide valid consent. The model also includes estimates for approving Urgent ECT for refusal/advance choice.

18. The usage of SOADs post implementation is modelled as follows:

Number of SOAD visits *equals:*
Refusals (to start in 2027/28): Number of Section 3 detentions and Part III detainees in hospital<3 months, and Section 2 detainees (>10 days) multiplied by rate of refusal visits per detainee *plus*
Lacking Capacity (to start in 2027/28): Number of Section 3 detentions and Part III detainees in hospital with lengths of stay 2-3 months multiplied by rate of lacking capacity visits per detainee *plus*
CTOs (to start in 2028/29): Number of CTOs multiplied by rate of CTO visits per CTO *plus*
ECT (to start in 2027/28): Number of Section 3 detentions with all lengths of stay multiplied by rate of ECT visits per detainee
Urgent ECT refusals (to start in 2028/29): Number of patients refusing ECT multiplied by the rate of visits

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

1. The NHSD length of stay data indicates that an additional 5.3% of Section 3 detainees are captured from the move from 3 months to first day of detention for refusals. It also shows that an additional 16.4% of Section 3 detainees would become eligible for those incapable by extending from 3 to 2 for those lacking capacity.

Rates of SOAD Visits

2. 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

3. 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.

4. 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[204]:

	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
Total	**£5,042,938**	**£368**
Unit Cost of SOAD Visit in 2022/23 prices		**£411**

5. 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

6. 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.

7. The average total cost of all of the elements above has been calculated as £339 per SOAD in 2022/23 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 Additiona*l SOADs

8. Training of new SOADs is short, so the model assumes that SOADs needed in year Y are trained in year Y. Standard training consists of a one day course at a cost of £809 (2022/23 prices), Additional shadowing costs £840 (2022/23) prices and Mandatory refresher training costs £133 (2022/23 prices).

Sensitivity Analysis – see Risk and assumptions, sensitivity analysis section.

[204] 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)

B.VI. Estimating the impact on Clinical Teams

Background and proposed policy change

1. The purpose of this model was to assess the impact on clinical teams (includes responsible clinicians, nurses, occupational therapists and care co-ordinators), and related expenditure, as a result of the MHA reforms – primarily for support to tribunal hearings challenging detention, more engagement with SOADs, more frequent renewals of CTOs, setting up Care Treatment Plans (CTP), ACDs and Guardianships.

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. 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 policy under the MHA).

5. Main data sources:

    - Tribunal receipts were provided by the MoJ

    - Detentions and CTOs forecasts are sourced from other models in this IA.

Model Assumptions

6. Main assumptions – Option 1 (BAU)

7. Tribunal numbers are assumed to remain the same (at 2020/21 levels).

8. Staff: Three staff are 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.

9. Staff time: 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

10. Staff costs are adjusted to 2022/23 prices, using GDP deflator.

11. Main assumptions – Policy option:

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

    - Assumes that different policies start at different points in time, as set out in Table 1.

Option 1. BAU Model

12. 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.

13. Staff costs for RCs, additional clinicians and Community Supervising Clinicians include salary, oncosts and overheads, and were estimated based on the costings for a hospital based consultant in

psychiatry[205]. The total cost per hour is estimated to be £123 (in 2020/21 prices) and £127 (in 2022/23 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 £36 per hour (in 2020/21 prices)[206] and £38 (in 2022/223 prices).

14. All costs were inflated to 2022/23 prices using a GDP deflator[207].

Option 2. Policy Model

15. 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.

Area of pathway	Staff Type	Cohort	Extra hours
All detentions			
CTP Set Up	Responsible Clinician	All detentions	4
Section 3			
Contact with SOAD	Responsible Clinician	Increased Visits	1.5
Contact with SOAD	Nurse	Increased Visits	1.5
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)	0.5
CTO			
Application	Community Supervising Clinician	All CTOs	4
Renewal	Additional Clinician	CTOs over 6 months	4
Additional decision maker	Community Responsible Clinician	All CTOs	4
ACDs			
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
Guardianships			
Mental Health Assessment and reviewing and renewing guardianship	Responsible Clinician	See Annex B.IX	

[205] Jones, K. & Burns, A. (2021) Unit Costs of Health and Social Care 2021, Personal Social Services Research Unit, University of Kent, Canterbury. Accessed at: https://www.pssru.ac.uk/pub/uc/uc2021/hospitalbased.pdf

[206] As above.

[207] Office for Budget Responsibility (23 March 2022). Economic and Fiscal Outlook – March 2022. Accessed at https://obr.uk/efo/economic-and-fiscal-outlook-march-2022/

Area of pathway	Staff Type	Cohort	Extra hours
Supporting care plan	Nurse	See Annex B.IX	
Supporting care plan	Occupational Therapist	See Annex B.IX	

16. 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.

17. Sensitivity Analysis – 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 the impact on Administrative staff

Background and proposed policy change

11. Policies that could bring additional administrative costs are:

    - The nominated person, for example through updating the NP in the patient's record, providing information to the NP and consultations with the patient,
    - ACDs, through coordinating meetings and updating documents,
    - CTPs, particularly for the CTP audits,
    - The changes to the frequency with which patients can access the MHT.

    Assumptions about additional workload were discussed and most were agreed with some providers and will need to be refined alongside further development of the policy[208].

12. We also estimated administrative costs associated with the SOAD work, which are included in the SOAD cost estimates – see Annex B.V..

13. To estimate these additional administrative staff costs, we used assumptions on the extra time required for the additional tasks, then multiplied it by the number of detentions or tribunal hearings and by the average staff costs, as set up below.

Policy	Staff [a]	Activity	Cohort	Additional time required
Changing Nearest Relative to Nominated Person	Clinical (Band 4/5 Nurse)	Time spent updating patient records	All detentions [b]	0.3 hrs[g] per detention (range 0.1-0.7)
Changing Nearest Relative to Nominated Person	Clinical (Band 4/5 Nurse)	Time spent providing information to nominated person(s)	All detentions	c. 0.5 hr per detention (range 0.2-0.9)
Care Treatment Plans	Clinical (Band 8b Psychiatrist)	Setting up automated system	25[c] Mental Health (MH) trusts set up an automated system	26 hrs (range 17-35)
Care Treatment Plans	Clinical (Band 8b Psychiatrist)	Creating CTP audit report	77 MH trusts/Independent MH Providers submitting data on the MHA[d]	22 hrs per month (range 17-26)
Care Treatment Plans	Clinical (Band 4/5 Nurse)	Manual audits of CTPs	38%[e] of all detainees	10-15 mins per CTP
Change to Tribunal referral rights / Tribunal Frequency	Clinical (Band 4/5 Nurse)	Setting up tribunal	All tribunal hearings[f]	c.1.25 hrs per hearing (range 1-1.5)

Notes:

a. As a proxy for administrative staff costs, we used clinical staff costs, which may produce overestimates. Source: Unit Costs of Health and Social Care | PSSRU
b. Uses the forecast of detentions – see Annex B.I
c. 42% of the 60 MH trusts. Source: Mental Health Act Statistics, Annual Figures: Background Data Quality Report (digital.nhs.uk) - Table 1a
d. 60 NHS MH Trusts submit data on MHA per year and 17 independent MH providers. Source: Mental Health Act Statistics, Annual Figures: Background Data Quality Report (digital.nhs.uk) - Table 1a

[208] It is quite uncertain how the NP changes will be in practice and how much more additional administrative they would require. Due to this uncertainty, agreement on illustrative scenarios was more difficult and they would need to be refined.

e. 92% of total detentions are in MH trusts and 33% of these trusts do no process CTP audits using an automated system. 3% of detentions are from independent mental health providers and 5% from acute trusts and will require manual audits. Therefore (0.92*0.33) + 0.03 + 0.05= 0.38 (or 38% when multiplied by 100) is the proportion of detentions that will require a manual audit of CTP. Source: Mental Health Act Statistics, Annual Figures: Background Data Quality Report (digital.nhs.uk)
f. Internal forecast used in this IA
g. Assumes on average, nominated persons will be changed 1.25 per year, per detainee and it takes 0.25 hrs to update record each time.

B.VIII. Estimating costs and benefits for Advance Choice Documents (ACDs)

Background and proposed policy change

1. The MHA reforms 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:

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

    - 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.

    - 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.

    - 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. As there are generally more nurses in community mental health teams than other professionals, we are assuming that 80% of care coordinator roles would be fulfilled by a nurse and 20% by an AMHP. Similarly, as we assume the peer supporter role can be done by either a Band 5 community-based nurse or AMHP, we again use the split of 80 and 20 percent receptively. We assume administrative staff are band 4 community-based scientific and professional staff. For the cost of a medical consultant, we have used the average salary of an NHS consultant[209] (although this role could be performed by other professional groups with different wages, as outlined in the table below).

    - Upon discharge, all detainees will be offered an ACD, if they do not already have one. Therefore, all detainees who are subject to repeated detention throughout a given year, would have been offered an ACD as they would have been discharged at least once to have been re-detained. Of detainees who have been detained only once during the year, based on the average proportion of detainees discharged in 2019/20 and 2020/21[210], we assume that around 67% of detainees detained only once during the year, would have be discharged and therefore offered an ACD.

    - The estimated number of detentions forecast was gained from the detention model used in the IA.

[209] All staff costings except for medical consultants, IMHAs and AMHPs were sourced from Jones, K. & Burns, A. (2021) Unit Costs of Health and Social Care 2021, Personal Social Services Research Unit, University of Kent, Canterbury. 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.

[210] NHS Digital. Mental Health Act Statistics, Annual Figures. Accessed at: Mental Health Act Statistics

- Evidence[211,212] suggests that the uptake rate of facilitated ACDs would be between 30-50%, therefore the central scenario is a 40% uptake rate of ACDs in each year.
- The average multiple detention rate in England from 2017/18 to 2020/21 was 15.7%[213]. We have assumed this rate also applies between years, i.e., 15.7% 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 (2027/28) where no detainees would have an ACD at the beginning of the year.
- Even though patients already have the ability to make advanced decisions to refuse treatment in relation to ECT, we are assuming that no patients have ACDs prior to the policy start date in 2027/28.

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 and 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 and 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 and 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

[211] 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

[212] 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.

[213] NHS Digital (26 October 2021). Mental Health Act Statistics, Annual Figures 2020/21. Accessed at: Mental Health Act Statistics, Annual Figures 2020/21 - NHS Digital

5. Caveats:

    - 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.

    - The discharge rate of detainees is only based on two years of data (2019/20 and 2020/21 MHSDS) due to not being published in previous years, and may vary in future years, which cannot be adjusted for in the model.

    - 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.

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

    - 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.

6. Estimating monetised benefits – Reduction in compulsory admissions

7. 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).

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

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

    - Evidence from a recent systematic review[214] 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:

        - 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 (15.7% from 2017/18 to 2020/21[215]), i.e., 15.7% 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 (2027/28) where no detainees would possess an ACD at the beginning of the year.

        - 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

[214] 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

[215] NHS Digital (26 October 2021). Mental Health Act Statistics, Annual Figures 2020/21. Accessed at: Mental Health Act Statistics, Annual Figures 2020/21 - NHS Digital

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 2020/21.

9. Caveats:

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

10. Estimating monetised benefits – Costs of healthcare when not in detention

11. 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[216] and deflated to £6,004 at 2022/23 prices) from the costs of avoided detentions.

Sensitivity analysis – 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 (see sensitivity analysis . *See* Risk and assumptions, sensitivity analysis section.

[216] 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)

B.IX. Estimating costs and benefits for changing the detention criteria for people with Learning Disabilities and Autism through use of Guardianships

Background and proposed policy change

1. Guardianships are a community-based, minimally restrictive measure, where most people have the local authority (LA) take the role of their guardian, with some people opting for a private guardian, such as a family member.

2. Currently, you can be detained under the Mental Health Act (MHA) if you have a mental health (MH) condition, or if you have a learning disability, autism spectrum disorder, or both (LDA) and are abnormally aggressive or undertake seriously irresponsible conduct. Under Part II of the MHA a person can be detained for up to 6 months. This detention can then be renewed. People with a learning disability and autistic people have been identified as being more likely to be detained within inpatient settings without treatment which provides therapeutic benefit[217].

3. Under the proposed policy changes, people with a LDA will no longer be detained under the MHA Part II unless they have a mental health condition as a co-morbidity that justifies the application of the Act. The assessment criteria are staying the same for Guardianships, meaning that they can still be applied to people with a LDA, whether or not they also have a mental health condition. Therefore, it is possible that we might see an increase in Guardianships for this cohort, where other community-based alternatives are unavailable. The powers are more limited, because they cannot deprive someone of their liberty and are often appropriate for people who are willing to comply. Guardianship could therefore be a suitable measure for a proportion of the LDA population. To note, whilst it is not our intention to increase Guardianships, we considered this to be a potential alternative scenario for LDA inpatients who no longer meet the MHA detention criteria, for analytical modelling purposes.

4. Guardians have three specific powers: residence, attendance, and access. Guardianship can be used to convey a person to a place of residence and to return a person to that address. Guardians have the exclusive right to decide where a person should live. The guardian can require the person to attend a specific time and place for treatment, work training, or education. For example, to attend a depot clinic to receive medication/treatment, or to attend supported employment/college. The guardian can require that a doctor, an approved mental health professional (AMHP), or another relevant person has access to the person at the place where they live. However, this does not include a power to force entry if this is denied. Not all Guardianships will employ all three powers and the frequency of which they are applied depends on the person's treatment plan. Note that Guardianship is still a compulsory power, but it does not involve compulsory treatment or meet the criteria for deprivation of liberty.

5. In summary:

    - In the "do nothing" scenario, we assume that people with a LDA can be detained under the MHA Part II if they have a MH condition, or if they have a LDA and are abnormally aggressive or undertake seriously irresponsible conduct.

    - In the policy scenario, we assume people with a LDA will no longer be detained under the MHA Part II unless they have a mental health condition as a comorbidity that justifies the application of the act.

[217] DHSC. Consultation Outcome Reforming the Mental Health Act. (2021). Accessible here.

Methodology

Identifying inpatients with a learning disability and/or autism who could be eligible for Guardianships

6. There are two key datasets that report figures on LDA inpatients – the Mental Health Services Data Set (MHSDS) and the Assuring Transformation (AT) dataset [218,219]. There are known data quality issues in the way LDA patients are recorded by providers in MHSDS and identified by NHS Digital for reporting due to low compliance on the use of clinical coding. Consequently, the numbers of these patients are potentially misreported and, therefore, the AT dataset was used for all data on LDA inpatient numbers.

Step 1: Identifying the number of LDA inpatients who could be eligible for Guardianships in the "do something" scenario.

7. Firstly, we determined the number of LDA inpatients who do not have a mental health condition as a comorbidity but are currently detained under the MHA Part II. The number of LDA inpatients who also have a co-occurring mental health condition is not explicitly reported. We conducted a search of academic literature to determine the prevalence of mental health conditions amongst people with a learning disability, autistic people, and people with a learning disability and autism. It should be noted that there is a potential selection bias. People in inpatient settings may be more likely to have a co-occurring MH condition than the general LDA population for example. This was an area of uncertainty in the analysis, but due to evidence limitations, it was challenging to specifically account for this. Our approach to handling uncertainty across this piece of analysis is explained further in this annex, for example, by presenting costs and benefits across a wide take-up range (of 10%-100% Guardianship take-up).

8. Whilst the AT dataset does report whether a person had a mental illness diagnosis on admission, the question is in its current format was only made mandatory in June 2021 and there remains a significant number of inpatients for whom this data is not recorded. Additionally, it was possible to provide more than one diagnosis on admission, so using this data would result in double counting. However, this data was used to check the order of magnitude of mental health prevalence.

9. When conducting the search of academic literature, we found that the prevalence of mental health conditions varied by age and condition. Cooper et.al report that 37.0% of people with a learning disability only have a diagnosed mental health condition [220]. One of the leading charities for people with a learning disability, Mencap, cites this paper when reporting on the estimated prevalence of mental health disorders [221]. Lever and Geurts found that 79.0% of adults with autism spectrum disorder have a mental health condition [222]. For children with autism, Simonoff et. al found a mental health prevalence of 70.8% [223]. Both of these sources are quoted in multiple papers from the All-Party Parliamentary Group on Autism, and leading autism and mental health charities in the UK, including the National Autistic Society, Autistica, and Mind [224,225,226]. There is a lack of literature around mental health conditions amongst people with both a learning disability and autism. Therefore, the higher prevalence rate for children (70.8%) and adults (79.0%) with autism was assumed for people with both

[218] NHSD. Mental Health Services Monthly Statistics, LDA01. (2021) Accessible here.

[219] NHSD. Learning Disability Service Statistics, Assuring Transformation. (2021). Accessible here.

[220] Cooper SA, Smiley E, Morrison J, Williamson A, Allan L. Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. T*he British journal of psychiatry*. 190, 27-35 (2007).

[221] Mencap. Mental health. (No date). Accessible here. Note that the other papers referenced were excluded due to the learning disability populations they covered being limited.

[222] Lever, A.G., Geurts, H.M. Psychiatric Co-occurring Symptoms and Disorders in Young, Middle-Aged, and Older Adults with Autism Spectrum Disorder. *Journal of Autism Developmental Disorders.* 46, 1916–1930 (2016).

[223] Simonoff, Emily & Pickles, Andrew & Charman, Tony & Chandler, Susie & Loucas, Tom & Baird, Gillian. Psychiatric Disorders in Children with Autism Spectrum Disorders: Prevalence, Comorbidity, and Associated Factors in a Population-Derived Sample. *Journal of the American Academy of Child and Adolescent Psychiatry*. 47, 921-9 (2008).

[224] All Party Parliamentary Group on Autism, Autism Act, 10 Years On. (2019).

[225] Harper, G et al. Autistica Action Briefing: Adult Mental Health. (2019).

[226] National Autistic Society. Good practice guide. (2021).

a learning disability and autism. We think this is reasonable due to the likely reasons of higher rates of mental health conditions among autistic people, particularly lower life satisfaction, greater social difficulties, loneliness, and insomnia, which we believe reasonable to assume for an individual with both a learning disability and autism spectrum disorder[227]. The assumed mental health prevalence rates are summarised in Table B.IX1.

Table B.IX1: Summary of the prevalence of mental health conditions amongst people with a learning disability, autistic people, and people with a learning disability and autism, by age.

Learning disability or autism category	MH Prevalence
Learning disability only (all ages)	37.0%
Autism only (under 18)	70.8%
Autism only (over 18)	79.0%
Learning disability and autism (under 18)	70.8%
Learning disability and autism (over 18)	79.0%

10. We extracted the number of inpatients subject to the MHA Part II from the AT dataset for all age groups. The AT dataset does not report the number of people subject to the MHA by the learning disability or autism category. To calculate this, we:

    1. Multiplied the number of inpatients subject to the MHA Part II by the percentage of people who have a learning disability only, autism only, or both a learning disability and autism.
    2. Determined the number of those with a learning disability only, autism only, or both a learning disability and autism, who have a co-occurring mental health condition, by multiplying the number subject to the MHA Part II, by the relevant prevalence rates, as outlined in Table B.IX1.
    3. Calculated the number of inpatients eligible for Guardianships by subtracting the number of people with a LDA with a mental health condition as a comorbidity from the number of inpatients subject to the MHA.
    4. Repeated the above for all age groups and summed to give a total number of people eligible for Guardianship.

11. We checked this method by commissioning NHS England and Improvement (NHSE/I) to provide a disaggregation of the number of patients subject to the MHA Part II by the learning disability or autism category. Steps 2 to 4 outlined above were repeated with this data. The difference in results was negligible and, as the NHSE/I data would not be published frequently, we decided it was appropriate to use the published AT dataset. However, any future revisions and evaluation should reconsider this check through engagement with NHSE/I.

Guardianship uptake:

12. It is not possible to predict the exact uptake of Guardianships. Therefore, we used a range of uptake from 10% to 100%. We considered a high end of 100% uptake to be reasonable as there are no other legal frameworks this population would be subject to if they did not enter Guardianships.

Assumptions on age profile:

13. People are eligible for Guardianships from aged sixteen. However, the disaggregation by age of those subject to the MHA Part II in the AT dataset reports all under 18s as one age group. As there is no minimum age at which someone can be subject to the Act, we assumed an even distribution from 0 to 17[228]. The total number of under 18s eligible for Guardianship, which we calculated using the method

[227] Stark et al. Psychological therapy for autistic adults. Authentistic Research Collective. (2021).

[228] NHS South West Yorkshire Partnership. Mental Health Act 1983. (2018). Accessible here.

described in points 1 to 4 above, was multiplied by 2/17 to give only those sixteen and over.

14. We tested this assumption by excluding all under 5s and then all under 10s from the calculation of the number of under 18s eligible for Guardianship. When comparing these results to the even distribution, we found that the difference was negligible and, therefore, used an even distribution of age in further calculations.

Step 2: Identifying how the number of LDA inpatients has changed over time.

15. We calculated the annual rate of change of the number of LDA inpatients from 2015 to 2021 to forecast the number of inpatients for the years 2021/22 to 2043/44. We assumed that this was a linear function and fitted a trend line to the data, as shown in Figure 1. We found that the number of LDA inpatients fell by around 4.3% each year, since 2015. We assumed that the percentage of people eligible for Guardianships changes at the same rate throughout the appraisal period. To note, we conducted sensitivity tests on this rate of reduction, and found that reducing this rate does not have a substantial impact on the final figures. We will revisit this assumption for the Final Stage Impact Assessment.

16. We estimated the number of additional Guardianships by multiplying the maximum number of people eligible for Guardianships by the rate of change. As mentioned, whilst it is not our intention to increase Guardianships, we considered this to be a potential alternative scenario for LDA inpatients who no longer meet the MHA detention criteria, for analytical modelling purposes. Estimating the change in inpatients over time, and uptake of Guardianships is highly uncertain. Hence, our analysis looked at a range of 10% to 100% uptake in Guardianships, by an estimate of the LDA inpatients no longer meeting the MHA detention criteria, over the full appraisal period. This was the “do something” scenario that we modelled. It should be noted that the 10%-100% range, and estimates of number of LDA inpatients (and those who may no longer meet the criteria for MHA detention) are highly uncertain and hypothetical, and these assumptions have been made purely for modelling purposes.

17. The AT data set presents data for people with a learning disability, autistic people, and people with a learning disability and autistic spectrum disorder., However, it does not show data by these three patient categories throughout the publication. Although the AT dataset suggests the percentage of LDA inpatients that have autism spectrum disorder has increased over time, due to data limitations, we have not been able to disaggregate the number of LDA inpatients into the learning disability or autism spectrum condition categories in the annual rate of change calculations. This is a potential limitation of our analysis, given that:

    - The literature noted above suggests the prevalence of mental health conditions amongst autistic people is higher than for those with a learning disability only; and
    - For analytical modelling purposes, we make a simplifying assumption that autistic people with a co-occurring mental health condition would still meet the MHA detention criteria.

18. Then, if the proportion of inpatients with autistic spectrum disorder continues to increase, by assuming that the percentage of people eligible for Guardianships changes at the same rate as the total number of LDA inpatients, we may be overestimating the number of LDA inpatients moving to Guardianships and the corresponding costs and cost savings. However, given there is such high overall uncertainty in the uptake of Guardianships, we deemed the range of 10% to 100% as reasonable to account for this. Any future revisions and evaluation should reconsider using the rate of change of LDA inpatients by

the learning disability or autism category, instead of the total number of LDA inpatients.

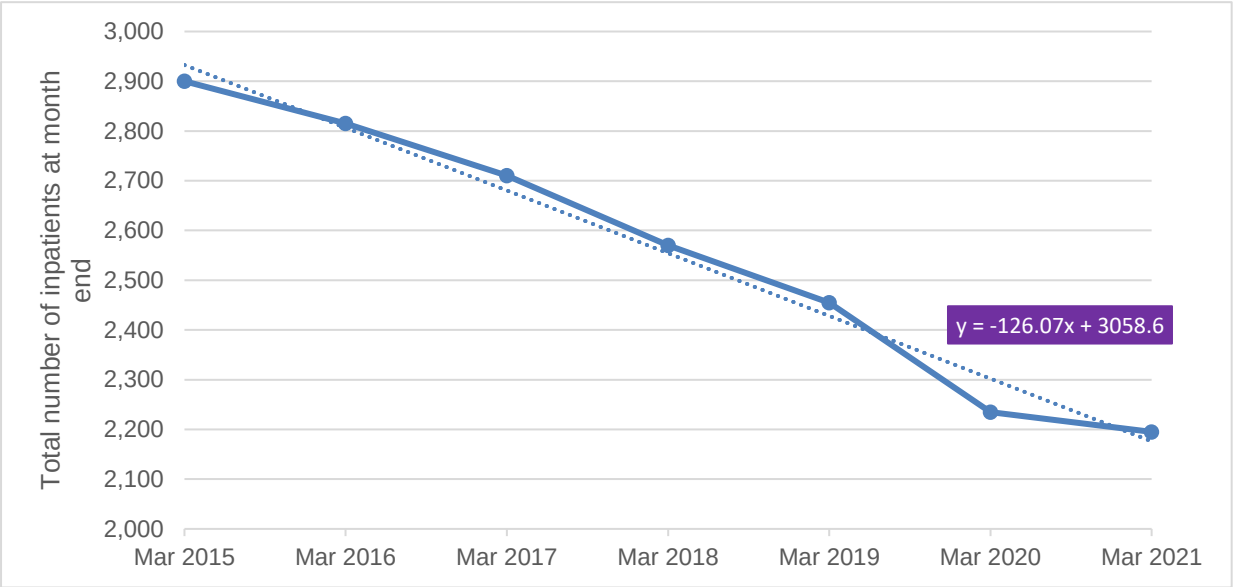

Figure 1: The total number of LDA inpatients from 2015 to 2021 and the trend line used to calculate the annual rate of change of inpatient numbers over that period. The former is shown by the solid line and the latter by the dotted. Since 2015, the number of LDA inpatients has fallen by around 4.3% each year.

Step 3: Identifying how the number of Guardianships has changed over time.

19. We calculated the annual rate of change in the number of Guardianships from 2003/04 to 2020/21 using the Guardianships under the Mental Health Act 1983 national statistics [229]. We assumed that this was a linear function and fitted a trend line to the data, as shown in Figure 2. This was used as a counterfactual, i.e. how many people would use Guardianships if no changes were made to the MHA. We assumed that the number of Guardianships would continue to change at the same rate across the appraisal period.

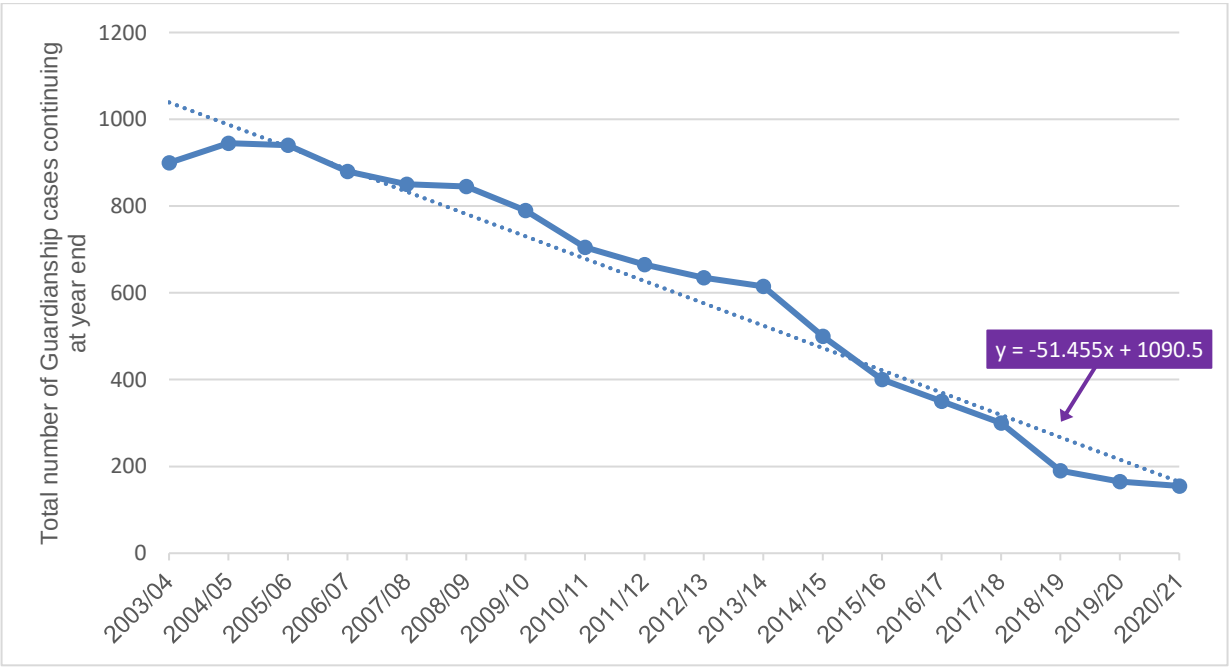

Figure 2: The total number of Guardianship cases continuing at the end of each year from 2003/04 to 2020/21 and the trend line used to calculate the annual rate of change of Guardianship numbers over that period. The

[229] NHSD. Guardianship under the Mental Health Act 1983, England – 2018-19, 2019-20 & 2020-21. (2021). Accessible here.

former is shown by the solid line and the latter by the dotted. Since 2003/04, the number of Guardianships has fallen by around 51 cases each year.

20. The AT dataset provides a "snap-shot" of LDA inpatient services at the end of that month and the Guardianships statistics dataset shows the number of active Guardianships at the end of the reporting period. Figures here are not cumulative, therefore.

Total Costs

Step 1: Estimating workforce costs for Guardianships.

21. The main costs associated with Guardianships are workforce costs, as Local Authorities will need to pay nurses, responsible clinicians, etc. to provide this service. Given the data limitations on this, we estimated the costs based on the workforce hours required per Guardianship each year.

22. There is no published data on the number of workforce hours required for Guardianships. Therefore, discussions with, and written responses from, the Mental Health Social Work Lead for the Department of Health and Social Care (DHSC), a Local Government Association (LGA) representative, and a Senior Policy and Practice Officer from the Association of Directors of Adult Social Services (ADASS) helped us to understand workforce roles and their associated time involved in Guardianships.

23. Throughout, we used the higher estimate of time required for each staff group. This affects AMHPs' one-off cost (3-5 days), Responsible Clinicians' one-off cost (3-5 hours), and Care Plan costs (2-3hours per week), per Guardianship. Given the high overall uncertainty in the uptake and cost of Guardianships, we deemed the range of 10% to 100% as reasonable to account for this uncertainty. We ran a sensitivity test and found that, if we did change the analysis from the high estimate (5 days/5 hours/3 hours) to the central estimate (4 days/4 hours/2.5 hours), the total cost over 5 years would drop by between c£198k and c£1.9m and over 10 years would drop by between c£371k and c£3.7m. To note, the ranges here reflect uncertainty around Guardianship take up, from 10%-100%, and all figures are in 22/23 prices, undiscounted. The number of workforce hours assumed in the analysis, for Guardianships are summarised in Table B.IX2.

24. We determined that the assessment of a person being considered for a Guardianship requires 5 days of an Approved Mental Health Professional's (AHMP) time and an additional 5 hours each for two responsible clinicians to review the patient's file and write letters of recommendation. A responsible clinician must be Section 12 approved, so for cost estimation purposes we assumed that they were a consultant psychiatrist[230]. This is consistent with other models used in the Impact Assessment. An assessment is a one-time cost for each Guardianship.

25. According to Section 28.89 of the Reference Guide to the Mental Health Act, responsible local authorities must arrange for patients subject to Guardianship to be visited on their behalf at intervals of no more than three months[231]. The frequency and which professionals visit a patient depends on the individual's care plan. Through conversations with the LGA and ADASS it was determined that visits of 0.75 hours per week each from social workers, nurses, occupational therapists (OTs), and independent mental health advocates (IMHAs) averages out to the hours required by the Reference Guide for a care plan per quarter.

26. A person placed under Guardianship must have their placement reviewed after 6 months and then once every 12 months. This is called the review and renew process. Our discussions with the LGA and ADASS suggested that review and renew requires approximately 1.5 days for an AMHP to make the recommendation to continue or terminate the Guardianship, and 1 day for a responsible clinician to

[230] The British Psychological Society. Approved Clinician frequently asked questions. (2017). Accessible here.

[231] DHSC. Mental Health Act 1983: reference guide. (2015). Accessible here.

review all relevant documentation.

27. A patient has the right to appeal their Guardianship placement. This would require around 2 days of a LA officers' time to set up and hold a tribunal. However, it was found that there are a minimal number of appeals, with the Mental Health Social Work Lead, LGA, and ADASS representative all stating they had only encountered 1 or 2 appeals in their careers. Therefore, we assumed that the yearly cost of appeals would be negligible, and these costs were omitted from the model.

28. Responsible clinicians, social workers, nurses, and OTs, all salary and working hours information was obtained from the Personal Social Services Research Unit (PSSRU)[232]. For IMHAs, we compared advertised salaries in multiple job posts and applied the overheads and capital proportions for social workers outlined by the PSSRU to calculate their salary and working hours. For AMHPs, we extracted the base salary from Skills for Care[233]. As approximately 95% of AMHPs are social workers[19], we applied the overheads and capital proportions for social workers outlined by the PSSRU to calculate an AMHPs' annual salary and working hours. We also assumed that nurses and occupational therapists involved in Guardianships are community-based staff.

29. The cost per Guardianship for assessments, care plans, and review and renew were calculated by multiplying hourly pay by the number of hours required and the number of full-time-equivalent (FTE) staff required. These figures were converted to real prices using the GDP deflators for the base year 2022/23.

Table B.IX2: Summary of workforce hours, FTE staff, and the frequency at which they are required for each Guardianship case.

Workforce	FTE required	Time required		Frequency of cost
Assessment				
AMHP	1	5	days	One-time cost
Responsible Clinician	2	5	hours	
Care Plan				
Social worker	1	0.75	hours per week	Annual
Nurses	1	0.75	hours per week	
Occupational Therapist (OT)	1	0.75	hours per week	
Independent Mental Health Advocate (IMHA)	1	0.75	hours per week	
Review and Renew				
AMHP	1	1.5	days	6 months in first year of Guardianship, and then every 12 months
Responsible Clinician	1	1	day	
Appeal				
LA officers	1	4	days	One-time cost

Step 2: Estimating the total annual Guardianships costs.

30. We calculated the annual costs for the additional Guardianships generated due to the policy change for each staff group. As we are assuming Royal Assent of the Bill[234] in 2023/24, that is when the bill becomes law, and that this policy will start from mid-2024/25, we halved all costs in year 1 to account for this. In year 1 (2024/25), we assumed that all forecasted Guardianships were new. For subsequent appraisal years, we assumed that 50% of the forecasted number of Guardianships each year were new and that 50% were a continuity of care from the previous year. We verified this assumption using

[232] Jones, K. & Burns, A. Unit Costs of Health and Social Care 2021, Personal Social Services Research Unit, University of Kent, Canterbury. (2021). Accessible here.
[233] DHSC. The Approved Mental Health Professional Workforce in the adult social care sector. (2021). Accessible here.
[234] UK Parliament. Royal Assent - UK Parliament.

the AT dataset by calculating the average number of admissions and discharges as a percentage of the average total number of LDA inpatients. We applied these assumptions to the annual Guardianships cost calculations. The timings of the cost assumptions are outlined in Table B.IX3.

31. The cost of each workforce was summed to give the total costs of additional Guardianships for each appraisal year. This was repeated for a range of 10% to 100% uptake in Guardianships. All prices were in 2022/23 base year and undiscounted.

Table B.IX3: Outline of the timings of the cost assumptions used to calculate the annual Guardianship costs

Workforce	Year 1 (2024/25)	Year 2 (2025/26) onwards	Notes
AMHP	Mental health assessment costs for 100% of additional Guardianships and review and renew costs for 100% of additional Guardianships. Costs halved due to legislative powers starting mid-2024/25.	Mental health assessment costs for 50% of additional Guardianships and review and renew costs for 100% of additional Guardianships	For review and renew, 100% accounts for 50% of people receiving a review at 6 months into their Guardianship and 50% of people having their annual review as part of their continuity of care.
Responsible Clinician			
Social Worker	Annual care plan costs for 100% of additional Guardianships. Costs halved due to legislative powers starting mid-2024/25.	Annual care plan costs for 100% of additional Guardianships.	100% of Guardianships have a care plan regardless of whether they are new or a continuity of care from the previous year.
Nurse			
OT			
IMHA			

Total Cost Savings

32. The policy change being proposed will also generate some cost savings, as fewer LDA inpatients means lower costs in inpatient settings. In year 1 (2024/25), we assumed that the reduction in LDA inpatient beds due to the policy change was 100% of the number of additional Guardianships and, for the subsequent appraisal years, this was 50% of the number of additional Guardianships.

33. The NHS Benchmarking Network Mental Health Dashboard reports the mean cost of LDA inpatient care per 10 beds. We used the GDP deflators for to convert this figure to real 2022/23 prices and divided by 10 to get the cost per bed. We multiplied this by the reduction in LDA inpatient beds expected. This gave the total cost for that number of LDA inpatient beds as the total cost savings for the policy change. To account for the policy change starting in mid-2024/25, we halved all costs in year 1. This was repeated for a range of 10% to 100% uptake in Guardianships. All prices were in 2022/23 base year and discounted by 3.5%.

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 (2030/31) when legislative changes are assumed to be in place until the end of the time horizon (2043/44).

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, although detention numbers do have an effect on receipts. Consequently, it is apparent that the relationship between total annual detentions and MHT workload is not a simple linear relationship in the real world. The proposed policies of automatic referrals would see increased referrals to the MHT.

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.

4. 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.

Average costs

5. 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.

6. The average cost used for a MHT sitting day was put at £2,262 in 2019/20 prices, it is based on staff costs (£205), judicial salaries (£1,910), estates (£21), other costs (£127). The average cost is assumed to remain constant in real terms - i.e., change in line with the annual UK GDP deflator throughout the appraisal period. The monetised proposals have been broken down by their impact on the MHT and associated legal aid costs.

7. 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.

8. 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

9. This input variable underpins the cost estimates of all of the automatic referral proposals as well as the proposal concerning reviewing a patients CTP. 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.

10. 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.

11. Hearings taking longer than expected, late cancellations and adjournments are just some of the reasons why the hearings per sitting day ratio used in the IA is estimated at 1.36.

Cancellation fees

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

13. Daily sitting fees for non-restricted judges, medical members and specialist lay members in 2019 were provided by the MARTHA data system[235]. 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.

14. Due to recent fluctuations in claims, an average of 5 years of recent data (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 using average of 5 years before 2019/20

Section 3 Claims	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37
Judge	216	216	216	216	216	216	216
Medical Member	295	295	295	295	295	295	295
Specialist Member	238	238	238	238	238	238	238

Section 3 Claims	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44
Judge	216	216	216	216	216	216	216
Medical Member	295	295	295	295	295	295	295
Specialist Member	238	238	238	238	238	238	238

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

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 system's impacts of the IA and the largest aspect of our costs.

2. Since civil patients can be discharged at any point by the Responsible Clinician (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[28].

3. The Government's proposal is to accept recommendations on automatic referral policies to reduce the initial maximum detention criteria and ensure there is an automatic referral to the tribunal at specified time periods (3 months after the detention started then at 12 months and annually after that). This is expected to shorten the application and referral periods for people detained under Section 3 of the MHA. The proposals to allow patients to apply to the MHT in the first 3 months of their detention and to implement a first automatic referral point at 3 months rather than 6 months would 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 3 months of their MHA detention.

4. Given the data limitations around determining what proportion of patients currently go to the MHT in the first 3 months, an alternative methodology was devised. The proposal meaning patients are able to apply 3 times in their first year of detention as opposed to twice 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)[165], an increase in the volume of actual Section 3 applications annually was estimated.

5. It was assumed that the move from 6 to 3-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 these two of the Government proposals relating to automatic referrals.

Table D1. Estimated monetised additional costs including legal aid (£millions, 2022/23 prices, undiscounted)

2022/23 £m	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2036/37**
Total BAU Costs	20.9	20.7	20.6	20.4	20.2	20.0	19.9
Total Policy Costs	29.4	29.1	28.9	28.6	28.4	28.1	27.9
Total Difference	8.5	8.4	8.3	8.3	8.2	8.1	8.0

2037/38	**2038/39**	**2039/40**	**2040/41**	**2041/42**	**2042/43**	**2043/44**	**Total**
19.7	19.5	19.4	19.2	19.1	18.9	18.8	277.3
27.7	27.4	27.2	27.0	26.8	26.6	26.4	389.6
8.0	7.9	7.8	7.8	7.7	7.7	7.6	112.3

6. The Government has accepted a recommendation 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 this recommendation.

Table *D2. Estimated monetised additional costs (£millions, 2022/23 prices, undiscounted and rounded to the nearest £1m)*

2022/23 £m	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2036/37**
BAU Costs	2	2	2	2	2	2	2
Policy Costs	11	11	11	10	10	10	10
Additional	8	8	8	8	8	8	8

2037/38	**2038/39**	**2039/40**	**2040/41**	**2041/42**	**2042/43**	**2043/44**	**Total**
2	2	2	2	2	2	2	**32**
10	10	10	10	10	10	10	**142**
8	8	8	8	8	8	8	**110**

7. The Government proposes to introduce a completely new right for 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. 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.

9. 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. However, it gives an indication of the volume of current conditional discharge patients that could be suitable for immediate absolute discharge.

10. 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.

11. The current success rate of applications to the MHT under Section 75(2) is around a quarter[166]. 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 absolute discharge is 6 years 8 months[167]. 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.

Table D3. Estimated monetised additional costs (£millions, 2022/23 prices, undiscounted and rounded to the nearest £1m)

2022/23 £m	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2036/37**
Policy Costs	5	0	2	1	5	1	3

2037/38	**2038/39**	**2039/40**	**2040/41**	**2041/42**	**2042/43**	**2043/44**	**Total**
2	2	2	2	2	2	2	33

12. The Government has accepted proposals 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.

13. 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.

14. The cross-cutting assumption used for this analysis was a central scenario of a 40% reduction in CTO's over our appraisal period. This policy is expected to start for DHSC in 2028/29, starting with a gradual decline before reaching the estimated 40% reduction in 2032/33. As MoJ's appraisal starts in 2030/31 it appears as though there is a sharp decline in CTO's from the start of our appraisal when it is more gradual.

15. 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 avoided cost (£millions, 2022/23 prices, undiscounted)

2022/23 £m	**2030/31**	**2031/32**	**2032/33**	**2033/34**	**2034/35**	**2035/36**	**2036/37**
BAU Costs	11.1	11.0	10.9	10.9	10.8	10.7	10.7
Policy Costs	6.6	5.2	4.5	4.5	4.5	4.4	4.4
Difference	4.5	5.9	6.4	6.4	6.4	6.3	6.3

2037/38	**2038/39**	**2039/40**	**2040/41**	**2041/42**	**2042/43**	**2043/44**	**Total**
10.6	10.6	10.5	10.4	10.4	10.3	10.3	149.2
4.4	4.3	4.3	4.3	4.3	4.2	4.2	64.1
6.2	6.2	6.2	6.1	6.1	6.1	6.0	85.2

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

Background

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.

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

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

   - 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.
   - 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.
   - 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.

3. The social value of a QALY is now estimated by DHSC at £70,000 (2021/22 prices). This is based on inflating previous estimates of the social value of a QALY (£60k estimate in 2014 prices) and appropriately rounding to avoid spurious accuracy.

4. 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. 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 £70,000, based on analysis by the Department for Transport of individuals' willingness to pay to avoid mortality risks. 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 £70,000, according to these estimates.

   <u>Example of an Impact Assessment calculation</u>

5. 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.

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

   i. 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 £70 million.

ii. 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 £84 million.

iii. The net benefit of the project is therefore 200 QALYs, or, expressed in monetary terms £14 million.

7. 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. 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 £70,000 / QALY).

Annex F. Breakeven Analysis – Method

Background

1. The breakeven analysis described below seeks to estimate the non-monetised benefits required to offset the net cost of the policy from the proposed MHA reforms. We use three ways to illustrate breakeven: i) reduction in the length of stay for detainees; ii) reducing readmissions; iii) improved quality of life.

Reduction in length of stay

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

3. We first estimate the base clinical cost of a period spent in detention (by multiplying the estimated number of detentions by the median length of stay and by the national average unit cost per bed day using NHS Reference costs[236]), and add on the further costs associated with detentions assessed in this IA in both our BAU and policy scenarios.

4. To get an indication of the average cost per detention to the Health and Social Care system and Justice system with and without the introduction of additional safeguards by the proposed reforms, these totals are divided by the number of detentions (see annex B.I).

5. The current average length of a detention is estimated to be around 54 days (for the average of Sections 2 and 3 detentions)[237]. The proposals may help to deinstitutionalise patients who previously were subjected to long-term detentions but would now have better access to appeals and more effective care treatment plans, potentially bringing a higher chance of earlier discharge. Focusing on the clinical costs associated with a period in detention discussed above (which constitute the majority of costs), these would have to reduce by 1% across the appraisal period in order to offset the net costs of the reforms, ignoring associated benefits to patients which have not been monetised. Assuming such costs are proportional to lengths of stay, we estimate that this would be equivalent to a 0.56 days reduction in all detainees' lengths of stay.

Reduction in readmissions

6. Another potential benefit required to offset the policy costs is 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 more suitable treatment and improved treatment adherence and, in turn, a reduction in the number of people with repeated detentions.

7. On average from 2017/18 to 2020/21, around 15.7% of people are detained twice or more in a year – around 7,000 people in 2020/21[238]. Dividing the annual additional net cost of the policy by the estimated cost of a detention in each year under the policy scenario suggests, on average, the required reduction in the number of detentions to make the policy cost effective. This is around 610 per year on average during the appraisal period.

8. We assume that in the absence of policy intervention, the proportion of detainees with repeated detentions would remain constant at 15.7% for the 20 year period. Following policy implementation, we estimate that this would need to fall to 14.8% throughout the period, for the net costs of the policy to be completely offset by the savings gained from a reduction in the number of repeat detentions.

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[236] NHS England and NHS Improvement (June 2021). 2019/20 National Cost Collection data – National schedule of NHS costs (tab PLMHPS – PLICS Mental Health Provider Spells). Accessed at: NHS England » National Cost Collection for the NHS

[237] NHS Digital (26 October 2021). Mental Health Act Statistics, Annual Figures 2020/21. Accessed at: Mental Health Act Statistics, Annual Figures 2020-21 - NHS Digital

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Example of reducing multiple detentions using 2031/32

9. To illustrate the method, we use a worked example for 2031/32. We estimate that the reduction in repeated detentions required to offset policy costs would be around 840 in that year.

10. BAU. In 2031/32, our forecast under BAU is around 68,000 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 71%, 22%, 7%, respectively), we assume that there are around 48,500 detentions for those detained once, 7,500 detentions for those detained twice and 1,500 detentions for those detained 3 times or more. So therefore in total 48,500 x 1, 7,500 x 2, 1,500 x 3 =68,000 detentions in total.

11. To estimate number of people detained, as illustrated above, we divided these numbers of detentions by 1, 2 or 3 detentions respectively and obtained around 48,500 people detained once, 7,500 people detained twice, and 1,500 people detained three times or more; around 57,500 people detained in total. That is, around 15.7% of people are detained twice or more times (7,500+1,500 divided by 57,500 detainees).

12. Option 2. Policy scenario. In 2031/32, and considering a decrease by around 840 repeated detentions needed to offset net policy costs, we would have around 67,200 detentions (68,000 under BAU minus 840). 77% of repeated detentions are two times, and 23% are three or more, so 650x2 times and 190x3 or more:

13. We can assume the number of detainees would be the same, but the decrease of 840 detentions needed would come from a change downwards in the numbers of repeated detentions. This would give around 49,000 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 48,500 detentions for those detained once plus 650 that previously would be detained twice.

    - Around 14,000 detentions for those detained twice – the number of detentions pertaining to those assumed to be detained twice (15,000) minus the assumed decrease of 650 detentions (those detained twice under BAU and now detained once) multiplied by 2 detentions, plus the 190 people (detained three times or more under BAU and are now detained twice) multiplied by 2 detentions. That is, 15,000 minus 640*2 detentions plus 190*2 detentions.

    - Around 3,900 detentions for those detained three times or more – the number of detentions pertaining to those already assumed to be detained three times or over (4,500), minus the assumed decrease of 190 people detained 3 times or more under BAU and now detained twice, multiplied by 3 detentions. That is, 4,500 minus 190*3 detentions.

14. 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 49,000 people detained once, 7,000 people detained twice, and 1,300 people detained three times or more (around 57,500 detainees in total). That is, an estimated 14.5% of people are detained twice or more times (7,000+1,300 divided by 57,500) in 2031/32 (compared to 15.7% estimate under BAU).

Increase in health benefits

15. 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.

16. 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 £70,000.

17. To estimate the health benefits following from the policy intervention completely offsetting the costs of the policy in each year, we divided the additional overall cost of the policy in each year by £70,000 to work out the number of QALYs this would be equivalent to. Then this was divided by the estimated number of people detained (including some who may have repeated detentions) in each year to work out the health gains that would need to be gained per detention.

Example of increase in health benefits using 2031/32

18. To illustrate the method, we use a worked example for 2031/32:

    - the overall annual additional net cost of the policy in that year is estimated at £29 million (undiscounted), which divided by the social value of a QALY at £70,000, gives an estimated number of 415 QALYs in 2031/32;

    - dividing this number of QALYs by the estimated number of people detained under BAU (around 57,500 detainees in total, as explained in the section above) produces an estimate of a health gain per patient at around 0.007 QALYs in 2031/32, which equates to 2.6 days in full health for this example year compared to very poor health comparable in QALY terms to death.

19. In summary, over the 20 year appraisal period, it is estimated that each person detained would need to experience an additional health improvement (reduction in health loss) equal to 0.006 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 2 days in the year following treatment (0.006*365 days = 2.0 days), compared to very poor health comparable in QALY terms to death. However, we should assume that these people would be in moderate health rather than in perfect health, so this estimated 2 days in perfect health would be equivalent to someone experiencing perfect health (i.e. health-related quality of life (HRQoL) of 1) rather than moderate health (i.e. HRQoL of 0.5) for 4.1 days[239].

[239] There are various scales available to quantify HRQoL e.g. EQ-5D (euroqol.org), Mental Health Quality of Life Questionnaire - iMTA.

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[240];

    - 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[241];

    - 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[242];

    - Clinical staff typically consist of a responsible clinician, a care co-ordinator, occupational therapists 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.

    - Administrative staff

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 2021 Lang & Buisson Healthcare Market Review[243] 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. 68-69).

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[244] (see table G1 below).

[240] 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

[241] 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

[242] 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

[243] Laing & Buisson (2021). UK Healthcare Market Review, 33rd Ed. London (p.71)

[244] Source: Laing & Buisson (2021). UK Healthcare Market Review, 33rd Ed. London (p.71)

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

Book edition	25th	26th	27th	28th	29th	30th	31st	32nd	33rd
Year of data collection	2011	2013	2014	2015	2016	2017	2018	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	67.5
Public funding/independent sector supply (%)	25.6	26.5	29	25.2	27.9	26.6	28.8	29.6	29.6
Private funding/public sector supply (%)	0	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	2.9

Note: 33rd 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. 71)

Source: Laing & Buisson (2021). UK Healthcare Market Review, 33rd Ed. 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).
    - and for administrative staff supporting the additional safeguards.
6. 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.
7. For the EANDCB calculation, the NPV is expressed in 2019 prices and discounted back to 2020, irrespective of the pricing and present value base years in the rest of this IA. This is to allow comparability across all IAs across government. We used the March 2022 Impact assessment calculator published by the Department for Business, Energy & Industrial Strategy[245].

[245] Impact assessment calculator - GOV.UK (www.gov.uk)

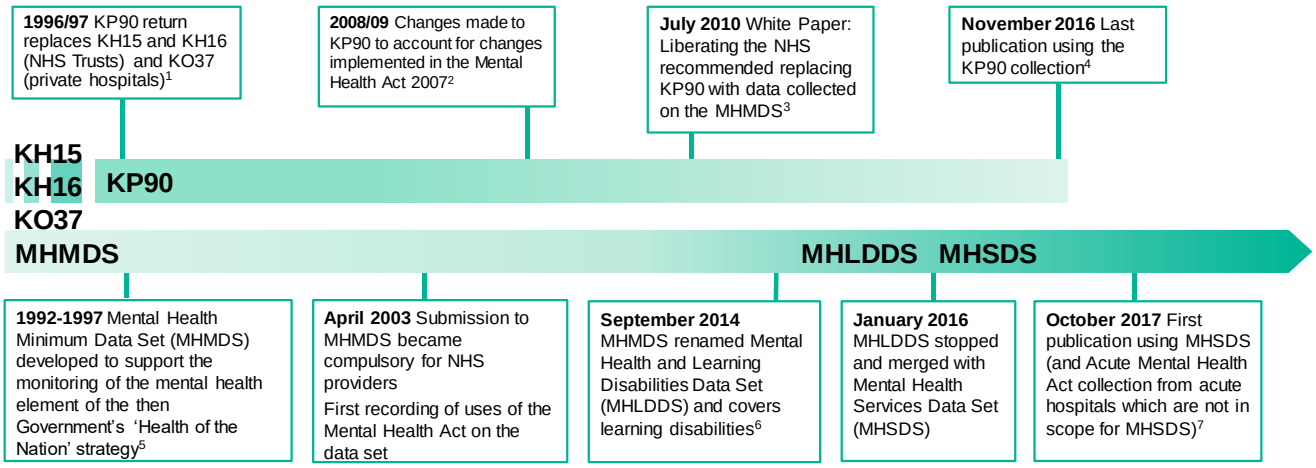
Annex H. Changes in data on the uses of the Mental Health Act

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



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2 NHS Digital (14 October 2009). Inpatients Formally Detained in Hospitals Under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment - 1998-1999 to 2008-2009. 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-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment-1998-1999-to-2008-2009

3 NHS Digital (2012) Fundamental Review of Returns and the KP90 collection. Accessed at: https://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/media/12646/Fundamental-Review-of-Returns/pdf/KP90_Fundamental_Review_of_Returns_2012_HSCIC.pdf/

4 NHS Digital (30 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

5 NHS Digital (29 October 2008). Mental Health Bulletin, First report on experimental statistics from Mental Health Minimum Data Set (MHMDS) annual returns, 2003-2007. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/mental-health-bulletin-first-report-on-experimental-statistics-from-mental-health-minimum-data-set-mhmds-annual-returns-2003-2007

6 NHS Digital. Mental Health and Learning Disabilities Statistics Data. Accessed at: https://data.gov.uk/dataset/9989e4ee-3cae-4747-9b72-b948d1df9f62/mental-health-and-learning-disabilities-statistics-data

7 NHS Digital (10 October 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

Other annual publications accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures