

Title: Revised Code of Practice: Mental Health Act 1983 IA No: 7086 Lead department or agency: Department of Health Other departments or agencies: Ministry of Justice Home Office	Impact Assessment (IA)	
	Date: 27/06/2014	
	Stage: Consultation	
	Source of intervention: Domestic	
	Type of measure: Other	
Contact for enquiries: Razwan Hussain (Policy) Panos Zerdevas (Economist) mentalhealthcode@dh.gsi.gov.uk		
Summary: Intervention and Options		RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Two-Out? Measure qualifies as
£113.5m	0	0	No In/Out/zero net cost

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

A number of reviews and reports have highlighted significant concerns with the quality of care under the Mental Health Act (MHA) and the lower health outcomes for these patients. CQC's annual report consistently highlighted that a number of safeguards were not being applied or not properly applied. Evidence from Winterbourne View Hospital most clearly illustrated the potential consequences where this was the case. Since 2008, when the current Code was published, there have been changes to primary legislation, case law, professional practice and policy which need to be reflected. Stakeholders advise that in some areas the Code is confusing, contradictory or does not give useful guidance to support their professional practice and the delivery of consistently high quality care.

What are the policy objectives and the intended effects?

The primary and overarching policy objectives are to ensure consistently high quality care for patients subject to the Act, enhance equality, promote recovery and positive health outcomes. Patients, their families and carers, and professionals will have greater awareness and understanding of the Act, its safeguards, their rights and responsibilities and are better able to be involved in decisions about care and treatment and raise concerns if they think the Code is not being properly applied. In particular, the Code supports delivery of a number of key commitments in 'Closing the Gap' including to promote recovery, reduce the use of restrictive interventions and eliminate discrimination.

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

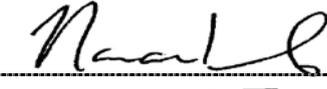
Two main options have been considered:

- Option One: Do nothing. This would mean retaining a Code, that is out of date, not reflective of current best practice and ignores concerns raised in CQC's annual MHA report and at Winterbourne View or support delivery of 'Closing the Gap'.
- Option Two (preferred option): Revise the Code. Since 2008 (when the Code was last updated) there have been changes and updates in legislation, policy, case law, and professional practice. Updating the Code to reflect these changes ensures that our guidance is consistent with best practice and up to date, whilst addressing specific concerns raised in CQC's annual MHA reports and other places, especially about Winterbourne View Hospital.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 04/2018

Does implementation go beyond minimum EU requirements?		Yes / No / N/A			
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro Yes/No	< 20 Yes/No	Small Yes/No	Medium Yes/No	Large Yes/No
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:

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:  Date: 08/07/14

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year 2014	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: £113.5m

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	£2.9m	£12m	£60.24m

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

Increasing transparency, accountability and greater involvement of patients and carers; Reviewing existing policies on seclusion, segregation; Costs of holding more people in health-based place of safety when detained under section 136 of the Mental Health Act; Costs of providing more Independent Mental Health Advocates; Costs of giving patients modern ways to communicate with friends and family; Costs of updating chapter numbers in policies; Cost of extra staff to lift blanket restrictions.

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

Potential cost redistribution between NHS providers, commissioners and local authorities; Costs of providing separate and appropriate sleeping and washing facilities due to family history, religious, cultural, and other reasons

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			£173.8

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

Reduced anxiety due to increased transparency & accountability of decisions on detentions & discharge; greater involvement of the patient in care planning; increased use of health-based places of safety; increased availability of independent mental health advocates; improved ways of communication, reduction in blanket restriction, reduction in the use of seclusion and segregation. Cost savings to Police due to fewer patients under section 136 are being detained in police stations.

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

Quicker recovery of patients. Increased psychological well-being of carers, family members and care staff

Key assumptions/sensitivities/risks	Discount rate (%)	3.5%
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(1.5% discount rate for health benefits).

Key cost assumptions include the assumption that providers can deliver training on the changes in the Code as part of their recurrent training at no extra cost. The key benefit assumption include the assumption that all patients who are detained under the Mental Health Act will experience a 0.04 QALY gain due to the reduced anxiety (which is assumed to be the outcome of the revised Code).

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs:	Benefits:	Net:	Yes/No	IN/OUT/Zero net cost

Evidence Base

1.0 Background, context and rationale

This impact assessment provides analysis of the costs and benefits of the Government's intention to revise the existing Mental Health Act Code of Practice, including a section considering the potential equality impact of the proposed changes. It relates to the costs and benefits identified in relation to the specific revisions and enhancements proposed to the Code, which we are now consulting upon. It is intended that the Code will be made subject to the parliamentary procedure set out in section 118 of the Act and will come into force on 1 April 2015.

- 1.1 The Code is statutory guidance, made under section 118 of the Act, which is addressed to registered medical practitioners, approved clinicians, managers and staff of hospitals and care homes, AMHPs, and other professions in relation to the medical treatment of patients suffering from mental disorder). As a matter of law, the Code must be followed by those to whom it is addressed unless there are strong reasons for not doing so (*R (Munjaz) v Mersey Care National Health Service Trust* [2005] UKHL 58). If such professionals' use of the Act is legally challenged, the guidance given in the Code will be relevant in determining the challenge. The Code is not statutory guidance, but may be helpful for others, including commissioners of health services, the police and ambulance services, and others in health and social services (including the independent and voluntary sectors).
- 1.2 We are not revising the primary or secondary legislation. The revisions to the Code provide guidance on legislation already in place and case law. In cases where an existing regulation is being updated or replaced and where compliance with the existing regulation is not 100%, cross-government guidelines require the impact assessment to take the actual compliance as the baseline, but assume 100% compliance with the updated regulation. This is the approach taken within this Code as CQC's annual reports consistently show that some of the current guidance in the existing Code is not adhered to. Since 2008 there have been changes and updates in legislation, policy, case law, and professional practice that also need to be reflected in the Code. These changes indicate that now is a suitable time to update the Code in order to ensure that it is up to date and fit for purpose.
- 1.3 In *Transforming Care: a national response to Winterbourne View Hospital*¹, the Department of Health committed to reviewing and consulting on a revised MHA Code and publishing a new version by the end of 2014, which would take account of the findings of the investigations into Winterbourne View.
- 1.4 The Department has been actively engaging with patients, former patients, carers, professionals and stakeholders to identify issues they would like clarified. The major issues identified that can be addressed by the Code, are included in the proposed revisions to the Code. Any issues identified that would require legislative change are not within the scope of these proposals.
- 1.5 **This impact assessment is a consultation stage impact assessment and is the Department's first attempt at assessing and quantifying the major impacts of the changes proposed by option 2 – updating the Code. We welcome your views during the consultation on the impacts identified, the level and extent of these and others you can identify. We particularly welcome evidence to support the accurate assessment of the degree of impact and any costs or benefits. Please provide information to support the development of a full impact assessment under questions 35 and 36.. Please provide information to support the equality analysis under question 6..**

2.0 What policy options have been considered?

2.1 Option 1: Do nothing

- This option would mean retaining the existing Code for the Act. This would enable continuity for professionals in a Code that they are familiar with, is well used and generally provides good guidance on key areas of the Act.
- Pursuing this option would result in having a Code that was out of date and not reflective of changes since 2008 in legislation, policy, case law, technological developments and professional practice.

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

- The Secretaries of State (for Health and for Justice) could be challenged for failing to revise the Code.
- The Care Quality Commission's (CQC) annual reports on the MHA have identified areas where the safeguards of the MHA were either not applied or where there were concerns with the quality and safety of care being delivered. Stakeholders have supported this, highlighting a number of areas where the existing Code is confusing or could be improved.
- Evidence from CQC and others strongly indicated that patients and carers had little awareness of the Code, or understanding of their rights under the Act. This option would ensure that this continued.

2.2 **Option 2: Revise the Code**

- Reviewing the Code does not affect the existing legislation, but aims to address some of the issues raised by CQC, in the response to Winterbourne View, and in the Health Select Committee review of the Mental Health Act 2007.
- Updating the Code would enable the changes and updates in legislation, policy, case law, and professional practice to be reflected in the Code. The accumulation of these changes indicate that now is a suitable time to update the Code in order to ensure that it is up to date and fit for purpose. This would increase clarity, remove confusion and assist professionals at key points.
- Stakeholders have strongly supported the need to update the Code in a number of key areas, whilst acknowledging that in many others it provides high quality, useful and timely guidance.
- Stakeholders, especially patients, former patients and their families and carers have reported little knowledge and understanding of the Code and the protections it provides. Making the Code more accessible and increasing awareness could fundamentally improve and increase the voice of these stakeholders in decisions about their care and treatment.
- In January 2014 the Government published *Closing the Gap: priorities for essential change in mental health*² outlining its 25 priority areas for action. The new proposed Code is a key lever for facilitating these changes, for patients subject to the Act, their families and carers.

2.3 **Option 3: Update the legislation *and* revise the Code (not considered further)**

- This option was briefly considered but was not considered a viable option.
- Stakeholders did not generally favour a comprehensive reconsideration of the primary legislation and preferred an update to the Code as it could be implemented much more quickly.
- The consultation document includes a small number of suggestions about possible changes to the secondary legislation which we have sought views on.

2.4 **Overall costs and benefits of Option 1 - Do nothing**

- The costs of doing nothing would be to perpetuate and exacerbate the issues identified in the Serious Case Review into Winterbourne View, the CQC's Annual MHA Reports and those identified through our engagement with patients, carers and service providers. Unless changes are made and the Code is made clearer and stronger in certain areas, we expect that problems will persist around the roles and responsibilities of service providers and the rights of service users. These costs cannot easily be estimated or monetised, though the anecdotal evidence that has emerged from cases like Winterbourne View, indicates that human costs are very high.
- Option 1 would avoid any transitional costs to services associated with revising and implementing a new Code.

2.5 **Overall costs and benefits of Option 2 - Preferred option**

- Option 2 allows the Code to reflect developments in legislation, policy, case law and current good professional practice and to provide improved guidance to those exercising powers under the Act. Benefits include:
 - 2.5.1 Enhanced awareness and understanding of the Code by patients, carers and professionals.
 - 2.5.2 Some new inclusions reflect policy development and best practice to improve quality of care.

2.6 **Preferred option: Option 2 is strongly preferred because:**

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

- Updating the Code of Practice enables the Department to relatively quickly provide greater clarity around certain areas of the use of the Act to reflect developments in legislation, policy, case law and current good professional practice.
- Stakeholders are strongly supportive of this approach, especially the need to address major issues raised by CQC and the need to ensure policy improvements set out in *Closing the Gap* apply equally to patients detained under the Act.
- Option 1 would mean that confusion in a number of key areas would remain and that the existing guidance was not reflective of the legislation, policy or practice in key areas. In particular, it would not enable the benefits of greater awareness and understanding on the part of patients, their families, carers and professionals to be fully realised.

2.7 Specific impacts assessed for implementation of option 2 – Changes to the Code of Practice

In cases where an existing regulation is being updated or replaced, and where compliance with the existing regulation is not 100% (see, for example, the Francis or Cavendish reports as well as CQC inspection reports), cross-government guidelines³ require the impact assessment to take the actual compliance as the baseline, but assume 100% compliance with the updated regulation.

3.0 individual Changes of significant impact:

Change A: Better joint working between professionals, NHS providers, commissioners and local authorities.

The new guiding principle 'Efficiency and equity' requires commissioners, providers and other relevant organisations to establish effective relationships to ensure efficient working and accountability defined through joint governance arrangements. This will enable them to provide more holistic and joined up packages of care, that considers the whole patient, and both their mental and physical health needs.

Benefits

This should enable better care and treatment, less delay in care planning and therefore discharge, and a more joined up approach. Good joint planning, which takes account of the patients history and circumstances, should reduce the "revolving door" of individuals being repeatedly detained in hospital. This should promote recovery and reduce costs especially in the longer term. It promotes Governmental policies on personalisation and integration.

Risks

This requires all 'partners' in the system to cooperate and work closely together in the interests of the patient. With tight budgets organisations can sometimes look inwards rather than looking at overall benefits to the patient and the public purse and fail to cooperate. The emphasis in the Code on the overarching principles, joint working and the duty of integration in the Care Act 2014 mitigate against this.

Costs

The revised Code aims to facilitate better joint working between the NHS, Local Authorities and providers with more holistic, integrated packages of care, considering how best to provide the right care at the right time. This can lead to cost savings in the long run, but may lead to changes in the distribution of costs between the NHS and Local Authorities in the shorter run. For example, the greater transparency around decisions on detentions and discharge may mean that some people, who are held in a more restrictive setting than would be clinically appropriate, may be discharged to the community. In these cases, there may be a cost re-distribution from the NHS to local authorities. We are seeking the views of stakeholders about the extent to which this is likely.

Change B: Increasing transparency, accountability and greater involvement of patients and carers

This range of changes (more transparency and accountability in decisions including discharge or renewal of detention, and greater awareness about one's rights when under the Act) are designed to ensure that patients, their families and carers are more informed and involved in the decisions that affect them. This includes, in particular, those decisions to which patients, their families or carers are unlikely to consent.

Benefits

These policies should have a number of direct benefits. They should increase the dialogue and trust between professionals and their patients, potential future patients and family members. It will also mean that individuals are more likely to be able to seek recourse about things they disagree with or where the Code or Act have not been properly applied. This is likely to lead to a reduction in anxiety for both patients and their families, which may be monetised as a QALY gain, and also to a quicker recovery.

Risks

³ See paragraphs 103-106 of the guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/31608/11-1112-impact-assessment-toolkit.pdf

There is a possibility that the additional costs and requirements to ensure transparency outweigh the benefits of doing this, including putting additional pressures on staff.

Costs

The revised Code expects providers to make their policies and individual decisions more transparent and to conduct more frequent reviews. Data collection and analysis would be essential to achieve this.

We assume that achieving this would require ten days additional work by NHS mental health trust managers, and five days additional work by independent sector mental health hospital managers. We do not assume direct costs, only the opportunity cost of managers' time. We assume a five-year, linear transition for the system to reach its new steady state (reaching full compliance), giving a total cost of £0.8 million.

Change C: Training of staff who use the Act

A range of professionals are likely to require a half-day refresher training setting out the changes in the Code of Practice. Examples include mental health nurses, psychiatric doctors, section 12 doctors, Approved Mental Health Professionals (AMHPs), Independent Mental Health Advocates (IMHAs), Police officers, clinical commissioning groups (CCGs), CQC inspectors, Mental Health Act Commissioners, and hospital managers.

Benefits

Professionals will be up to date with the changes and able to adapt their practice to reflect this. This should increase clarity and reduce poor practice such that compliance with the Code increases and risk of legal challenge reduces.

Risks

Training may be inconsistent or insufficient to instil knowledge or may incorrectly interpret guidance leading to perpetuation of poor practice. Most providers will probably provide half a day's training, but this may be insufficient. This could be supplemented through cascade training, on the job training and self-learning of the new Code.

Costs

This should not constitute a considerable additional burden on providers, as staff, who are expected to deal with patients who are subject of the Mental Health Act, already receive training on the Mental Health Act and the Code of Practice with annual refreshers⁴.

As service providers and professional bodies will anticipate the publication of the revised Code (and, from the consultation documents, they will also have a good understanding of the likely changes it will include), it will be possible to schedule annual refresher training courses to include the revised Code. In these cases, there will not be any additional training-requirement (apart from replacing its content – which is not assumed to be considerable), and therefore the training will impose *no extra* opportunity cost (in terms of the value of the best alternative use of staff members' time while attending the training) or direct costs on providers.

Change D: Reviewing and revising existing policies on restraint, seclusion, segregation, enhanced observation, rapid tranquilisation, mechanical restraint

The Code provides additional guidance on the use of restrictive interventions. Only those changes beyond the *Positive and Proactive Care: reducing the need for restrictive interventions* (2014) guidance (which is part of the baseline) will be assessed.

Benefits

The new chapter together with Positive and Proactive Care is designed to deliver on the Governmental commitment to reduce the use of physical interventions in health and social care, and in particular in inpatient mental health care. The reduced use of seclusion, segregation and restraint and emphasis on de-escalation and alternative techniques, notably Positive Behaviour Support, should lead to reduced anxiety, stress, and trauma for patients, family and staff and confrontation between them. This in turn should promote recovery and reduce the amount of time patients spend in hospital. Further benefits are set out in the impact assessment supporting the implementation of *Positive and Safe*, the Department of Health's two year programme to support the implementation of the new guidance.

Risks

Staff need to be appropriately trained in the relevant de-escalation techniques and supported in a phased approach to use alternatives to restrictive interventions. For some staff and organisations this will require a culture and leadership change to take forward.

Some providers may come up with 'divergence' or 'alternative' strategies to try and circumvent the new guidelines.

⁴ For example, people who are expected to regularly deal with people under the Mental Health Act receive some 50 hours of training as part of their Continuing Professional Development – part of which is about the Mental Health Act and the Code of Practice.

Costs

We expect that mental health hospitals will implement a number of changes to reflect the revised Code on the use of restrictive interventions including seclusion, segregation, rapid tranquilisation, mechanical restraint, as well as on enhanced observation. Many of these are already included in the government's Positive and Proactive Care guidance, therefore most of these would have been implemented anyway, and, for this reason, are part of the baseline.

In particular, the Code requires all hospitals giving patients mental health treatment, should set up and regularly review a restrictive interventions reduction programme.⁵ These should also include improvement targets and identify who is responsible for progressing the different parts of the plan.

The proposed Code also expects providers to assess patients on admission for potential risks of behavioural disturbance⁶. The results of the assessment should be used to guide the development and implementation of effective, personalised and enduring systems of support that seek to meet patient's needs, promote recovery and enhance quality of life outcomes for the patient and others who care and support them. The results should also be used in developing individual behaviour support plans, which, based on an understanding of a patient's needs and includes circumstances that are likely to predict behavioural disturbance, sets out preventative strategies.

The proposed Code (unlike the 2008 Code) includes guidance on 'enhanced observation', on rapid tranquilisation, and additional guidance on mechanical restraint. The revised Code also requires providers to conduct more frequent reviews regarding seclusion of patients and long term segregation.

The revised Code expects providers to set up 'provider's policies' guiding day-to-day operation of services with specific guidance on;

- a) individualised assessments of risks and need for support;
- b) the use of behaviour support plans;
- c) how restrictive interventions should be implemented⁷;
- d) how restrictive interventions which are used by the provider should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention;
- e) local recording and reporting mechanisms around the use of restrictive interventions;
- f) post-incident analyses; and
- g) workforce development, including training requirements relating to the application of restrictive interventions.

These are all new requirements compared to the 2008 Code. However, the majority of these requirements are in line with the government's *Positive and Proactive Care* guidance. As these requirements have been costed as part of the impact assessment of the costs of benefits of the implementation of the supporting *Positive and Safe programme [forthcoming 2014]*, these will remain un-costed for the current impact assessment. In other words, it is part of the baseline ('Do Nothing') scenario. In 2012/13 only 80⁸ children and young people were detained under the Act and a smaller proportion subject to restrictive interventions. The costs and benefits of applying the forthcoming volume 2 of *Positive and Proactive Care* which will deal with reducing the need for restrictive interventions on children, young people and those in transition will be costed as part of the impact assessment to support the implementation of *Positive and Safe*. Volume 2 of the guidance will be published by March 2015 and will share the principles and, where appropriate, key actions of *Positive and Proactive Care*.

In some areas, the Code is more specific in detailing the required actions than the *Positive and Proactive Care*. These include setting out 'provider's policies'. These requirements can be seen as a practical guidance (or a clarification) on how to implement the requirements of the *Positive and Proactive Care* guidance. For this reason, these are unlikely to impose an additional burden on providers compared to the baseline.

There are a few areas where the revised Code's requirements go beyond the *Positive and Proactive Care* guidance in setting out specific requirements, although it remains in line with the aims of *Positive and Proactive*

⁵ Restrictive intervention reduction programmes are overarching, multicomponent action plans which aim to reduce the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care.

⁶ Assessments should take account of the patient's history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances. Assessments of behavioural presentation are important in developing an understanding of a patient's needs.

⁷ Including an assessment of the potential of restrictive interventions to cause harm to the physical, emotional and psychological wellbeing of patients and policy on how providers will take account of a patient's individual vulnerabilities to harm such as unique needs associated with physical / emotional immaturity, older age, disability, poor physical health, past history of traumatic abuse etc.

⁸ Page 15, Mental Health Bulletin, Annual Report from MHMDS Returns, England 2012/13, <http://www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf>

Care guidance throughout. These include guidance regarding 'enhanced observation', mechanical restraint, rapid tranquilisation, as well as review procedures around seclusion and long term segregation. Given these additional requirements, providers may need to review and revise some of their existing policies. In addition, the revised Code includes some new definitions including rapid tranquilisation and long term segregation, which potentially requires the revision of some existing policies.

We assume that NHS Mental Health Trust manager will have to spend five days, while independent sector mental health hospital trusts will have to spend three days to review and potentially revise existing policies. The rationale behind assuming that it would take longer for NHS mental health trust managers is that these typically have more varied patient mix and physical environment. We do not assume direct costs, only the opportunity cost of managers' time. We assume that this will be a one-off cost.

There are 52⁹ Mental Health Trusts and 190¹⁰ independent sector mental health hospitals in England. We assume that the average earnings of these managers are £80,000 and £60,000, respectively. Ignoring employer costs, this gives a total opportunity cost of £0.2 million.

Change E: Fewer people who are detained under section 136 will be held in police cells and those that are will be held for less time

A revised chapter drafted with the Home Office and building on the Crisis Care Concordat, focuses on reducing the use of police stations as places of safety in favour of health based places of safety.

Benefits

People should be assessed more quickly and in a setting that is able to care for them appropriately and where appropriate discharge them to community services more quickly. Police officers should be freed up to deal with other emergencies for which they are uniquely trained and equipped.

Risks

There may be insufficient capacity in health based settings especially at crucial times or in certain locations to meet demand. Patients may be taken to other unsuitable places of safety or held for longer to avoid use of police stations.

Costs

It is assumed that the current number of detentions (7760 in 2012-13 this section will be updated to reflect most up to date figures when the full IA is published) in police cells will decrease to fewer than 10% of all section 136 detentions (or approximately 2200) over five years. The costs are assumed to be the hospitalisation costs of the 5,560 people for an average of one day each (This is likely to be an over-estimate since section 136 detentions typically last just over 10 hours, however, we need to allow for extra capacity to allow the system to deal with fluctuations in section 136 detentions. We are also examining whether the improvement of the system's overall response to mental health crisis is leading to a reduction in the overall number of people who are detained under section 136).

The revised Code strengthens the requirement that 'a police station should not be used as a place of safety except in exceptional circumstances'. Unlike the 2008 Code, which suggested that it was 'preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting where mental health services are provided', the revised Code sets out that '[i]n most cases, a person thought to be suffering from a mental disorder and taken to a place of safety under section 136 should be detained in a hospital or other health-based place of safety'. It is expected that the strengthening of this requirement will lead to a considerable reduction in the number of cases where people are held in police custody rather than in a hospital. During 2012/13, an estimated 7,761¹¹ orders were made where the place of safety was a police custody suite, these account for 36% per cent of the total orders made under Section 136 during 2012/13. It is difficult to judge what proportion of these people were inappropriately held in a police cell, however, the fact that in some local areas only a few percentage of those, who are held under Section 136, are taken to police custody, suggests that the proportion of cases where it is appropriate to use a police cell as a designated place of safety is very low indeed.

Based on this, it is assumed that as the outcome of the revised Code, 10% of those, who are held under Section 136, will be taken to police cells, suggesting that approximately 5,580 more people will be taken to hospital. The average length of stay of these people is 10 hours and 32 minutes¹². It cannot be assumed that mental health

⁹ List of Mental Health Trusts: <http://www.nhs.uk/services/directories/pages/mentalhealthtrustlisting.aspx>

¹⁰ List of independent sector mental health hospitals: <http://www.carehome.co.uk/mental-health-hospitals/index.cfm/searchcountry/England/>

¹¹ Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment Annual report, England, 2013 <http://www.hscic.gov.uk/catalogue/PUB12503/inp-det-m-h-a-1983-sup-com-eng-12-13-rep.pdf>

¹² <http://www.publications.parliament.uk/pa/cm201314/cmpublic/care/140204/am/140204s01.htm#Column597>

hospitals, with their current occupancy rates¹³ could necessarily accommodate this extra number without some extra investment in creating additional capacity. Due to the unpredictable frequency of these admissions, it is assumed that each mental health trusts would have to invest in one more bed to deal with this caseload. The average cost of an inpatient bed day in mental health wards is approximately £321¹⁴.

It is assumed that the transition to the new steady state (in the reduction in the number of patients detained under section 136 who are taken to police custody) would take 5 years and that the rate of transition will be linear (20% in year 1, 40% in year 2 and so on). For the five-year transition period, these assumptions give a total discounted present value of £16.3 million. This estimate will be updated when the 2013-14 data is available.

Change F: More IMHAs have to be provided

A new change has been proposed, to provide that if a patient lacks capacity to decide whether to seek help from an IMHA, an IMHA should be introduced to the patient so that the IMHA can explain what help they can offer.

Benefits

*A Right to be Heard*¹⁵ sets out a long list of benefits of IMHA provision and recommended that provision be promoted for individuals whom lack capacity. This is likely to increase understanding and involvement of patients in discussions about care and treatment, and reduce patient anxiety and confusion. Given their specialist knowledge of the Act, IMHAs are likely to provide an effective safeguard and champion of a patient's rights.

Risks

There may be insufficient capacity to provide the IMHA support required, in particular where this needs to be a specialist e.g. with knowledge of learning disability or autism, or to accommodate cultural or religious preferences. There is also a need to adequately support individuals who are deaf, for whom English is not a first language or who have difficulty communicating for other reasons.

Costs

The revised Code requires that if a patient lacks capacity to decide whether to seek help from an IMHA, an IMHA should be introduced to the patient so that the IMHA can explain what help they can offer.

The CQC has found that in 2012/13, patients in 92%¹⁶ of wards had access to IMHA services. Newbigging et al (2012¹⁷) found that providers spend £162 on IMHA services per qualifying patients (including training costs and overheads). The cost of ensuring that, following the publication of the revised Code, all qualifying patients will have access to IMHA services, is estimated to be £0.6 million each year. For a five-year period following the publication of the revised code (so that the cost-calculation remains consistent with the calculation of other recurrent cost items in the impact assessment) the present discounted value of costs will total £3 million.

We acknowledge that take-up rates of IMHA services (in terms of the proportion of eligible patients who request IMHA services) could increase as the outcome of the revised Code, but we are currently seeking stakeholders' views on whether or not take-up rates would increase, and for this reason, we have not incorporated an assumed change in the take-up rates in the cost estimates presented above.

We also acknowledge that training IMHAs who can provide services in different languages, and who can help people who have learning disabilities or other types of communication problems may cost more, for which reason the estimates presented above might be underestimating the costs. However, we do not know how much more these would cost, and we are seeking stakeholders' views on this.

Change G: Provision of separate and appropriate sleeping and washing facilities due to family history, religious, cultural, and other reasons and to enable patients to meet and communicate with family, friends and other visitors in private and/or electronically

¹³ A Freedom of Information request revealed an average occupancy rate of 101% in mental health wards in August 2013. This is despite the Royal College of Psychiatrists recommends occupancy levels of 85%. <http://www.communitycare.co.uk/2013/10/16/patients-at-risk-as-unsafe-mental-health-services-reach-crisis-point-2/>

¹⁴ 2010 figure (http://www.pssru.ac.uk/pdf/uc/uc2010/uc2010_s07.pdf) uprated to 2014/15 prices using GDP deflator.

¹⁵ University of Central Lancashire, *The Right to be Heard: Review of Independent Mental Health Advocate (IMHA) Services in England* (2012)

¹⁶ Monitoring the Mental Health Act in 2012/13 (page 26), http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

¹⁷ Newbigging, K; J Ridley, M McKeown, K Machin, D Poursanidou, L Able, K Cruse, P Grey, S de la Haye, Z Habte-Mariam, D Joseph, M Kiansumba, J Sadd (2012) 'The Right to Be Heard; Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England', University of Central Lancashire, http://www.uclan.ac.uk/research/environment/projects/assets/mental_health_wellbeing_review_of_independent_mental_health_advocate_research_report_190612.pdf

The Code already requires that separate sleeping and washing facilities are provided for men and women but CQC reports high levels of non-compliance in this area (see Equality Analysis for more information). This change also highlights other reasons why separate facilities may be required.

Evidence from Winterbourne View Hospital and other places has highlighted that patients are not able to communicate privately with family and friends, including on the telephone, in person or due to access to the internet. These changes are designed to ensure that this does not happen and that patients can communicate privately if and when they wish.

Benefits

Ensuring separate sleeping and washing facilities is a key means of advancing quality and reducing discrimination (see equality analysis) and promoting recovery for these individuals. Evidence indicates that where these are not available there are greater numbers of complaints, self-harm and that lack of these can be a trigger for confrontations and use of restraint.

This should promote greater contact with family, friends and community which can all be strong drivers in promoting recovery. Private communication should enable a patient to raise any concerns they have about their care and treatment without fear that they will be overheard by members of staff and hence have the possibility to be addressed more quickly. Use of the internet and mobile communications are considered essentials in maintaining a private and family life and employability skills.

Risks

It may not be possible for providers, especially in the short term, to provide these reasonable adjustments. It has proven difficult for all organisations to consistently provide separate facilities for men and women.

For some patients and in some hospitals, safeguards may need to be put in place to ensure that a patient does not access inappropriate websites, make inappropriate phone calls or take inappropriate photographs on smart phones. The rights and privacy of other patients and staff need to be protected and any restrictions need to be proportionate and risk based.

Costs

Some patients may require separate facilities for religious, cultural or other reasons. We are currently examining whether this will have any additional cost implications and welcome views from stakeholders on the impact of this change.

Following the implementation of the revised Code, and in light of the research carried out by the CQC¹⁸ in 2012/13, we can expect an increase in costs associated with the requirement that patients cannot have restricted internet access unless clinically appropriate. In particular the CQC report found that some 53.3% of wards have a 'blanket ban' on internet access – with 48.3% applying this blanket ban regardless of whether a patient is detained under the Mental Health Act. Assuming that patients currently residing in a ward without any blanket ban already have the appropriate level of internet access, and assuming that following the revision 80% of wards that have a blanket ban now will no longer restrict internet access, we can expect 8175 new patients to require access at any given point.

We are seeking stakeholders' views on whether or not providing internet access to patients can be achieved via patients' own private communication devices (smartphone, tablet, computer) or providers will have to purchase extra computers for these purposes. There may be a difference between the two approaches in ensuring that the device is only used in ways which are appropriate – in particular, we believe that restricting communal computers (so that these cannot be used inappropriately) is easier than to do so with patients' private devices.

If providers would have to purchase computers, and assuming 3 computers will be needed per 15 person who should be given access to the internet (at a cost of £321.41¹⁹ each), we estimate a one off cost of £0.5 million to purchase the required number of computers. We assume that there is already internet-access in these wards, therefore it will not be an extra expenditure.

Change H: Some people will be discharged, either completely, or to CTO or guardianship

The Code includes the guiding principle 'Least restrictive option and maximising independence'. This will encourage, where appropriate, discharging an individual or placing them in the community under a CTO or guardianship.

Benefits

¹⁸ http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

¹⁹ NHS Supply Chain data,
<http://my.supplychain.nhs.uk/catalogue/search?LastCartId=&LastFavouriteId=&HideMaskedProducts=false&QueryType=All&Query=laptop>

People living in the community are more likely to maintain contact with family and friends, which has been proven to be a key driver in promoting recovery and reducing the amount of time spent in hospital, including over the longer term.

Risks

To be fully effective this requires a high degree of inter-agency joined up working. Evidence since CTOs were first introduced has indicated that the expected benefit of a corresponding reduction in detentions has not materialised. However the full cost-benefit study of the use of CTOs has not yet been completed. The revised Code emphasises the need to make decisions on the use of CTOs only for patients who will benefit from them and ending their use as soon as they are no longer appropriate.

Costs

It is not possible to judge whether the revised Code will increase (through emphasis on least restrictive option) or decrease (through emphasis on more discriminating use of CTOs and clear discharge procedures) the use of CTOs. We welcome views on this. An increase in CTOs may lead to some costs shifting to local authorities paying for support for people whose hospital care costs are currently completely funded by the NHS. As the number of CTOs has been increasing in the previous years, we do not expect large changes above those already occurring. If CTOs did increase at least some of those would be people who would otherwise be receiving s117 aftercare, with the same cost to local authorities. The overall impact of a significant move to the least restrictive option is likely to be an overall reduction in care costs, given the high costs of inpatient care.

Change I: A large number of organisations such as local authorities, commissioners, and providers will have to update their policies, producers and documentation

To implement the changes set out in the Code relevant organisations will need to update their documentations, forms and training/publicity material on the Code including any references to particular pages/paragraphs in the Code.

Benefits

This will make it easier for staff and patients to understand the changes and ensure that the materials being used are up to date and accurate, hence promoting compliance. It will lessen the possibility of organisations not being compliant and continuing with poor practice in some areas.

Risks

This will be an additional task which many organisations may not have factored in and which will take time to implement effectively. This may be a particular concern for smaller providers.

It is important that organisations have sufficient time to update policies, procedures and documentation and to train staff in the changes. To mitigate this we are consulting on the changes in advance and ensuring that there will be at least three months between when the Code is laid in Parliament and when the changes come into force. This will give organisations time to make the necessary changes.

Costs

Updating chapter numbers in policy documents which refers to the Code of Practice:

The revised Code will have different chapter numbers, which will have to be updated in Local Authorities', Commissioners', Mental Health Trusts' and independent sector mental health providers' policies and guidance's. We assume that managers from each of these bodies will spend three days to update their policies and guidance's. We do not assume direct costs, only the opportunity cost of managers' time. We assume that this will be a one-off cost.

There are 52 Mental Health Trusts, 211 CCGs, 152 Local Authorities and 190 independent sector mental health hospitals in England. We assume that the average earnings of these managers are £80,000 for Mental Health Trust and CCG managers and £60,000 for Local Authorities and independent sector mental health hospital managers. Ignoring employer costs, this gives a total opportunity cost of £0.5 million.

Change J: Use of the MHA may be affected by a recent Supreme Court judgment (P v Cheshire West) concerning the use of the MHA or the MCA for people who lack capacity.

The Supreme Court judgment P v Cheshire West set the test for deprivation of liberty as being: when a person lacks the mental capacity to consent to the arrangements for their care and/ or treatment, and the person is under continuous supervision and control and not free to leave.

This clarified test applies across all care homes, hospitals and State-arranged placements in community settings (such as supported living). The scope of the judgment is far broader than the interface between Act and the

Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act 2005 (MCA). However, the judgment is relevant to considering the use of the Act or the MCA for patients lacking capacity.

P v Cheshire West will increase the cost of administering the DoLS (particularly for local authorities giving DoL authorisations) and the workload of the Court of Protection. The practical implications of the new test remain to be fully explored through evolving case law. Local authorities are monitoring closely the impact of the judgment and will report the numbers of DoLS applications they receive and DoL authorisations they give to the national level. The Department will continue to monitor these numbers and keep the need for additional guidance under review – working closely with our system partners.

However, increased costs are a result of the judgment not the revised Code. For this reason, the expected increase is part of the baseline and should not be costed as part of this impact assessment. This impact assessment does not consider the implications of P v Cheshire West, although the new chapter 13 provides guidance to reflect the judgement.

Change K: Reduction in blanket locked door policies

Entire unit or ward populations should not arbitrarily be denied access to outside space or areas of the hospital e.g. the kitchen or fridge. This is particularly true for informal (voluntary) patients who are free to leave at any point. Restrictions and the use of blanket locked door policies that are not based on detailed assessments of risk and are a proportionate response to those risks, cannot be justified. CQC have raised concerns about the use of blanket restrictions across whole wards/units, and found that over 77% appeared to be without justification. Under no circumstances can a locked door be a substitute for low staffing levels.

Benefits

Chapter 8 aims to ensure that providers avoid the use of blanket restrictions which apply indiscriminately to all patients on a ward or in a hospital, e.g. restricting access to outside areas or the internet. This is designed to promote a risk based approach to decisions about blanket restrictions especially blanket locked door policies. This should improve relationships between patients and staff as we know that blanket locked door policies can be a major source of confrontation and even aggression as patients do not understand why they are not able to leave. It can be a major trigger for incidents that involve restraint. In the case of informal (voluntary) patients removal of blanket restrictions prevents them being unlawfully deprived of their liberty in this way. Removing this will ensure benefits in terms of a patient's wellbeing and recovery is promoted and reduce the risk of litigation for unlawful detention.

Risks

Given the current low levels of compliance with the current guidance in the Code, there is the potential for some providers to have difficulty in implementing this satisfactorily. Evidence from CQCs inspections should monitor the impact this has including on the welfare and recovery of patients.

Costs

The requirement in the revised Code of Practice that blanket locked door policies can only be implemented where it does not constitute unlawful deprivation of liberty, and the fact that the Care Quality Commission's (CQC) 2012/13 report 'Monitoring the Mental Health Act' finds that in many of these cases staff-shortages explain to the use of blanket policies, imply an increase in staffing costs for mental health hospitals. The CQC found that "in one in five"²⁰ wards patients who were not formally detained were prevented from leaving. The revised Code aims to ensure that no policy results in the unlawful deprivation of liberty (or 'de facto detention') of patients who are not subject to legal powers of detention.

Extrapolating from, in 2012/13, a total non-detained inpatient population of 55,849²¹, a mean number of in-year bed days of 73²² in 2012/13 and a recommended ward size of 15²³ we can expect 148 wards that were previously locked to be opened. Assuming an opportunity cost (the implicit cost that the staff member cannot fulfil its main duty) of monitoring a now unlocked ward at 2 hours per ward per day, totalling 14 hours of the typical 37.5 hour week²⁴ worked by a mental health nurse with an assumed salary of £25,000, this implies costs across mental health institutions of £1.4 million per annum.

²⁰ Monitoring the Mental Health Act, CQC report 2012/13 (page 41), http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

²¹ The Mental Health Bulletin England, HSIC report 2012/13 (page 12) <http://www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf>

²² The Mental Health Bulletin England, HSIC report 2012/13 (page 29) <http://www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf>

²³ Ten standards for adult in-patient health care, Royal College of Psychiatrists report 2011 (page 4) http://www.rcpsych.ac.uk/pdf/OP79_forweb.pdf

²⁴ Mental health nurse Job Information, National Careers Service <https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/mentalhealthnurse.aspx>

Assuming that it would take 5 years for the system to reach its new steady state and compliance with the Code to reach 100% (with a linear transition), we find a discounted present value cost of £3.8 million.

Change L: Increase in take up of Victim Contact Scheme

It is not clear if there will be an increase in the number of victims in the Victim Contact Scheme as a result of the revised Code.

The revised Code sets out more clearly what statutory obligations hospitals have in respect of victims, and contains clearer information on the rights of victims. Increased awareness of their statutory obligations by professionals, combined with a clearer understanding of their rights by victims, may result in an increase in the number of victims who are offered victim contact, and who elect to receive it.

Benefits

An increased number of victims may seek to use the Contact Scheme to address issues resulting from the crime they were subjected to. This may to a sense of healing between the offender and their victim/s, the victim recovering from the trauma they have experienced sooner and may decrease the likelihood of the offender reoffending.

Risks

There is the possibility that expectations may be raised and not all victims may be able to access the Contact Scheme. Victims and offenders may not receive appropriate support to adequately prepare them and support them during the contact.

Costs

It is not clear if there will be an increase in the number of victims in the Victim Contact Scheme as a result of the revised Code. The revised Code sets out more clearly what statutory obligations hospitals have in respect of victims, and contains clearer information on the rights of victims. Increased awareness of their statutory obligations by professionals, combined with a clearer understanding of their rights by victims, may result in an increase in the number of victims who are offered victim contact, and who elect to receive it, but we are unsure of the likely effects.

We are seeking the views of stakeholders to clarify whether or not there will be an increase in the number of victims in the Victim Contact Scheme as a result of the revised Code and what cost implications this might have and on which organisations.

Change M: Changes to CQCs inspection regime to monitor compliance with the Code more effectively

The Care Quality Commission (CQC) already had statutory responsibility for monitoring the MHA and used the Code to inform their methodology for discharging this duty. The new introduction makes it clear how CQC intends to do this generally for all providers it registers and in particular how they will use the Code to monitor the application and discharge of powers under the MHA.

Benefits

Providers, inspectors and MHA Commissioners should be clearer what they are looking for and what a good service looks like. This should improve the quality of care and ensure that where care is not up to standard that quicker and more appropriate action is taken. The Code will provide clear guidance to both the CQC and the providers it regulates on what CQC will expect to see in place for the MHA when they are carrying out inspections and monitoring visits.

Risks

There may be different and conflicting information about what good looks like and inspectors may take different judgments about this. This should be mitigated by the training they will receive, wider changes to CQCs regulatory and inspection approach and by ensuring consistency of messaging. Further information is available in CQCs impact assessment to support the development of their new approach.

Costs

CQC will have to adapt its inspection regime, its inspections might take longer, and there may be additional litigation costs where a rating is challenged in the courts

These additional cost implications have been included in CQC's own impact assessment regarding changes in their inspection regimes to reflect new legislation, and for this reason these remain un-costed in the current impact assessment.

4.0 Summary of costs taking into account the opportunity cost of using these monies

It should be noted that NICE estimates that an increase of expenditure of £20-£30,000 will on average force the NHS to make economies (e.g. on staff or on drugs or on procedures) that will lead to a loss of a QALY. DH methodology for assessing policies is designed to ensure that we observe the same budget constraint as NICE does. Thus, we compare the benefits of a policy with the costs, in terms of the health benefit, that could have been generated through funding to the NHS (at a rate of £25,000 per QALY). At the same time, DH assigns a value of £60,000 to a QALY, consistently with similar valuation of policies that mitigate mortality or morbidity risk by other government departments, based upon studies of what members of the public are on average willing to spend to reduce their own mortality risk, or to improve their own health outcomes. A policy proposal that costs £25,000 to the NHS is therefore presented with an opportunity cost of £60,000 on the assumption that it would force an economy that would displace a QALY, and therefore lead to a drop in overall health benefits that would be valued by the public at £60,000. As a rule of thumb, the true opportunity cost of funding in the health and social care system is assumed to be £2.4 for every £1 lost (=£60,000/£25,000). The present value of the total of all costs, including opportunity costs, is about £60.24 million.

5.0 Summary of benefits:

Increased trust in services, reduction in patient's anxiety and quicker recovery

The revised Code is likely to lead to more trust in services and as an outcome could improve the psychological well-being of patients who are detained under the Mental Health Act or can be expected to be detained under the Mental Health Act in the near future and can also lead to quicker recovery.

We believe that, following the publication of the revised Code, due to;

- a.) The increased transparency and accountability of decisions on detentions and discharge;
- b.) The greater involvement of the patient as well as carers and family members in patients' care planning;
- c.) The increased use of health-based places of safety (rather than Police cells) in section 136 detentions;
- d.) The increased availability of independent mental health advocates
- e.) The improved ways of communication with friends and family and the greater privacy in doing so while being detained in hospitals;
- f.) The reduction in blanket restrictions;
- g.) The reduction in the use of seclusion and segregation;
- h.) And all other changes in the way patients are treated while under the Mental Health Act;

Patients who are detained under the Mental Health Act (as well as those who are likely to be detained in the future) will be less anxious while under the Mental Health Act. To remain conservative in our assumptions, we assume that, as the outcome of the revised Code, only the 22,207 patients who are detained under the Mental Health Act at one point in time will experience a slight reduction in the anxiety they experience. We also assume that the reduction in patients' anxiety will be proportional to the extent of increased compliance with the revised Code in the five years following publication. We assume a linear transition in compliance rates (20% in the first year, 40% in the second year, and so on...). We assume that the slight reduction in anxiety will correspond to a half-notch increase in the EQ-5D questionnaire's anxiety / depression dimension (one notch increase would correspond to going from 'extremely anxious' to 'severely anxious', from 'severely anxious' to 'moderately anxious', or from 'moderately anxious' to 'slightly anxious'). Such a move is associated with a 0.04 QALY gain on average. In the calculations, we monetise the QALY gains from the marginally reduced anxiety for 22,207 patients over five years (in proportion to the predicted increase in compliance with the revised Code), and also discounting future gains by 1.5% to take into account time preference rates. The assumptions used to monetise QALY gains follow standard cross-government guidelines. The net present value of benefits due to lower anxiety of patients, who might be detained under the Mental Health Act, accrued over the five years is estimated to be totalling £153.7 million.

There is also likely to be a beneficial effect of reduced anxiety on both care staff and family members of patients. Informal patient could also benefit from the increased transparency as the outcome of the revised Code. To remain conservative in our calculations, we chose not to monetise these effects.

In addition, it is expected that, due to the revised Code, patients will be more involved in discussions regarding their care and could be discharged more quickly. These may promote recovery and wellbeing and lower length of stay. These effects could result in patients' quicker recovery. We are currently seeking stakeholders' views on the extent to which these effects might contribute to quicker recovery, and may choose to monetise the corresponding health benefits in the light of the information received.

Utilisation of Police cells which are no longer used for section 136 detentions

It is not assumed that Police forces would be able to make direct savings by closing custody suites if fewer people were held in custody under section 136. But it can be reasonably assumed that these custody places could be used to accommodate prisoners when the number of cells in prisons becomes critically low (as part of the 'Operation Safeguard' contingency plan). The average cost of holding someone in a police custody is approximately £400 per person per night, therefore using the same assumption as for the costs of additional health-based places of safety (five year transition during which compliance will linearly increase reaching 100% in the final year, affecting 5580 patients five years after the publication of the revised Code), this amounts to £20 million cost savings.

Summary of monetised benefits (£ millions) over five years assuming linear transition in compliance rates

	Year 1	Year 2	Year 3	Year 4	Year 5	Present Discounted Value
Assumed compliance rate	20%	40%	60%	80%	100%	
Value of Reduced Anxiety	£10.7	£21.0	£31.0	£40.8	£50.2	£153.7
Police cost savings	£1.5	£2.8	£4.1	£5.3	£6.4	£20.1
					Total:	£173.8

6.0 Implementation and next steps

This is a consultation stage impact assessment. During the consultation on the proposed revisions to the Code we are also seeking views and evidence to enable us to more accurately assess and quantify the scale and nature of any impacts, to clarify who the impact will be on and identify any further significant impacts. Two consultation questions are provided to enable stakeholders to feed back.

This consultation stage impact assessment will then be amended and updated to reflect the views and evidence and republished alongside the new Code.

The intention is to lay the Code in Parliament by the end of 2014 in order to give professionals and organisations a minimum of three months in order to ensure that they are compliant from 1 April 2015, when the new Code is proposed to come into force.

7.0 Equality Analysis

Title: Stronger Code: Better Care

Consultation on proposed revisions to the *Code of Practice: Mental Health Act 1983*

This initial consultation stage equality analysis sits alongside the revisions to the *Code of Practice: Mental Health Act 1983* ('the Code'). It forms an important part of our Consultation as one of our key objectives through the revisions proposed is to advance quality and eliminate discrimination and will be updated using evidence collected during the Consultation. We welcome views and evidence to further develop our equality analysis, and ways in which the Code, or supporting materials, can be revised and used to address this.

What are the intended outcomes of this work?

This consultation sets out proposed changes to the Code. The Code was last published in 2008. Since 2008, there have been changes in legislation, policy, case law, and professional practice that need to be reflected in the Code. The review of the Code and its accompanying reference guide (which will be undertaken after the consultation on the Code) will ensure that they are up to date, fit for purpose, and make real differences to the care and treatment of patients suffering from mental disorder. In particular, the revised Code aims to:

- embed policy developments in the areas of use of restraint and seclusion, use of sections 135 and 136 by the police, independent mental health advocates (IMHAs), and the use of Community Treatment Orders (CTOs);
- clarify the interaction between the Mental Health Act 1983 ('the Act') and the Mental Capacity Act 2005 (MCA), particularly the Deprivation of Liberty Safeguards (DoLS);
- reflect changes resulting from the Health and Social Care Acts 2008 and 2012 and the Care Act 2014;
- address relevant recommendations from the Care Quality Commission (CQC)'s annual reports about the use of the Act;
- consider issues raised by the recent Health Select Committee report on the post-legislative scrutiny of the Mental Health Act 2007, Her Majesty's Inspectorate of Constabulary/ CQC report on the use of section 136 and the recent Home Office/Department of Health section 135 and 136 review;
- tackle relevant issues arising from the serious case review into Winterbourne View and subsequent investigations and reports by the CQC; and
- support the delivery of a number of actions in *Closing the Gap: Priorities for essential change in mental health* (2014), including particularly:
 - to promote high quality services focused on recovery;
 - to radically reduce the use of all restrictive interventions and take action to end the use of high risk restraint, including face down restraint;
 - to identify poor quality services sooner and take action to improve care and where necessary, protect patients;
 - to ensure carers are better supported and more closely involved in decisions;
 - to ensure mental health care and physical healthcare are better integrated; and
 - to stamp out discrimination and stigma around mental health.

Of particular importance to this analysis are the objectives to enhance equality and eliminate discrimination.

Who will be affected?

In 2012-13 there were 50,408 detentions under the Act.

Category	Total
Detention under Part 2 (civil)	46,928
Detention under Part 3 (court and prison disposals)	1,788
Holding powers	10,420
Community treatment orders (CTOs)	4,647

The Code is the key source of guidance to professionals in respect of the use of the Act. It is helpful to individuals subject to the Act (e.g. those detained for assessment or treatment, on a CTO or subject to guardianship) or who are otherwise being treated for mental disorder (e.g. informal patients) Act and their families/carers as it explains how the Act should be applied. We know that Approved Mental Health Professionals (AMHPs), responsible clinicians, hospital managers and other health and social care professionals consult it on a daily basis to inform their exercise of powers and duties under the Act and clinical practice. The Code is the key document which professionals use to ensure patients' rights are protected and that their practice is consistent with the law.

The Code is statutory guidance, made under section 118 of the Act, which is addressed to registered medical

practitioners, approved clinicians, managers and staff of hospitals and care homes, AMHPs, and other professions in relation to the medical treatment of patients suffering from mental disorder). As a matter of law, the Code must be followed by those to whom it is addressed unless there are strong reasons for not doing so (*R (Munjaz) v Mersey Care National Health Service Trust* [2005] UKHL 58). If such professionals' use of the Act is legally challenged, the guidance given in the Code will be relevant in determining the challenge. It is useful to other professionals, such as the police and ambulance staff, who need to ensure its safeguards are being applied appropriately.

Evidence

What evidence have you considered?

In preparing the draft Code for consultation we have:

- requested evidence from professionals, providers, commissioners and other stakeholders; u
- consulted CQC and the evidence in their annual reports on the use of the Act, reports by the Health and Social Care Information Centre e.g. National Mental Health Minimum Data Set (NMHMDS) and Hospital Episode Statistics (HES), the recent Learning Disability Census and other publications such as *A Right to be Heard*²⁵ that have considered the operation of parts of the Act;
- held engagement events with professionals and practitioners;
- established an expert reference group of patients and carers with recent or current experience of the Act;
- sought views from specific stakeholders via our steering group and experts by experience, professionals and representative bodies, including the Mental Health Alliance.

Additionally, the University of Birmingham has undertaken a literature and data review for the Department of Health of the impact of in relation to both equalities and human rights. This identified issues related to all the protected characteristics especially age, sex, religion or belief and race and in particular the interplay of characteristics, where things work differently for different people.

The current draft Code includes a new chapter on equalities and human rights and strengthens existing parts of the Code. We have asked questions in the consultation document and are holding a dedicated consultation event (31 July in London) to explore the equalities impact of the changes proposed in the revised Code, and if further changes are needed to advance equality, eliminate discrimination and protect human rights in the use of the Act. We are also holding dedicated engagement with patients and carers, including patients currently detained under the Act.

This analysis is not comprehensive and is our first attempt to quantify the impact of the changes proposed in the Code in order to advance equality and eliminate discrimination, including minimising any potential disadvantages for people with protected characteristics (within the meaning of the Equality Act 2010). The intention is to use the consultation period to collect further information and evidence to enable a more detailed and comprehensive assessment of the implementation of the Act. This includes a dedicated consultation event to explore these issues further to which we particularly welcome individuals with detailed knowledge of these issues. The evidence collected during the consultation will be independently analysed and feed into the final equality analysis, revisions to the draft Code and recommendations for implementation.

This equality analysis supersedes the Race Impact Assessment (RIA) undertaken to support the Mental Health Act 2007 and the Equality Impact Assessment to support preparation of the existing Code published in 2008.²⁶ The evidence indicates that whilst many issues identified by this 2008 analysis were addressed, Actin some areas

²⁵ HSCIC, *Mental Health Bulletin: Annual report from MHMDS returns-England 2012/13* (2013); HSCIC, Learning Disability Census – further analysis (2013), <http://www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf>; University of Central Lancashire, *The Right to be Heard: Review of Independent Mental Health Advocate (IMHA) Services in England* (2012)

²⁶ Mental Health Bill 2006 - Race Equality Impact Assessment (2006) http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_062695; Code of Practice: Mental Health Act 1983 - Equality Impact Assessment (2008) http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087353.pdf

there are still issues with advancing equality and concerns which need to be addressed. This analysis draws heavily on publically available evidence from the reports of the Health and Social Care Information Centre and CQC for 2012/13. This analysis does not therefore reflect any changes which may have resulted from the changes to the health and care system introduced by the Health and Social Care Act 2012 from 1 April 2013.

There are however concerns with the amount and robustness of available data, with greatest amounts of information relating to age, sex and race and to a lesser extent religion and belief. For the other protected characteristics the lack of detail reflects the paucity of information available for this analysis.

Evidence indicates that all the protected characteristics are relevant to a discussion about advancing equality under the Equality Act. It is also important to consider the interplay between different characteristics as what may be most important for one person may be different to another.

Disability

Mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities is a disability for the purposes of the Equality Act. The mental disorder suffered by patients subject to the compulsory provisions of the Act is likely to be a disability under the Equality Act for at least the period in which they are subject to the Act. Patients with a learning disability and/or autism spectrum disorder may also have a disability for Equality Act purposes.

People subject to the Act are disadvantaged in their access to physical health care. CQC highlighted the need for the physical health needs of people subject to the Act to be a priority.²⁷ In 2011/12-2012/14 of the 595 deaths of people subject to the Act, one third were under the age of 60 suggesting a far lower life expectancy for these individuals.

Learning Disability

CQC has also considered the use of the Act in relation to individuals with a learning disability and/or autistic spectrum disorder. We have updated chapter 20 to provide further guidance. Anecdotal evidence suggests that individuals with a learning disability are more likely to be detained, detained for longer, often further from home and may be more likely to be restrained. At Winterbourne View concerns were raised about the lack of proper reviews and people moving automatically from detention to informal admission and it appears that individuals who raised complaints were not listened to.²⁸

The Learning Disability Census has provided more information about individuals with a learning disability subject to the Act. This showed that the primary reason for admission was 'learning disability', relatively low use of Deprivation of Liberty Safeguards (33 of 3250 people) and that a significant proportion (20.3%) of people were subject to greater restrictions on census day than on admission. The numbers detained under Part 3 (criminal proceedings) orders represented a far higher proportion (41.3%) than the overall population subject to the Act.²⁹ This evidence needs to be fully compared with other data about people subject to the Act to determine if additional guidance is required to enhance equality for them.

More generally individuals with a learning disability have significantly lower health outcomes with men with learning disabilities died on average 13 years sooner, and women with learning disabilities 20 years sooner, than those without learning disabilities. 22% of people with learning disabilities were under 50 when they died, compared with 9% of people without learning disabilities.³⁰

Sex

Evidence indicates some differences in relation to detention rates for men and women and in the use of Community Treatment Orders (CTOs) although some of these are also related to different age profiles between different ethnic groups. Men are more likely to spend time in hospital either as an informal patient or subject to the Act and be subject to higher levels of restriction using the HSCIC categorisation of sections of the Act. In particular, men were five times more likely than women to be subject to court and prison disposals (Part 3 patients). This difference accounts for the largest part of difference in figures between men and women. Men were also more likely to spend longer in hospital subject to the Act or as an informal patient.³¹

²⁷ Care Quality Commission, *Monitoring the Mental Health Act in 2012/13* (2014), pp.3-4, 79

²⁸ South Gloucestershire Safeguarding Adults Board, *Winterbourne View Hospital: A Serious Case Review* (2012); Care Quality Commission, *Review of Compliance: Castlebeck Care Ltd.* (2011); *Transforming Care: a national response to Winterbourne View Hospital Department of Health Review: Final Report.* December 2012.

²⁹ HSCIC, *Learning Disability Census – further analysis* (2013), <http://www.hscic.gov.uk/catalogue/PUB14046/ld-census-further-sep13-rep.pdf>, pp. 24-31

³⁰ *Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD)* (2013), <http://www.bris.ac.uk/cipold/reports/fullfinalreport.pdf>

³¹ HSCIC, *Mental Health Bulletin: Annual report from MHMDS returns-England 2012/13* (2013), p.5, 10, 14, 16, 29

Evidence also indicates that many providers are still not consistently providing single sex accommodation and are not always able to accommodate other needs. For example a 2011 study³² found that: The unit is mixed and there were times when the Mental Health Act Commissioner saw female patients on their own with all male staff and patients. There is no gender separation apart from bedrooms. There was no evidence to suggest that women had their individual needs met. There was no evidence that vulnerable women were identified and thought about in the day to day running of the unit. There was no evidence that staff were trained to think about women's issues.' The proposed Code addresses this issue by strengthening guidance about providing single sex sleeping and washing facilities (chapter 8).

Race

The 2008 Equality Impact Assessment and 2006 Race Impact Assessment preceding the Mental Health Act 2007 both identified that certain ethnic and racial groups were more likely to be detained under the Act. Recent evidence supports this and also indicates that individuals from black and minority ethnic (BME) backgrounds, especially Black African, Black Caribbean, Other Black and Other groups being more likely to be in patients, detained, and detained for longer periods. Individuals from BME especially black people also have poorer health outcomes, lower life expectancy, and report lower satisfaction levels from mental health services. However, the reasons for this overrepresentation are complex, with some studies suggesting that figures needing to be adjusted to reflect the age profiles and geographical distribution of different ethnic groups. Black and Black British Ethnic groups were least likely to be put on the Care Programme Approach (CPA) (see Chapter 34) whilst on detention and are significantly over-represented on CTO. CQC estimated that Black or Black British people represented 16.2% of all CTOs in 2012-13.³³

The NMHMDS is currently considering how to monitor the experience of all inpatients, including any association with ethnicity and is likely to provide further evidence.

Age

In contrast to what the 2008 analysis showed recent evidence from the NMHMDS does tend to indicate difference by age group, including between men and women in different age groups. Males aged 18-35 were most likely to be subject to the Act in hospital, whilst 36-64 year olds represent by far the largest age group (59%) on CTOs and the over 65s a very low proportion of those on CTOs. This tends to suggest that age can be important in influencing professionals' decisions about the level of restriction someone should be subjected to. Generally, more men than women are subject to detention under Part 2 of the Act; however, in the 65 and over age group more women than men were detained under Part 2. Less than 80 people under 18 were detained under Part 2; this was evenly split between males and females.³⁴ There were also reported differences in the age profile of patients in NHS trusts and foundation trusts and independent sector providers, with the independent sector tending to have a lower age profile.³⁵

We welcome further views on this evidence, including if anything further is needed in the Code to enhance equality in relation to age, in particular on chapter 19 which provides specific information relevant to children and young people.

Gender reassignment (including transgender)

We have not identified robust evidence indicating disparity in the use of the Act for transgender and transsexual people, although evidence does indicate that individuals in this group are susceptible to high levels of bullying. Some professionals have indicated difficulties in making adjustments to fully support these individuals and we have included some new guidance e.g. on provision of suitable washing and sleeping facilities to support the 'gender of choice' in Chapter 8.

Sexual orientation

The Act specifically states that sexual orientation is not a mental health disorder.

Evidence indicates that gay, lesbian and bi sexual people are more likely than people in other groups to experience mental health problems, although it is not clear how this relates to the number of people subject to the

³² <http://www.dwmh.nhs.uk/wp-content/uploads/2013/06/876-2010-8-25-5649476.pdf>

³³ Care Quality Commission, *Monitoring the Mental Health Act in 2012/13*, pp.20-3; HSCIC, *Mental Health Bulletin: Annual report from MHMDS returns-England 2012/13* (2013), pp. 23-6

³⁴ HSCIC, *Mental Health Bulletin: Annual report from MHMDS returns-England 2012/13* (2013), pp.5, 10, 15-16

³⁵ HSCIC, *Mental Health Bulletin: Annual report from MHMDS returns-England 2012/13* (2013), p.30

Act. Stonewall has also indicated that there is discrimination in the NHS in relation to gay, lesbian and bi sexual people.³⁶ It is also suggested that gay, lesbian and bisexual people are susceptible to high levels of bullying, which might be related to lack of appropriate sleeping and washing facilities (see chapter 8). For gay men being on a male only ward might not be the most appropriate reasonable adjustment.

New Chapter 3 (equality and human rights) emphasises that there should be no discrimination and that providers and commissioners must enhance their compliance with equality and review annually whether they are doing so.

Religion or belief

Whilst the Code seeks to promote equality of religion or belief, e.g. by ensuring that people have access to single sex sleeping accommodation and washing facilities appropriate to their religion (see Chapter 8), some evidence has highlighted examples of practices that prevent patients from fully practising their religion or belief, especially religions other than Christianity. This includes issues beyond appropriate food and access to prayer rooms and washing facilities. It includes where English is not a first language and individuals struggle to communicate fully e.g. older South Asian women.

A study in 2011³⁷ found that MHA commissioners raised concerns on 36 ward visits that suitable provision had not been made for patients' cultural or religious needs. Detaining authorities should pay particular attention to patients' diverse needs, values and circumstances, to meet both the expectations of the Code and their duties under the Equality Act 2010. The following are examples of their concerns in relation to Muslim patients:

'Patient X is not provided with Halal food in accordance with his religion. As a result, he does not eat a lot of the food provided and relies on cereals. He is prepared to cook some of his own meals in the rehab kitchen, however complains that staff are never available to supervise him there (this was confirmed by staff).

Patient Y has been on the unit for eight days and has been without a door [to his room]. He is Muslim and felt that his privacy was invaded and his religious and cultural needs were not respected as a result.

Patient Z raised the issue of the forthcoming festival of Ramadan. Muslim ritual requires that observant patients eat breakfast before sunrise and remain fasting until after sundown. Whilst he was uncertain whether he felt able to fast, due to the stresses of a new medication regime, he was concerned whether a strategy was in place to support the requirements of Ramadan.'

We welcome further evidence on how the use of the Act impacts people with a religion or belief.

Pregnancy and maternity

As the Equality Act 2010 added an additional protected characteristic of pregnancy and maternity, this was not considered in the earlier 2008 equality impact assessment.

There is some evidence that suggests that non-white women, especially black women, are treated very differently to white women when using mental health services, and are 20% more likely to receive a psychosis diagnosis compared to white women (who are likely to be diagnosed with a personality disorder when exhibiting the same symptoms). Evidence also indicates that black women are less likely than white women to display symptoms of postnatal depression and GPs are less likely to recognize any symptoms or signs of a mental health concern.⁶ We particularly welcome your views and evidence to consider this further.

We have included an additional sentence in the guidance to support the provision of appropriate sleeping and washing facilities for mothers and their babies, during and post pregnancy (see Chapter 8).

Carers

The Code strengthens the wording and guidance in relation to support for and involvement in carers, in line with Governmental policy on carers and the provisions in the Care Act 2014.

Anecdotal evidence has indicated that an individual without a known nearest relative or family carer may experience poorer health outcomes and may stay in in-patient care longer, especially individuals who lack

³⁶ British Journal of Psychiatry, *Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. Results from a survey based in England and Wales* James Warner, Imperial College London (2004), 185; pp. 479-485; Care Service Improvement Partnership/ National Institute for Mental Health Excellence, *Mental Disorders, suicide and deliberate self-harm in lesbian gay and bisexual people* (2007); Stonewall, *Being the Gay One* (2007).

³⁷ <http://www.dwmh.nhs.uk/wp-content/uploads/2013/06/876-2010-8-25-5649476.pdf>

capacity. We welcome evidence on this and ways in which the Code, or supporting materials, can be revised and used to address this.

Marital status and civil partnership

Marital status and civil partnership is a protected characteristic; it is relevant for the second and third aspects of the public sector equality duty in section 149 of the Equality Act 2010 (the duty to have due regard to advancing equality of opportunity and fostering good relations). People who are not married or civil partners do not have this characteristic.

The Act does not provide the same eligibility to be a “nearest relative” (the person defined by section 26 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative) to a father who is married or in a civil partnership compared to an unmarried father. Unmarried fathers will only be treated as the child or young person’s “father” for the purpose of section 26 of the Act if they have obtained “parental responsibility”. This may be acquired through a number of routes such as a parental responsibility agreement, subsequent marriage to the mother of the child or young person or by obtaining a residence order. From 1 December 2003, unmarried fathers can acquire parental responsibility for their children born after this date by registering themselves as the father on their child’s birth certificate. The Department of Health is considering reviewing section 26 but, as this would involve amending primary legislation, it is outside the scope of this consultation and revisions to the Code.

The eligibility provisions in the Act are consistent with the Equality Act because people with the protected characteristic, i.e. those who are married or in a civil partnership, are treated more favourably (rather than less favourably) than those who are unmarried and not in a civil partnership.

Other identified groups

CQC has heard anecdotal evidence that in some geographical areas, bed availability or similar systemic pressures may distort the thresholds for detention. This includes concern that some people may be detained because the individual would not agree to an admission to a hospital bed far from their home area. One particular concern is the human right to a ‘right to a family’, especially for people with children. Being placed out of areas restricts their ability to maintain this, and may reduce recovery rates.³⁸

Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#)? Y

How have you engaged stakeholders in gathering evidence or testing the evidence available?

We have engaged a range of stakeholders in gathering and testing the evidence. This included:

- working with the University of Birmingham to undertake a literature review and analysis of publically available data e.g. in the NMHMDS and CQC’s annual reports into the use of the Act.
- employing Inclusion North CIC, a not for profit organisation that supports inclusion, to lead a partnership of former patients, carers and support and advocacy organisations, to consider levels of awareness of the Code and to review existing materials on the Act and Code that are made available to patients and their families and carers in order to identify gaps, areas for improvement and developing an Action plan to increase awareness and understanding of the Code and safeguards under the Act, Individuals and groups for whom existing information is inadequate will be prioritised.
- seeking views from patients, recent patients, their carers and families on their experiences of the Act, in particular via our expert reference group which has met on six occasions and by employing a carer and recent patient to comment on the proposed changes to the Code. This included individuals covering the full range of protected characteristics.
- seeking views and evidence from professionals working in health and social care and support and advocacy organisations.
- drafting a new chapter 3 on ‘Equality and human rights’ which is included in the Code for consultation and making amendments to other chapters within the Code. These chapters were reviewed during meetings and via email by members of our expert reference group, steering group of professionals and the Mental Health Systems Board.

³⁸ CQC, *Use of the Mental health Act 2012/13*, pp.13-15

- We are using the consultation exercise to gather further evidence and to test our findings and recommendations further.

How have you engaged stakeholders in testing the policy or programme proposals?

We have Actively collaborated with a range of stakeholders. This has included a number of stakeholders, including service users and carers, contributing to and leading on the drafting and development of policy in key areas of the Code.

We convened an Active expert reference group consisting of individuals currently detained, recently detained or carers of individuals currently or recently detained. We held a monthly steering group, which also provided detailed comments by email, of professionals from across the health and social care system, including professionals, providers, commissioners, local authorities, and support and advocacy organisations. The steering group included professionals with expert knowledge in, and experience of, the Act as it applied to children and young people and the interface with the Mental Capacity Act 2005.

Individual policy and chapter leads took forward specific engagement and testing with relevant stakeholders. This individuals and organisations with experience of how the Act applied to children and young people, individuals with legal expertise including Counsel on certain chapters, section 12 doctors, the criminal justice system and police holding powers and places of safety.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Engagement activity includes:

- September 2013 onwards – monthly Steering Group including range of professional groups, providers, commissioners, local authorities and support and advocacy organisations
- September-October 2013– recruitment of patients and carers to be part of expert reference group – national appeal for representatives to be on the group. 9 patients/former patients and 6 carers were selected from over 60 applications.
- October-November 2014 – call for evidence –range of individuals and organisations suggesting changes to the Act.
- 4 November and 3 December 2013 - pre-consultation engagement events with professionals – over 60 professionals from across health and social care sectors, including AMHPs, responsible clinicians, section 12 doctors, Mental Health Act commissioners, service commissioners, providers, legal and academic specialists
- November 2013 onwards – six meetings of expert reference group of patients and carers, including meeting directly with the Minister for Care and Support
- Attendance at briefing and engagement meetings with range of stakeholders, including Mental Health Alliance, CQC Service User Reference Panel and College of Social Work AMHP network
- Exchanges (by email, by telephone and in person) with range of stakeholders on whole Code or specific chapters
- Arrangement for seven consultation events and further engagement activity with stakeholders during the consultation including patients currently detained under the Act

The key outputs are:

- The draft Code of Practice being consulted on
- The consultation document *Stronger Code: Better Care* and questions for the consultation, including an online version of the form
- The impact assessment and draft equality analysis
- The easy read consultation document
- It is also intended to update the Reference Guide and other supporting materials when the Code is finalised to further improve awareness and understanding of the Act, the Code and the safeguards they provide, including what to do if these are not being followed.

Summary of Analysis

Equality and human rights considerations are considered throughout the Code to address concerns and potential concerns. Individual chapters explain relevant human rights and equality issues and give good practice guidance. The 2008 Code already included a number of chapters and sections providing additional and specific guidance in relation to individuals with a number of the protected characteristics: children and young people, learning disabilities and/or autistic spectrum conditions and people who are deaf. The intention of these chapters and

sections in the 2008 Code was to ensure that people with these protected characteristics are not disadvantaged and that professionals had additional information in order to support them, including what might be considered an appropriate reasonable adjustment. In the draft Code being consulted upon, we have strengthened these chapters in a number of ways and addressed some of the concerns and issues raised by stakeholders. The consultation document includes a number of questions focused on supporting individuals due to age or disability.

Changes includes:

- Five new 'Guiding Principles' which promote equality, especially 'Respect and Dignity' and 'Empowerment and Participation'
- The children and young people's chapter (chapter 19) has been significantly rewritten to provide additional guidance.
- Additional guidance has also been provided in relation to individuals with a learning disability or autistic spectrum disorder
- providing IMHAs for those who lack capacity to understand what they are and how they can support them
- strengthened guidance in relation to the provision of single sex and age appropriate accommodation.
- that patients should have access to the internet whilst in hospital and seeks to promote maintain relationships with family, friends and their local community. This should help patients maintain support and have access to greater information than they might otherwise be able to access.
- Greater clarity on the relationship between the Act and Mental Capacity Act 2005, such that individuals lacking capacity are not detained inappropriately, when a less restrictive option may be possible.

New chapter on 'Equality and human rights'

The new draft Code being consulted upon includes a new chapter on 'Equality and human rights' (chapter 3). Stakeholders indicated that they would appreciate greater clarity on the applicable legislation and the evidence tentatively supported that some stakeholders found this confusing, especially how these related to detained and Part 3 patients. This chapter builds on information provided elsewhere in the Code to:

- highlight specific areas where service delivery and professional practice in relation to the Act can protect human rights, eliminate discrimination and advance equality;
- indicate examples of positive practice to enable commissioners of services, providers and professionals to discharge their responsibilities in accordance with human rights and equalities legislation, and for NHS commissioners the duty to have regard to reducing health inequalities; and
- includes provision of an 'Equality and human rights policy' which all commissioners and providers must have to monitor compliance with human rights and equality legislation and which must be reviewed at Board level at least annually.

These additional requirements aim to ensure that all commissioners and providers understand fully what is required of them in relation to equality and human rights legislation and that Boards are accountable for reviewing implementation and addressing any concerns or issues that may arise. We believe that this will prove a significant driver in advancing equality, eliminating direct and indirect discrimination, tackling prejudice and promoting greater understanding about mental illness. In particular, applying a human rights and equality-based approach in the care and treatment commissioned from and provided by health and social care services to people with mental health problems will contribute to greater equality in people's access to treatment and their outcomes. In some instances, there will be consideration of competing human rights, which may require finely balanced judgments. Such decisions and the reasons for them should be clearly documented. We welcome your views on additional information and guidance that may be helpful to support this.

Accessibility project

In addition, the Department of Health in conjunction with Inclusion North and other partners has scoped an 'accessibility project' that is intended to be tendered and will be taken forward over the course of 2014/15. This aims to address concerns about the awareness of patients and carers of the Code and Act, particularly patients who lack capacity, do not speak English, have a learning disability, autism, are deaf or a physical disability, or communication difficulties such as a speech impediment. Indications were that many patients, their families and carers were unaware of the Code, the safeguards of the Act, how to be involved in discussion about care and treatment and how to seek redress if the relevant safeguards were not being appropriately applied. A major way we decided to promote equality was to increase awareness, understanding and appreciation of the Code to patients, their families and carers, but also to non-mental health professionals including GPs, social care staff and advocacy services that patients could be better supported whilst subject to the Act and could raise any concerns they have, thereby ensuring commissioners and providers are held to account.

The accessibility project includes:

- writing the Code in plainer English, improving cross referencing, structuring it around the patient journey and colour coding it so that it is easier to navigate and identify relevant information and in particular highlighting that information most relevant to patients, their families and carers;
- producing supporting material in alternative formats (e.g. shorter pamphlets on key issues, producing video clips and stories of key episodes so that individuals can better understand what will happen at significant points e.g. at admission or at the Tribunal, including where possible when they are well and enabling materials in alternative languages/pictures). This was considered key as some people especially when unwell reported finding it difficult to understand in writing what support they could get. The intention is to produce these in both hardcopy and electronic formats; and
- promoting awareness of the Code to patients, prospective patients, families, carers, voluntary and community organisations and a range of health and social care professionals so they know that it and the supporting materials exist and how to access it as required.

The consultation document includes a consultation question in this regard, to gain further information and views to support this work.

Specific human rights and equality issues

We have identified a number of issues where we think there is the potential to further advance equality and eliminate discrimination by amending the Code, but in respect of which we require further evidence of the scope of the equality impact and ideas about how this can be minimised. During the consultation period, we particularly welcome your views on these issues and other examples of potential equality concerns, including examples and case studies of when these have occurred, how widespread they are and ways of addressing/preventing them from occurring. For each of these six areas in particular we welcome evidence on how often this happens and for comments. Please provide answers on these topics to the relevant questions in the consultation document.

a) Appropriate sleeping and washing accommodation

Evidence from CQC indicates that many providers are still not consistently providing single sex accommodation and are not always able to accommodate other needs. Of particular importance to patients is the provision of sex specific accommodation for disabled persons, including separate washing and sleeping facilities, recognising that women are at risk of sexual and physical abuse and may have prior experience of this, such that admission to hospital in a mixed gender environment can lead to traumatisation. The provision of single sex sleeping accommodation may also be required: on the basis of cultural traditions and for patients who are transgendered. There also needs to be specific provision for mothers and babies to be accommodated appropriately and for children and young people under the age of 18. Chapter 8 includes guidance to support the advancement of equality in this area.

b) Communicating in a patient's first language

A failure to provide information and a means of communication in the person's first language may mean they are unable to meaningfully participate in decisions about their care and treatment. This includes a person who uses British Sign Language as their first language who may need an interpreter to understand what is happening to them and what rights they have.

The Code already includes information about the need to ensure that such patients were provided with an interpreter and could communicate in their first language) but evidence suggests that this does not always happen.

c) Ensuring services taken account of cultural, ethnic and religious diversity

This can include:

- access to specialist services such as Improving Access to Psychological Therapies (IAPT) example here e.g. inaccessibility of psychological therapies for certain groups based on barriers such as language and failure to take account of cultural diversity and needs of different faiths
- if the membership of the Tribunal does not reflect the local population it serves, patients may believe their diversity is not being accounted for by the decision made by the Tribunal.
- placing individuals requiring specialist services, e.g. individuals with a learning disability or children, far from home. This can reduce contact with family and friends, increase length of stay and delay

recovery.

Any evidence to point to this is very limited evidence. We welcome thoughts including research or case studies to develop this further and views on whether the Code should be amended.

d) Ensuring interpretation services are skills in medical or health interpretation

It is critically important that appropriate interpretation services or other kinds of advocacy/assistance are readily accessible to patients subject to the Act, including for those who lack capacity, for whom English is not their first language or those who have difficulty communicating for other reasons. Interpreters need to be skilled and experienced in medical or health related interpreting. The use of family members, particularly children under the age of 16, is not good practice and should be avoided (paragraph 4.5 of revised Code).

Stakeholder feedback indicated that there are often difficulties in securing these services and that this can have a significant impact on decisions about care and treatment, including detention, discharge and the use of CTOs.

e) Preventing unfavourable treatment for individuals from BME communities, including unconscious bias

It is reported that people from black and minority ethnic communities, particularly men of African, Caribbean or mixed heritage, may receive less favourable care, support and treatment than patients from other ethnic backgrounds. The consequences of this can be far reaching and appear to influence both the length of detention and the use of restraint and/or restraint.

f) Preventing harassment, bullying and abuse

In-patients with protected characteristics may be vulnerable to harassment, bullying or abuse from other patients, for example homophobic bullying, racist comments or sexual harassment. Evidence indicates that some providers have been unable to ensure a culture of zero tolerance and/or do not have clear policies in place to prevent and manage such behaviour. It has been suggested that this may be a particular issue for individuals who are gay, lesbian, bi-sexual or transgendered and/or who are Muslim. We welcome evidence of both good and poor practice and how these issues can be successfully tackled.

Eliminate discrimination, harassment and victimisation

People with mental health problems can be particularly vulnerable to abuse of their human rights and discrimination in the allocation of resources, service provision and professional practice. People with mental health problems who have one or more protected characteristics under the Equality Act 2010 may experience direct or indirect discrimination in the way that services are provided to them or the benefits they receive from services.

One of the major objectives of the revisions to the Code is to enhance equality and eliminate discrimination, harassment and victimisation. Evidence indicates that in-patients with protected characteristics may be vulnerable to harassment, bullying or abuse from other patients, for example homophobic bullying, racist comments or sexual harassment. The Code sets out that providers and commissioners should have in place an 'Equality and human rights' policy which should set out how they will comply with legislation and address any concerns raised. This policy is to be reviewed at least annually at Board level or equivalent.

The Act authorises the use of compulsory powers to detain a person and treat them without their consent, if the person meets certain criteria in the Act including suffering from mental disorder. However, the use of such powers is legally authorised under the Act if the criteria are met, and it is therefore not unlawful discrimination under the Equality Act on the basis of a person's disability.

Advance equality of opportunity

The revisions to the proposed Code aim to significantly advance equality, in the following ways:

in terms of removing/minimising disadvantage suffered by a person with protected characteristic:

- includes a new chapter on 'Equality and human rights', which highlights compliance with the Equality Act 2010, including the public sector equality duty; and
- includes a new guiding principle "Efficiency and equity", which will provide that "the quality of commissioning and provision of mental health care services should be equivalent to physical health and social care services;

In terms of taking steps to meet needs of a person with protected characteristic that are different:

- strengthens requirements for hospitals to facilitate access to IMHAs whose services can increase equality of opportunity for patients subject to the Act, to enable them to better understand the Act, put forward their views and challenge decisions made about them;
- includes new or updated chapters that encourage providers and commissioners to take steps to meet the needs of patient groups with particular characteristics (e.g. children and young people and people with a learning disability); and
- strengthens requirements to ensure patients are given information about the Code and the Act in a language and format they can understand. The wider accessibility project (see above) will increase awareness and understanding of the safeguards in the Act; Chapter 3 includes examples of a range of reason adjustments.

in terms of encouraging persons with a protected characteristic to participate in public life:

- the proposed changes to the Code do not directly do this, however, the wider work to involve patients and carers in the project to develop the Code has done this and the changes to the Code (especially chapter 4) should increase the involvement of patients and carers in decisions about care and treatment and promote recovery should support this.

Promote good relations between groups

The changes to the Code, and accompanying steps to promote awareness and understanding of it, should improve the relationship between patients, carers, other supporters and professionals across the health and social care system. This should enable improved care and treatment, reduced in-patient stays and promote recovery.

The new 'Guiding Principles' especially Empowerment and Participation' promote the involvement of family and carers and 'Purpose and Effectiveness' encourages a joined up and holistic approach to care with patients, commissioners, professions and providers all working together.

The proposed changes will also strengthen requirements to involve carers, family members and advocates in the patient's treatment and care. This should improve relationships between these groups and professionals.

What is the overall impact?

The overall impact of the proposed changes to the Code will be to increase awareness and understanding of the Act and safeguards provided by the Act and Code. This will advance equality and eliminate discrimination – which is a major objective in the revisions that have been proposed – particularly in respect of advancing equality between individuals with mental disorder (of a nature that is a disability under the Equality Act) and those who do not.

In respect of parity of access to, and outcomes of physical health care and mental health care, the revisions will reduce discrimination and advance equality. The new guiding principle "Efficiency and equity", provides that 'the quality of commissioning and provision of mental health care services should be equivalent to physical health and social care services. A range of professionals, including commissioners, mental health professionals, general practitioners and other professionals having a key role in ensuring that this is a reality.'. Paragraph 1.3 also provides that: 'Commissioners and providers, including their staff, should give equal priority to mental health as they do to physical health conditions.' Revisions which require patients to be involved in discussing and making decisions about their care and treatment will mean they should have reduced lengths of stay in hospital, a reduced 'revolving door', better health outcomes and improved recovery.

In respect of minimising disadvantages faced by detained patients, revisions also respond to concerns consistently raised by patients about restrictions placed on patients' freedom and contact with family, particularly: privacy, access to the internet and the inappropriate use of blanket restrictions, especially locked door policies.

We aim to further test these assertions during the consultation exercise and will publish a revised equality analysis alongside the new Code later in 2014.

Addressing the impact on equalities

To address the impact of the proposed changes in the Code on equalities we have:

- included specific guidance in the draft Code for consultation, including a new 'Equality and human rights' chapter. This chapter requires all providers and commissioners to have in place an 'Equalities and human rights policy' and to monitor their compliance against the applicable human rights, equality and health inequalities legislation;
- strengthened and clarified the Code to address the impact of the use of the Act and the proposed

- changes in the Code equalities for certain individuals and groups;
- included a question in the consultation exercise to gather further evidence, including of good practice and organised a specific event to discuss these issues and may include further guidance within the Code and/or update this equality analysis or take forward further initiatives;
- worked and will continue to work with key partner organisations that have expertise in equality issues, including in relation to the Act and who can feedback views of patients and carers; and
- started an accessibility project to increase awareness and understanding of the Code, including the formats in which information from the Code is available

Action planning for improvement

To support further improvement we will:

- analyse the additional evidence collected during the Consultation, including using an independent organisation to review this, and publish a fuller equality analysis alongside the revised Code by the end of 2014;
- promote awareness and improve access to information about the Code by a full range of stakeholders by April 2015, when it is proposed the new Code comes into force; and
- continue annually to monitor outcomes for patients via the NMHMDS, and monitor compliance with the Act and Code via CQC inspections and annual reports.

Please give an outline of your next steps based on the challenges and opportunities you have identified.

The immediate next step is to gain further evidence and stakeholder views as part of the consultation, in particular the event on 31 July 2014.

For the record

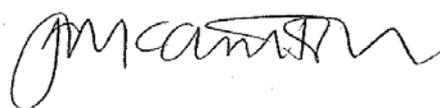
Name of person who carried out this assessment:

Dr Nicola Guy

Date assessment completed:

3/7/14

Name of responsible Director:



Sarah McClinton

Date assessment was signed:

04/07/2014