Title: Reforming the Mental Health Act **IA No:** 9562 **RPC Reference No:** N/A **Lead department or agency:** Department of Health & Social Care **Other departments or agencies:** Ministry of Justice	**Impact Assessment (IA)** **Date:** 16 December 2020 **Stage:** Development/Options **Source of intervention:** Domestic **Type of measure:** Other **Contact for enquiries:** via White Paper consultation Question 35; MHAconsultation2021@dhsc.gov.uk

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option (in 2020 prices)			
Total Net Present Social Value	**Business Net Present Value**	**Net cost to business per year**	**Business Impact Target Status**
-£1,988m (not including unquantified benefits)	–	–	Non Qualifying provision

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

The Mental Health Act 1983 (MHA) provides a legal framework to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves or others. The Independent Review of the MHA published in December 2018 proposed a number of recommendations to reduce the number of detentions, to improve the patient's say over their care and treatment, and strengthen safeguards. The Review also highlighted profound inequalities that exist for people from ethnic minority groups in terms of access to treatment, experience of care and quality of outcomes. The Government response in the White Paper analysed in this IA are states that it accepts and will take forward, the vast majority of the recommendations for change.

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

The main policy objectives of the Government response in the White Paper analysed in this IA are:

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

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

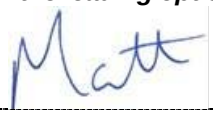
Option 1: Business As Usual (BAU) with no changes to the MHA. Note that improvements in mental health community care and crisis care, planned under the NHS Long Term Plan, are included in BAU and we estimate that this could lead to a decrease in detentions worth around £300m over a 10 year period.
Option 2: This option includes the recommendations by the Independent Review that have been accepted either fully or in principle in the White Paper. The IA's main focus is on those regarding improvement of safeguards both in the Health and Social Care system and in the Justice system.

Option 2 is the preferred option.

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

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

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

Signed by the responsible Minister:  Date: 16/12/2020

Summary: Analysis & Evidence

Policy Option 1

Description: Business as usual

FULL ECONOMIC ASSESSMENT

Price Base Year 20/21	PV Base Year 20/21	Time Period Years 13	Net Benefit (Present Value (PV)) (£m)		
			Low:	**High:**	**Best Estimate:**

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

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

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

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

N/A

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

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

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

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

N/A

Key assumptions/sensitivities/risks	Discount rate	N/A

N/A

BUSINESS ASSESSMENT (Option 1)

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

Summary: Analysis & Evidence

Policy Option 2

Description: Implementation of the accepted recommendations

FULL ECONOMIC ASSESSMENT

Price Base Year 20/21	PV Base Year 20/21	Time Period Years 13	Net Benefit (Present Value (PV)) (£m)		
			Low:	High:	Best Estimate: -1,988m (not including unquantified benefits)

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low			£93m	**£932m**
High			£441m	**£4,405m**
Best Estimate			£199m	**£1,988m**

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

Costs of improving safeguards for all those detained under the MHA:

- in the Health and Social Care system – costs of additional workforce requirements for Independent Mental Health Advocates (IMHAs), Approved Mental Health Professionals (AMHPs), Second Opinion Appointed Doctors (SOADs), and clinical teams; Total cost: £1,862m (94% of £1,988m)
- in the Justice system – costs of changes in Mental Health Tribunal (MHT) activity (including Legal Aid). Total cost: £125m (6% of £1,988m)

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

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

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

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

No benefits have been monetised in this IA. We use a breakeven analysis to illustrate the amount of benefits per patient required to offset the costs of the policy.

Three potential benefits we have measured are a reduction in the average length of stay per patient, a reduction in the number of repeat detentions and also direct health benefits resulting from improved treatments. We estimate that it would take either a reduction of 2 days in the average length of a detention, a reduction from 15.5% to 12.7% in the number of people facing repeat detentions or a QALY increase of 0.04 for each detainee each year for the costs of this policy to be offset by these savings. Alternatively, some combination of all three measures could also offset the costs.

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

The key non-monetised benefits pertain to the improved health outcomes experienced by patients under the improved safeguards following from the recommendations of the Review, potential reduction in length of detentions, and wider economic benefits such as increased participation in the labour market.

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

The key overall assumption concerns the rate at which detentions under the MHA and Community Treatment Orders (CTOs) will change throughout the policy period. Both of these forecasts have been sensitised to best and worst case scenarios. Key assumptions have also been identified in each of the cost models and sensitised to approximate low and high estimates of the additional costs of the policy option.

BUSINESS ASSESSMENT (Option 2)

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

Evidence Base

Problem under consideration

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

2. The current MHA is considered out of step with a modern-day mental health service and in significant need of reform to make it work better for everyone. Following the publication of the Independent Review of the MHA[2], the Government response in the form of a White Paper sets out proposals to amend the MHA and these proposals are analysed in this Impact Assessment (IA).

3. The Independent Review of the MHA was commissioned by the Government and the Review's findings were published in December 2018[3], where they stated that:

> *"There is a clear case for change: the rate of detention is rising; the patient's voice is lost within processes that are out-of-date and can be uncaring; there is unacceptable overrepresentation of people from black and minority ethnic groups amongst people detained; and people with learning disabilities and or autism are at a particular disadvantage. We are also concerned that we are out-of-step with our human rights obligations."* (p.45)

4. The Independent Review made 154 recommendations on areas including but not limited to:

    - Supporting patient voice and autonomy by giving them greater say and control over decisions concerning their care and treatment – for example, through the introduction of Advance Choice Documents, in which the individual can set out their care and treatment preferences and the medical treatments they wish to refuse, and enabling the patient to a choose a 'nominated person' to help represent their needs and wishes, instead of the 'nearest relative' role;
    - Improvements and investment in in-patient physical and social environments so they are more therapeutic for the individual;
    - Increasing the patient's access to, and expanding the duties of the Mental Health Tribunal (MHT);
    - Requiring that all patients have a statutory Care and Treatment Plan, ensuring that discharge planning begins at the point of detention and improving patient after-care post discharge;
    - Reducing the number of and length of detentions and Community Treatment Orders (CTOs)[4];
    - Reducing racial disparity in detentions and CTOs by introducing an organisational competency framework, which has at its core service user and carer accountability measures;

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

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

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

[4] Community Treatment Orders (CTOs) are a form of supervised community treatment for people who have been detained under section 3 of the MHA (that is, when the detention is used specifically to treat a patient, and the appropriate treatment must be available when the order is made).

- Ensuring the least restrictive approach is the default option when considering whether someone should be detained under the MHA.

5. One of the key issues raised by the Independent Review is the overall increase in detentions in recent years. Between 2006[5] and 2016[6] the number of detentions rose over a third – due to improvements in the data collection, this increase should partially reflect a rise but it also includes some double counting of detentions when hospital transfers took place. Data from the last four years suggest that this trend may be changing, with estimated annual increases of around 2% or lower[7]. The Review considers that improvements in community mental health services and crisis care services could have a substantial contribution in tackling this increase. These improvements are planned under the NHS Long Term Plan (LTP) and are expected to cover England by 2023/24[8].

6. The White Paper is focussing on the other areas for improvement, and this IA focusses on analysing costs and benefits associated with improving safeguards in both the Health and Social Care system and in the Justice system.

7. The current MHA applies to both England and Wales. However, health policy is devolved to Wales, whereas Justice policy is reserved. The Government response to the recommendations for health policy cover England, and the same applies to the Justice policy recommendations – the response to the recommendations in the White Paper only refer to the Mental Health Tribunal in England and not the Mental Health Review Tribunal for Wales (MHRTW)[9]. The Welsh Government and other partners are considering their position, and whether they agree it is feasible and desirable to take a similar approach to that set out in the White Paper, in Wales.

Rationale for intervention

8. The Independent Review consulted widely with service users and carers and their main findings indicated that the experience of patients detained under the MHA is poor – for example, patients are not sufficiently informed or involved in decisions concerning their care, they are not treated with dignity and respect, they can be subject to coercive mistreatment (e.g. limiting use of access to leave, or contact with families, to achieve compliance), they experience a lack of privacy, difficulty in maintaining social networks, delays in accessing care, particularly for those under the criminal justice system, and harassment and abuse on inpatient wards.

9. The Care Quality Commission (CQC) is responsible for monitoring the uses of the MHA, and their 2018/19 annual report[10] shows that while improvements have been made in the areas of patient choice and participation they measured, there is still work to be done to improve patient involvement – e.g. nearly 20% of care plans do not demonstrate patient involvement in care planning. Regarding other policies such as advance choice making, in 2018/19, the CQC also checked whether services have the mechanisms in place to store and check for advance decision documentation.Their findings are reassuring as 68% records checked showed services had good mechanisms in place, whilst 22% of records checked showed that there were no such mechanisms in place.

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[5] NHS Digital (14 October 2009). Inpatients Formally Detained in Hospitals Under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment - 1998-1999 to 2008-2009. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment-1998-1999-to-2008-2009

[6] NHS Digital (30 November 2016). Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment 2015/16, Annual Figures. Accessed at: https://webarchive.nationalarchives.gov.uk/20180328135613/http://digital.nhs.uk/catalogue/PUB22571

[7] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures

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

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

[10] Care Quality Commission (2020). Monitoring the Mental Health Act in 2018/19. Accessed at: https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201819

10. In terms of benefits, if the Independent Review recommendations are implemented, the Review expects that *"patients and service users should experience improved choice, less coercion and restriction of their liberties, care that is more consistently respectful, and meets their individual needs"* (p. 228)[11]. That is, patients would be more likely to feel more engaged with their care and, within the context of compulsory treatment, feel that they have a voice regarding treatment decisions. These outcomes are difficult to monetise but evidence indicates that they are highly valued by patients, improving health outcomes and quality of life, and that they are associated with the delivery of more appropriate and cost effective services, including reducing length of stay[12,13].

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

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

Policy objective

12. Following the publication of the Independent Review, the Government response in the form of a White Paper sets out proposals to amend the MHA, and accepts the vast majority of the recommendations made by the Review. Much of the White Paper concerns matters to do with improving detention, treatment and discharge, with a consideration of the wishes and preferences of the individual at every stage in the process. These proposals are informed by the principles guiding the Review:

    - **Choice and autonomy** – ensuring service users' views and choices are respected
    - **Least restriction** – ensuring the Act's powers are used in the least restrictive way
    - **Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged from the Act
    - **The person as an Individual** – ensuring patients are viewed and treated as rounded individuals

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

13. The key policy objectives for intervention and accepting the Independent Review's recommendations are to:

    - Modernise the MHA so people subject to it receive better care before, during and after their experience with the treatment initiated by the Act;
    - Allow patients more say over the care and treatment they receive by placing them at the centre of the decision-making processes, empowering them to share their wishes and preferences and requiring that there is a clear record where a patient's choice has not been followed;
    - Reduce racial disparities under the Act and promote equality by improving the ways in which patients access and experience treatment;
    - Ensure patients are treated with dignity and respect, and that treatment is tailored to their individual needs;
    - Allow patients greater access to the MHT, so detentions under the Act can be reviewed more frequently and so that patients can appeal decisions about their detention or treatment.

14. This White Paper sets out the Government's proposals for a substantive programme of legislative reform that will give people greater control over their treatment, ensure that patients are treated with the dignity and respect they deserve, and that the experience and outcomes of patients are improved. The White Paper's intention is that the reforms to the MHA will contribute to tackling the disproportionate number of people from black and minority ethnicities detained under the MHA.

Description of policy options

Option 1: Business As Usual

15. The Business As Usual option (BAU) assumes that there are no changes to the MHA and that none of the recommendations set out in the Independent Review are implemented. This is the counterfactual used in this Impact Assessment (IA), which reflects the status-quo considering only current national policies. Therefore, there are no additional costs and benefits to the baseline associated with the BAU option.

16. The NHS Long Term Plan[14] (LTP) presents plans for improvements in mental health community care and crisis care, which should lead to a decrease in detentions (see Annex B, paragraphs 10-14). These policies are planned to be implemented independently of the White Paper and the effects are therefore considered under the BAU. A decrease in detentions is one of the key expectations from the Independent Review recommendations and would have been considered under a policy option instead of under BAU if no improvements in care were planned in the LTP. This decrease in detentions is estimated to be worth £300m over a 10 year period which could have been attributed to the White Paper recommendations in the absence of the planned Long Term Plan improvements (see Annex A for further detail).

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

17. The Government accepts and intends to take forward the vast majority of the recommendations in its response to the Independent Review of the MHA, and the implementation of national policy changes associated with those recommendations are considered under Option 2 of this IA.would,. The main changes proposed in the White Paper and how they align with the Review's principles and the key policy objectives are summarised in table 1 below.

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

Table 1. Summary of key changes proposed in the White Paper

	Principles	Policy objectives				
		Modernise	Choice	Disparities	Dignity	Tribunal
Strengthening the patient voice in treatment choices and the right to refuse						
Advance Choice Documents (ACDs) Enabling people to set out in advance the care and treatment they would prefer, and treatments they wish to refuse, which will be followed when detained and lacking capacity, unless the Act specifies otherwise, ensuring they continue to have a voice.	Choice	yes	yes	yes	yes	
Care and Treatment Plans (CTPs) There will be a duty on the Responsible Clinician (RC) to formulate a detailed care and treatment plan for each individual. The White Paper proposes that this must be in place as soon as reasonably practicable (proposed at 7 days and reviewed within 14 days). That plan should govern everything up to and including leave and discharge. A key component of the plan should be the wishes and preferences of the patient, which should be considered and, if not followed, a record made of the reason why not. Care and Treatment Plans are current best practice for some providers, but the White Paper formalises them.	Choice Least restriction	yes	yes	yes	yes	
The right to an early challenge to compulsory treatment At present after 3 months a patient may have the benefit of a Second Opinion Appointed Doctor (SOAD) who must certify the treatment 3 months after it began.where the patient is refusing treatment or lacking capacity to consent. The White Paper proposes earlier access to a SOAD at 2 months or at day 14, at the request of the patient or their representative, when the CTP is finalised.	Choice Least restriction Therap. benefit		yes		yes	
Rights to challenge detentions in tribunal Patients will have increased access to the MHT and the White Paper proposes that patients should be able to appeal to the tribunal regarding treatment decisions. At the same time, there will be improvements to the system by, for example, requiring the clinical team to confirm they believe the patient still meets the detention criteria 10 days in advance of a hearing.	Choice Least restriction Therap. benefit		yes			yes
New detention criteria						
The White Paper proposes to revise the detention criteria so that individuals will only be detained if there is a substantial likelihood of significant harm to themselves or others, and the purpose of detention is to deliver a therapeutic benefit to the individual. The new criteria intends to revise the criteria for detention, which should apply not only to admissions under section 2 (admission for assessment and treatment) and 3 (admission for treatment), but also CTOs and decisions regarding renewal of detention and applications for discharge. Furthermore, it should cover the decision on starting a detention and, for example, when deciding on transfers from section 2 to section 3 and when reviewing the detention/applications for discharge.	Least restriction Therap. benefit	yes				

	Principles	Policy objectives				
		Modernise	Principles	Modernise	Principles	Modernise
Improving the support for people who are detained						
Nominated Person 'Nearest relative' - is a legal term used in the MHA and has various powers. For example, the nearest relative can ask for an MHA assessment and can apply to discharge somebody from the Act. The White Paper proposes that the patient should be able to choose their own "nominated person". A new right to choose a 'Nominated Person' will mean patients will be able to name the person who is best placed to look after their interests under the Act, for example by applying to the Tribunal on the patient's behalf when they lack capacity.	Choice	yes	yes	yes	yes	
Right to Advocacy Advocates support people who are detained so that they understand their rights and can exercise them appropriately. The right to an advocate will be extended to people who are informally admitted. The White Paper also proposes expanding the advocacy role will cover additional safeguards (e.g. care planning). Additionally, the right to an advocate will be extended to people who are informally admitted.	Person	yes	yes	yes	yes	
Community Treatment Orders						
The government is consulting on whether the criteria for subjecting an individual to a CTO should be revised. The Government also seeks to ensure that CTOs are scrutinised more regularly and that patients are supported to exercise their rights, for example CTOs should be tightened and both community and inpatient clinicians should be required to agree a CTO is necessary. Safeguards could also improve, particularly with greater access to Independent Mental Health Advocates, Approved Mental Health Professionals and via the Nominated Person.	Least restriction Therap. benefit	yes		yes		yes
Caring for patients in the Criminal Justice System						
Part III of the MHA relates specifically to offenders, or those involved in criminal proceedings. The White Paper supports the Independent Review's objective to ensure that Part III patients are able to access the care and treatment at the earliest and quickest opportunity, that decisions made over their care are timely and that patients are able to access sufficient information about their rights, and that they receive the necessary support. The Government is consulting on how this will best be done in respect of transfers from prison to hospital.	Choice Least restriction Therap. Benefit Person	yes			yes	

	Principles	Policy objectives				
		Modernise	Principles	Modernise	Principles	Modernise
People from Black, Asian and Minority Ethnic (BAME) Backgrounds						
The White Paper supports the introduction of a new Race Equality Framework - the Patient and Carer Race Equality Framework (PCREF). It will identify core competencies for culturally-aware services and opportunities to advance them by engaging with BAME communities. To address the evidence gap, as identified by the Independent Review, the National Institute for Health Research launched an open call in December 2019 for research on prevalence, interventions and outcomes for BAME people. Developing culturally-appropriate advocacy for people of all ethnic backgrounds and communities, in particular for black African and Caribbean people, will be a major priority in our plans to deliver higher quality services that respond appropriately to the diverse needs of individuals from ethnic minority communities. The Government has already announced funding to pilot culturally appropriate advocacy services.	Persons		yes	yes	yes	

Legend:

Principles: **Choice** – Choice and autonomy; **Least Restriction**; **Therap. Benefit – Therapeutic benefit**; **Individual** – The person as an Individual

Policy objectives: **Modernise** – Modernise the MHA so people subject to it receive better care; **Choice** – Allow patients more choice in the treatment they receive;

Disparities – Reduce racial disparities under the MHA and promote equality; **Dignity** – Ensure patients are treated with dignity and respect, and tailored to individual's needs; **Access** – Allow patients more access to the MHT

Cost Benefit Analysis

18. We have developed a number of models to estimate the various impacts on the Health and Social Care system and on the Justice system. We present their assumptions throughout the following section and, where necessary, have highlighted the level of uncertainty involved and the associated risks.

19. We have only provided estimates of costs and benefits (monetised and non-monetised) for those recommendations that have been accepted and for which we have a fair understanding of how they would be implemented in practice. However, there are a number of other recommendations for which costs have not been provided because further consultation or work is required before any reliable estimates can be provided, or which are already being considered as part of other Government reform programmes e.g. Her Majesty's Courts and Tribunals service (HMCTS) Reform.

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

21. The first costs incurred under Option 2 are assumed to take place from 2020/21, including one-off research costs that would take place before the legislative changes affecting the health and justice system take effect, and costs for the Quality Improvement Programme from 2021/22 to 2023/24. Therefore, the appraisal is over a thirteen-year period, from 2020/21 to 2032/33, with the legislative changes necessary for policy changes assumed to be in place by 2023/24. Tables that show the costs for the health and justice system only show costs for 2023/24 to 2032/33 as this is the period in which the costs will be incurred as a result of the legislation. The costs of Option 1 (BAU i.e. not intervening) are set at 0, and the costs of the Option 2 are assessed against this benchmark.

22. **Presentation of costs**. The cost tables for each policy present rounded[1] figures in constant 2020/21 prices using the most recent GDP deflator from the OBR's Fiscal Sustainability Report [2]. Figures in tables may not sum exactly due to this rounding. All financial costs/savings exclude VAT.

23. The summary tables for all monetised costs present discounted costs using a discount rate of 1.5% for NHS related costs and 3.5% for all other costs (see HM Treasury Green Book[3]).

24. **Impact of the Covid-19 pandemic.** The assumptions used in all the models and underlying the cost estimates were set up before the Covid-19 pandemic and do not account for potential impacts on mental health and services. At the time of producing this Impact assessment it was still too early to assess these impacts robustly; as we do not currently have the data to reliably estimate the impacts of Covid on people with severe mental illness and detention numbers under the MHA.

Option 1: Business As Usual

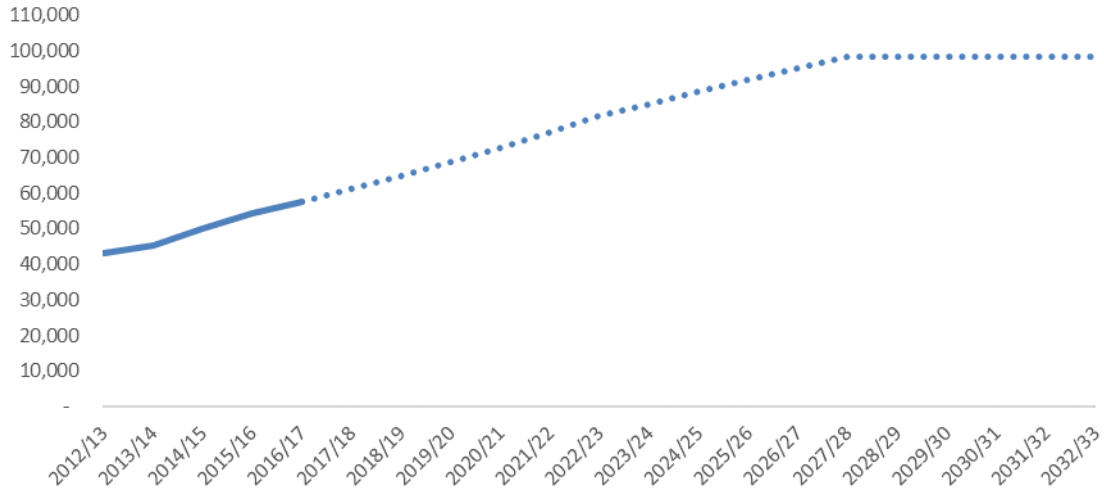
25. **Detentions.** From an analytical perspective, estimating the number of detentions under Option 1 (BAU) is crucial as it informs on estimates for the Health and Social Care workforce requirements for the additional recommended safeguards and for the volume of MHT activity.

[1] These figures are rounded to the nearest appropriate multiple based on the order of magnitude or degree of uncertainty, unless otherwise stated.
[2] OBR (14 July 2020) Fiscal Sustainability Report July 2020. Accessed at: https://obr.uk/fsr/fiscal-sustainability-report-july-2020/
[3] HM Treasurry (2018). The Green Book: appraisal and evaluation in central government. Accessed at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

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

- detentions under the MHA would increase by 6% per year (based on historical changes) if no policy improvements took place (see Annex B.I);
- we then assume in our central scenario that this trajectory will decrease by 10%, following improvements in mental health community care services and crisis services proposed and implemented within the NHS Long Term Plan[4]; this reduction is in line with the expectations in the Independent Review of the MHA (see Annex B.I);
- this reduction is assumed as a phased decrease over 5 years from 2023/24 to 2027/28; after which the number of detentions remains flat (at approximately 99,000 detentions per year), reflecting bed/capacity limitations – see Fig. 1.

Fig. 1 Number of detentions - BAU Forecast

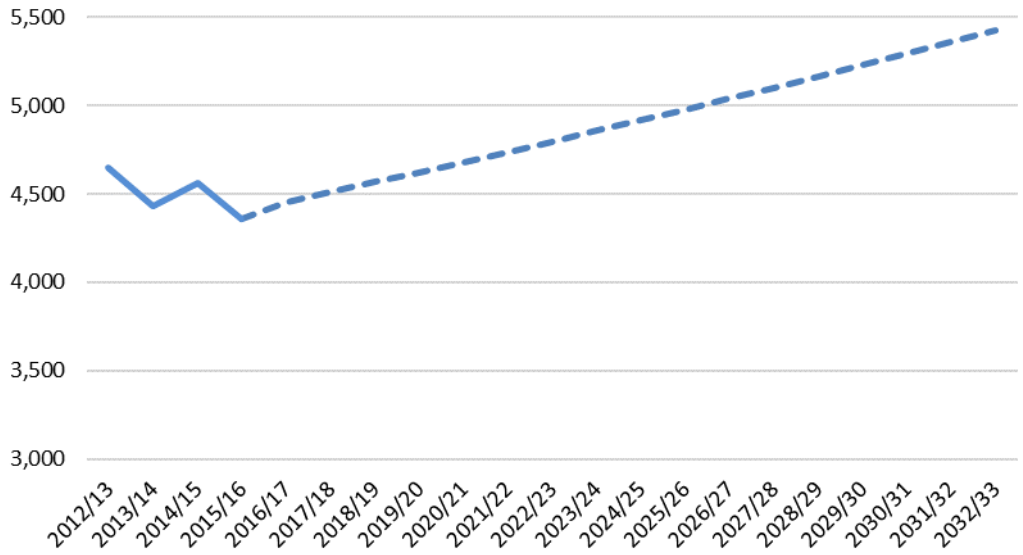


27. We also consider a best case and a worst case scenario in the sensitivity analysis, where the historical growth rate ranges from 2% to 10% (6% being the central scenario) and the reduction in detentions following NHS Long Term Plan improvements range from 0% to 15% (10% being the central scenario) (see Risks and assumptions section).

28. **Community Treatment Orders (CTOs).** We assume that CTOs would increase at 1.2% per year under BAU – this is based on historical changes (with a range from -6% to 9% in the sensitivity analysis) – see Fig. 2 (and Annex B.II).

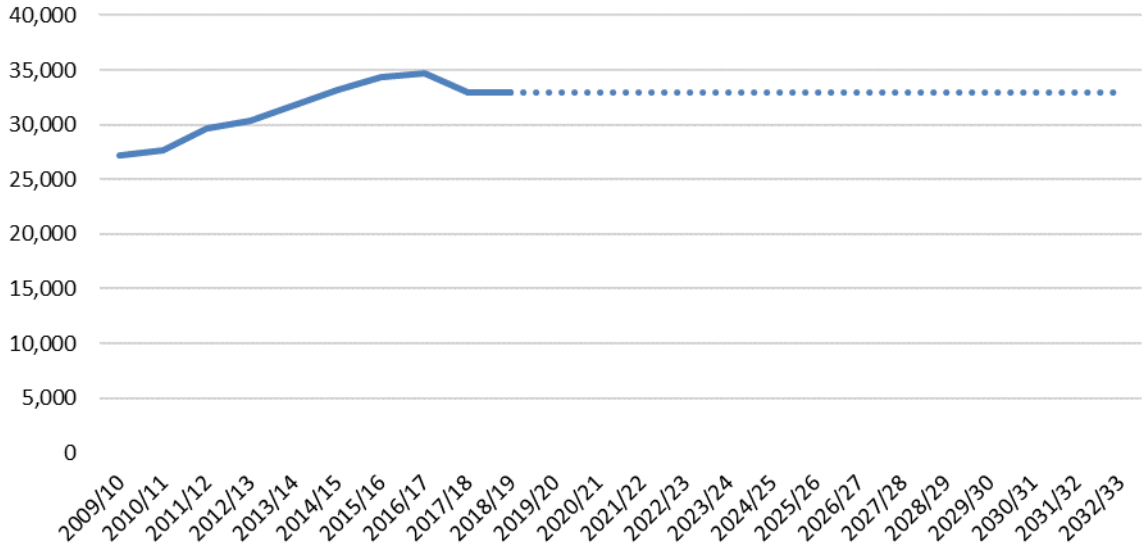
[4] NHS England (23 July 2019). NHS Mental Health Implementation Plan 2019/20 – 2023/24. Accessed at: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

Fig.2 Number of Community Treatment Orders - BAU forecast



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

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



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

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

Monetised Costs

31. Estimating costs for the accepted recommendations will focus on costs associated with improving the safeguards for those detained. We present estimated costs for:

    - Professional groups in the Health and Social Care System working together with patients to ensure patients have access to these safeguards - clinical teams, Approved Mental Health Professionals (AMHPs), Independent Mental Health Advocates (IMHAs) and Second Opinion Appointed Doctors (SOADs);
    - MHT activity in the Justice system.

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

Monetised costs – Health and Social Care System

Independent Mental Health Advocates (IMHAs)

33. An IMHA is an independent advocate who is trained to work within the framework of the MHA to support people understanding their rights under the Act and participating in decisions about their care and treatment. IMHAs are not employed by the NHS or any private healthcare provider; they are commissioned via local authorities[5].

34. Under the current MHA, independent mental health advocacy is available to the following groups: those detained with a length of stay greater than 72 hours, those on CTOs, those subject to guardianship, those under consideration for serious mental health treatment, informal patients aged under 18 years being considered for Electro-Convulsive Therapy (ECT), and conditionally discharged restricted patients[6].

35. In line with the Independent Review's recommendations, the White Paper states that the Government wishes to extend the statutory right to an IMHA to all mental health inpatients, including informal/voluntary patients; as is already the case in Wales.

36. The White Paper also proposes implementation of safeguards, which, despite not specifically aimed at the IMHA service, will result in additional responsibilities for IMHAs. Following conversations with professionals, we assume that these will be: setting up the CTP and reviewing it (for section 3 patients, those admitted for treatment), challenge to SOAD and to MHT for sections 2 (patients admitted for assessment and treatment) and 3, and CTO extensions, with IMHAs additional workload increasing by around 18 hours per section 3 detention, 12 hours per section 2 detention and by 12 hours per CTO (see Annex B.III for further details of the modelling).

37. Table 2 illustrates the spend over the ten year period from 2023/24 to 2032/33, showing an overall estimated additional cost of £82.5 million. The additional spend each year is highest in 2023/24 at £9.9m, this then drops and becomes fairly stable at around £7.8 million in the later appraisal years.

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

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

Table 3 shows the estimated additional number of full time equivalent (FTE) IMHAs required each year.

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	20.0	20.7	21.4	22.1	22.8	22.9	23.0	23.0	23.1	23.1	**222.2**
Option 2. Policy	30.0	29.9	30.0	30.3	30.6	30.7	30.7	30.8	30.8	30.9	**304.7**
Additional cost	9.9	9.1	8.6	8.2	7.8	7.8	7.8	7.8	7.8	7.8	**82.5**

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	370	380	390	410	420	420	420	420	420	420	**4,070**
Option 2. Policy	220	220	210	200	190	200	200	200	200	200	**2,040**
Additional IMHAs (FTE)	590	600	600	610	610	620	620	620	620	620	**6,110**

38. The Independent Review also recommends extending the statutory right to an IMHA to patients awaiting transfer from a prison or an immigration detention centre. We are not estimating the cost for these extensions as the White Paper consultation will seek to explore whether there is a strong argument to also introduce access to IMHAs for this group due to a potential overlap with this proposal and recommendations 131 and 140 around the creation of a new statutory, independent role to manage transfers from prisons and Immigration Removal Centres.

Approved Mental Health Professionals

39. Approved Mental Health Professionals (AMHPs) who are commissioned by local authorities are responsible for organising and undertaking assessments under the MHA and, where statutory criteria are met, authorising detention under the Act. Their work covers a wide range of activities, including, but not limited to, ensuring service users are interviewed in an appropriate manner, that they know what their rights are if they are detained, and that detainees are treated in the most humane and dignified way[7].

40. **New duties relating to Community Treatment Orders (CTOs).** Under Option 2, it is expected that the workload for AMHPs will increase. We assume that there will be new duties relating to CTOs: additional assessments and one additional meeting with the patient, Nominated Person and the community team before the CTO is finalised. Overall, AMHPs additional workload could increase by around 30 hours per CTO (see Annex B.IV for further details of the modelling).

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

42. Over the ten year period from 2023/24 to 2032/33 additional total costs are estimated to be £50.8m (non-discounted). In 2023/24 (year 1) the additional cost is £10.5 million (includes initial training), decreasing to £4.3 million by 2032/33 in line with the forecast decrease in CTOs over the period. These estimated monetised costs are summarised in table 4 below.

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

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	74.8	74.8	74.8	74.8	74.8	74.8	74.8	74.8	74.8	74.8	**748.3**
Option 2. Policy	85.3	80.3	79.8	79.4	79.0	79.0	79.0	79.1	79.1	79.2	**799.2**
Additional cost	10.5	5.4	5.0	4.6	4.1	4.1	4.2	4.3	4.3	4.3	**50.8**

43. Estimated additional staff required (see table 5 below) and corresponding training costs are placed in year 1 of Option 2 but training new staff may in practice spread over a longer period due to staff availability – this estimate will be improved in subsequent analysis supporting this policy.

Table 5. Estimated number of additional Approved Mental Health Professionals

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	1,118	1,118	1,118	1,118	1,118	1,118	1,118	1,118	1,118	1,118	**11,180**
Option 2. Policy	1,199	1,192	1,186	1,180	1,174	1,174	1,175	1,176	1,176	1,177	**11,809**
Additional AMHPs (FTE)	81	74	68	62	56	56	57	58	58	59	**629**

Second Opinion Appointed Doctors

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

45. Current SOAD provision, under Section 58 of the MHA, directs that, except in an emergency, after three months from first administration, medicines for mental disorder cannot be given without either capable consent of the patient or, in the absence of such consent, the authorisation of a SOAD. That is, currently, these treatments can be administered for a period of three months without the need for consent, even if the patient has the relevant capacity to refuse treatment. The White Paper proposes new safeguards for those receiving the majority of medical treatments (category 3 in the White Paper, which excludes invasive treatments):

- the SOAD's review of the patient's treatment will move from 3 months to as early as day 14 of detention if the patient is refusing with capacity or they have a valid ACD in which they refuse treatment;
- if the patient is not consenting because they are unable to consent, then the SOAD will be required to certify the patient's treatment at 2 months instead of 3 months (after treatment began.

46. A bespoke NHS Digital dataset on detainee length of stay for 2016/17[8] is used to estimate proportions of Section 3 patients captured by the proposals. The dataset does not provide the full profile of length of stay for a detainee as there is some movement between providers and this limited data only provide length of stay within the same provider. Data from the CQC show that there is 2 weeks between notification to the CQC and a SOAD visit. Combining this information suggests that 50% of Section 3 detainees would be captured from the move to SOAD eligibility from 14 days for refusals, and, 11% from the move to 2 months for those lacking capacity.

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

47. Management information on the SOAD service provided by the CQC has been used to calculate rates of SOADs visits per detainee. The CQC also provided national costs of SOAD provision which included SOAD fees, training and appraisal costs, management and support, travel and subsistence, and overheads. This provided an average unit cost per SOAD visit of around £385 (2020/21 prices), which has been applied to the forecast number of SOAD visits – see Annex B.V for further detail.

48. The additional total costs (undiscounted) are summarised in Table 6 below. Over the ten year period from 2023/24 to 2032/33 the costs are estimated at £42.2 million. Additional costs start at £4 million in 2023/24, rising to £4.3 million from 2027/28.

Table 6. Estimated monetised costs for Second Opinion Appointed Doctors (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	7.2	7.5	7.8	8.1	8.3	8.3	8.3	8.3	8.4	8.4	**80.7**
Option 2. Policy	11.2	11.5	11.9	12.3	12.7	12.7	12.7	12.7	12.7	12.7	**122.9**
Additional cost	4.0	4.0	4.1	4.2	4.3	4.3	4.3	4.3	4.3	4.3	**42.2**

49. SOADs do not work full-time, as the SOAD activity usually complements other activities, so headcount figures were estimated. Dividing the estimated number of SOAD visits by current caseload levels of 109 visits (estimate provided by the CQC) gives the estimated additional number of SOADs (headcount) required in future years.. These estimates are presented in Table 7 below:

Table 7. Estimated numbers of additional Second Opinion Appointed Doctors

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	170	180	180	190	200	200	200	200	200	200	**1,900**
Option 2. Policy	260	270	280	290	300	300	300	300	300	300	**2,890**
Additional SOADS (Headcount)	90	90	100	100	100	100	100	100	100	100	**990**

Clinical Teams

50. Clinical teams will be formed of multiple disciplines including responsible clinicians, other clinicians and nurses. These professionals are expected to play an increased role in MHA detentions following the implementation of the safeguards (see Annex B.VI). Assumptions about additional workload were discussed and agreed with NHS England and will need to be refined alongside further development of the policy.

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

52. Over the ten year period from 2023/24 to 2032/33 additional costs relating to supporting MHT hearings total £48.0 million. Healthcare setting costs relating to the extra work required of the clinical teams total £392.7 million between 2023/24 and 2032/33. The total additional costs relating to clinical teams across the appraisal period is £440.8m.

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
MHT hearings – Option 1. BAU	30.2	30.2	30.2	30.2	30.2	30.2	30.2	30.2	30.2	30.2	**302.0**
MHT hearings – Option 2. Policy	32.3	31.9	37.7	34.8	35.0	35.2	36.8	35.1	35.6	35.7	**350.0**
MHT hearings - Difference	2.1	1.7	7.5	4.6	4.8	5.0	6.6	4.9	5.4	5.5	**48.0**
Additional healthcare settings costs (note)	37.2	37.8	38.4	39.1	40.0	40.0	40.0	40.0	40.1	40.1	**392.7**
Total additional costs	39.3	39.5	46.0	43.6	44.8	45.0	46.6	45.0	45.4	45.6	**440.8**

Note. We only estimated additional healthcare setting costs, as it was challenging to estimate and forecast BAU.

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

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33
Responsible Clinician (FTE)	110	110	130	120	130	130	130	130	130	130
Clinician (FTE)	80	80	80	90	90	90	90	90	90	90
Nurse (FTE)	40	40	60	50	50	50	60	50	60	60
Non-Nurse (FTE)	10	10	20	20	10	10	10	10	10	10
Care Coordinator (FTE)	10	10	30	20	20	20	30	20	20	20
Additional Clinician (FTE)	10	10	10	10	10	10	10	10	10	10
Community Supervising Clinician (FTE)	10	10	10	10	10	10	10	10	10	10

Quality Improvement Programme

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

55. The QI programme will support the mental health system to address issues around quality, patient experience, leadership and culture. It will drive a renewed focus on improving patient choice and empowerment, to bring about positive change to improve people's experiences of assessment and detentions under the MHA. It is estimated that the QI programme will cost around £7m overall, including a pilot in 2021/22 followed by gradual roll out – see table below. This is based on scaling up the current QI programme on Reducing Restraint and Restrictive practice to cover all wards (currently only 38). The assumption is that the costs of a MHA programme would be similar as it is likely to take a similar implementation approach. These are initial estimates and they will be refined in future iterations of this work.

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

	2021/22	2022/23	2023/24	Total
QI programme	1	2	4	7

Monetised costs – Justice System

56. Out of the 154 recommendations made in the Independent Review, 24 were identified to have a direct impact on the Justice system and the White Paper addresses each of these with a proposed response.

57. In this section we present the costs and benefits associated with the recommendations that have been accepted in the White Paper and that have an impact in the Justice system. Details on our analytical approach for Option 1 (BAU) and Option 2 (policy changes scenarios), which underpin the cost estimates, can be found in Annex C. The monetised impacts have been broken down by their impact on the MHT system and associated legal aid costs (for which the recommendations are split into five themes below), restricted patients and places of detention (prisons/immigration centres).

58. The evidence base for the analysis conducted in this section has largely come from stakeholder engagement with the tribunal judiciary and Her Majesty's Courts and Tribunals Service (HMCTS) operational colleagues. Assumptions were generated with their support and provide the best estimated range of costs and benefits at this point.

59. Due to the inherent uncertainties in this type of analysis, we have conducted sensitivity tests and provided a low, central and high scenario in the aggregated analysis. More detail can be found in the sensitivity analysis section on page 41. The central scenario has been used for the individual sections below.

Mental Health Tribunal (MHT) System

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

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

62. As mentioned previously, some patients within Part III (those involveld in criminal proceedings or under sentence) are subject to restriction orders due to the risk of serious harm they pose to others. These "restricted patients" cannot be transferred between hospitals, discharged or allowed to leave without the consent of the Secretary of State for Justice. The MHT in England and the Mental Health Review Tribunal for Wales can also discharge restricted patients detained under a restricted hospital order if they conclude that the criteria for detention in hospital under the MHA is no longer met. Some of the recommendations and/or impacts may be specific to Part II, Part III or solely restricted patients.

63. The recommendations affecting the MHT can be categorised broadly into 5 themes:

    i. Changes to Tribunal Procedures - This covers several recommendations that have not been accepted (see White Paper) and recommendation 97 on data collection on protected characteristics (see Data and Digital section);
    ii. Automatic Referrals - This covers several accepted recommendations constituting a large proportion of the overall justice system costs. The overall costs are presented below and a discussion by individual recommendation detailing the methodology used can be found in Annex D;
    iii. Detention criteria - This covers certifying 10 days in advance of a hearing that it still needs to proceed;
    iv. Treatment choices - This covers the impacts of considering the statutory CTP at the tribunal hearing and the new route of appeal following a SOAD review;
    v. Expanded powers (see non-monetised costs section);

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

Central Scenario and Central Forecasts

65. Table 11 presents the total additional costs including legal aid of implementing the various recommendations accepted in the White Paper under the five themes with impacts on the MHT mentioned above (therefore excluding recommendation 133 on leave and transfer for restricted patients) in 2020/21 prices.

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	39.0	38.7	38.4	38.1	37.8	37.5	37.2	36.9	36.6	36.4	**376.6**
Option 2. Policy	51.0	49.0	61.3	54.0	54.0	53.8	56.5	52.9	53.4	53.3	**539.3**
Additional cost	12.0	10.3	22.8	15.9	16.2	16.4	19.3	16.0	16.8	16.9	**162.7**

Automatic Referrals

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

67. Since civil patients can be discharged at any point by the Responsible Clinician (RC), the MHT purpose is to offer a safeguard against unnecessary detention.One third of the section 3 cases (those admitted for treatment) disposed in 2018/19 involved the patient being discharged by their RC prior to the MHT hearing[9]. To avoid overestimating tribunal activity as a result of these discharges prior to the hearings taking place, we used MHT hearing volumes instead of receipt volumes in the

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

majority of the analysis for the MHT costs. However, given that some levels of legal aid fee can be claimed for preparation work relating to the MHT application rather than the full hearing itself, it was more appropriate to calculate legal aid costs using the number of MHT receipts rather than the number of hearings.

68. The White Paper acknowledges that automatic referrals to the MHT are an important safeguard to ensure that patients detained under the MHA have their case reviewed on a regular basis but recognises that there are currently significant constraints on the MHT with regards to assembling a panel with the relevant expertise and specialisms to be available at all hearings. Therefore, it has accepted the following recommendations in principle:

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

69. The legal aid costs of implementing the automatic referral recommendations discussed above were calculated using a different unit cost specific to the patient group in question, based on case level detail from the legal aid claim data. The majority of the costs relate to the implementation of recommendation 53, as this recommendation also has the greatest estimated MHT costs.

70. The estimated costs of automatic referrals are presented in Table 12 – see Annex D for detailed costs on these recommendations. The costs in the first two years of implementation are driven entirely by recommendation 46c, which is a detention criteria recommendation so has an earlier implementation date than the rest of the automatic referral recommendations. However, it has been included with recommendation 52 for the purposes of this analysis as the impacts on the MHT are analogous; both increasing access for section 2 patients:

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	35.8	35.5	35.2	34.9	34.6	34.3	34.0	33.7	33.5	33.2	**344.6**
Option 2. Policy	42.7	41.5	53.7	47.5	47.6	47.4	50.1	46.5	47.0	46.9	**471.1**
Additional cost	6.9	6.0	18.6	12.7	13.0	13.2	16.1	12.8	13.6	13.7	**126.5**

Detention Criteria

71. As well as its costs being included alongside the automatic referrals category of recommendations, the methodology regarding accepted recommendation 46c (on reducing the initial maximum detention period under section 3 so that there are three detention periods in the first year at 3 months, 6 months and 12 months of detention)[10] is discussed alongside recommendation 52 in Annex D.

72. Recommendation 46e stipulates that Section 3 patients should be certified as continuing to meet the criteria for detention 10 days in advance of a hearing at the MHT. The purpose of this

[10] Currently, the initial duration for a Section 3 is for a maximum of 6 months. It can be renewed for a further period of 6 months; after that, for further periods of 12 months.

recommendation is to reduce the burden of hearings cancelled at the last minute (deemed to mean within 48 hours) on the MHT.

73. Before analysing the impact of this recommendation on cancellation fees (due to assembling a panel that then does not sit), it is worth acknowledging that:

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

74. The overall impact of this recommendation is a cost saving from the reduction in cancellation fees, which can be claimed by the panel members. Option 2 estimated costs include the cancellation fees still eligible to be claimed. However, the costs are lower than in Option 1 (BAU) because of the estimated reduction in cancellations This reallocation means 50% of cancelled panels can be utilised and therefore patients may have their hearings held earlier.

Table 13. Estimated savings of implementing recommendation 46e (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3.2
Option 2. Policy	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.7
Difference	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-1.5

Treatment Choices

75. The unnumbered recommendation on the CTP affecting the MHT under the Treatment Choice theme (see p. 115 of the Independent Review) ensures the MHT panel are provided with and are able to review a patient's CTP ahead of or during the hearing.

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

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

78. Care and Treatment plans would become statutory for patients detained under section 2 although we do not expect that reviewing a section 2 patient's Care and Treatment Plan would affect the length of a Tribunal hearing, as existing patient plans already include reports to tribunals. Costs have therefore not been calculated for this subset of hearings to reflect this.

79. The additional estimated costs associated with changes to treatment choices over the 10 year implementation period are presented in Table 14 below. There is no BAU as the baseline being compared to is the same as the one being used in the automatic referral recommendations policy scenario outputs.

Table 14. Estimated costs of increased treatment choices on the Mental Health Tribunal (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Additional cost	4.8	4.0	4.0	3.0	2.9	2.9	2.9	2.9	2.9	2.9	**33.5**

Legal Aid Impact

80. The total cost of legal aid for patients appealing to the MHT will be affected by the Independent Review recommendations. If a recommendation results in a modelled change in MHT workload, then legal aid expenditure will change in the same direction. Legal aid impacts have been modelled for all of the recommendations accepted, with the exception of 46e and the unnumbered recommendation on the CTP, and the costs included in the estimates above. Given that most of the preparation work for a legal aid hearing, for which providers can claim a preparation level fee for, will be done more than 10 days in advance of the hearing date, we do not expect recommendation 46e to have much impact on the legal aid claim total. For the CTP recommendation, there is no impact on receipt volumes, so it has not yet been possible to estimate the potential legal aid costs associated with this recommendation. However, there is a chance it could increase the proportion of cases that escape the fixed fee scheme, which is the set fee legal aid providers can claim for the majority of their MHT work, thus increasing costs in this way.

81. For recommendations 46c, 52, 53, 61, 64 and 137, the 2018/19 legal aid claim expenditure data was separated out by the available category groups of 'Part II' i.e. non-restricted, 'Part III' i.e. mostly restricted patients, 'Conditionally discharged' and 'CTO' to generate individual unit costs per sitting day for these distinct patient groups. These unit costs are exclusive of VAT so as to be consistent with the MHT unit cost data, which is unlike the published figures on legal aid claim expenditure.

82. The Option 1 (BAU) scenario will not match the published claim value for legal aid in 2018/19 for various reasons. The first is that the modelling assumes that uptake is 100% of eligibility, which may not be the case. As such, the total legal aid costs may be an upper bound. Additionally, the BAU scenario is modelled for each recommendation individually using an approximate unit cost for the patient group and receipt/hearing volumes, which are estimations of the actual work completed by legal aid providers. It has not been possible, for example, to disaggregate the different levels of fees claimed for preparation work, so the unit cost is simply an average of all the levels of work for that particular patient group, as identified by the four types of category group mentioned above.

83. Table 15 below shows the total cost for legal aid which can be claimed by providers as a result of increased receipts and hearings in the MHT. It is important to note that the costs shown are just indicative of the workload expected to start in each year of implementation. The legal aid claim total for each year is likely to differ as providers will usually submit a final bill after all work on a case has been completed, resulting in a lag between the hearing date and the legal aid claim.

Table 15. Estimated monetised costs for legal aid from increased receipts and hearings in the Mental Health Tribunal system, central scenario (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	14.1	13.9	13.5	13.2	12.9	12.6	12.4	12.1	11.8	11.5	**128.2**
Option 2. Policy	17.5	16.9	21.2	18.8	18.6	18.2	18.8	17.4	17.3	17.0	**181.7**
Additional cost	3.4	3.0	7.7	5.6	5.6	5.6	6.4	5.3	5.5	5.4	**53.5**

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

Recommendation 133 – Leave and transfer for restricted patients

84. The aim of recommendation 133 is to speed up the process whereby restricted patients (mentally disordered offenders diverted to hospital for treatment by the courts, or prisoners who are transferred to hospital for treatment while on remand or serving a prison sentence) can access leave in the community or be transferred to a different hospital. At present, the RC must seek the Justice Secretary's consent for leave or hospital transfer for all restricted patients. Historically, stakeholders (primarily patients and their family/carers but also hospitals/NHS, legal representatives and the MHT) have never had clear guidance on timescales for these decisions. Furthermore, at the time of the Independent Review, there were substantial delays and a backlog of decisions, as the Mental Health Casework Section (MHCS), which is responsible for the management of restricted patients in England and Wales in Her Majesty's Prison and Probation Service (HMPPS), was carrying a number of vacancies for some months.

85. While the Government agrees with the goals and aims of this recommendation, it has decided to take an alternative approach to improve the speed of decision-making and has already invested time and resources in improving the current processes. It has increased the headcount of MHCS by five posts and is considering to recruit for an additional 5 staff in order to make further improvements. MHCS has published targets for the timeliness of decision-making[11] and has been delivering a programme of continuous improvement, in partnership and collaboration with health colleagues and other stakeholders. MHCS has improved the timeliness of decision-making substantially and will continue to make improvements once additional staff are in post.

86. The costs of the additional staff[12] are provided in table 16 below.

Table 16. Estimated monetised costs for Recommendation 133 (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.8	**28.8**
Option 2. Policy	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.3	**33.0**
Additional cost	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	**4.2**

Research on ethnicity and the Mental Health Act

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

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

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

88. The National Institute for Health Research Policy Research Programme (NIHR PRP), on behalf of the Department of Health & Social Care (DHSC) launched an open call for research proposals to address these gaps in the evidence base on the 10th December 2019, which closed on the 14th January 2020[13]. A budget of £4 million is available for this research initiative[14]. Decisions on successful applications were finalised in August 2020 and projects are expected to start within 6 months of outcome. However, due to the COVID-19 pandemic, some projects that were due to start in the Autumn 2020 are now expected to commence in early 2021.

89. The need to ensure that culturally-appropriate advocacy is provided consistently for people of all ethnic backgrounds and communities has been recognised, in particular for individuals of black African and Caribbean descent and heritage. The Government has committed to launching a pilot programme of culturally-sensitive advocates in partnership with local authorities and others, to identify how best to represent the mental health needs of ethnic minority groups. We expect the scoping work to be concluded this year, with a full pilot programme set up in the new year.

Data and Digital

90. The Independent Review identifies improvements to data and digitising the MHA as two of the enablers that would help support the wider system changes recommended in its report. The Government shares this view and is committed to working with all the organisations involved in the MHA system to bring about improvements to MHA data and digital offer.

91. The NHS Mental Health Implementation Plan 2019/20 – 2023/24[15] (within the NHS Long Term Plan) states the commitment to improve substantially mental health data quality over the coming years by improving the coverage, consistency, quality and breadth of national data. Seeking improvements to MHA related data is a part of this plan. The ongoing refinements to the Mental Health Services Data Set (MHSDS)[16], where a large proportion of MHA data are held, will support this activity.

92. Improvements to the quality and consistency of the ethnicity data are also an important part of improving MHA data. The Race Disparity Unit (part of Cabinet Office)[17] is working closely with the Office for National Statistics on the ethnicity classifications for the 2021 Census. Once this work is complete, the Race Disparity Unit will support delivery partners to reflect these changes in their reporting systems.

93. The White Paper proposes that NHS England should build on the work of the Mental Health Trust Global Digital Exemplars[18] and other trusts to test, evaluate and roll-out a fully digitised, consistent approach to the MHA. Digital transformation is at the heart of the NHS Long Term Plan. Through the wider transformation portfolio, including the Global Digital Exemplar and Local Health and Care

[13] further detail on: https://www.nihr.ac.uk/documents/improving-patient-experiences-and-outcomes-under-the-mental-health-act-call-specification/23257

[14] National Institute for Health Research (10 December 2019). Improving patient experiences and outcomes under the Mental Health Act - Call Specification. Accessed at: https://www.nihr.ac.uk/documents/improving-patient-experiences-and-outcomes-under-the-mental-health-act-call-specification/23257

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

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

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

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

Record programmes[19], all mental health providers are expected to progress, by 2024, to a core level of digitisation[20].

94. All of these workstreams will need to be considered under the priorities for developing the existing datasets, therefore no additional costs are included for Data and Digital in the NHS in this IA.

95. Regarding the Justice system, the White Paper proposal regarding the remaining recommendation 97 – *"statistics should be collected on the protected characteristics of those applying for a MHT hearing, and their discharge rates"* – is an agreement over the aims and goals and it will be taken forward as part of the wider HMCTS Reform Program. As a result, any costs and benefits relating to this recommendation will not be included in this impact assessment.

Non-Monetised Costs

Non-Monetised Costs – Health and Social Care System

Advance Choice Documents (ACDs)

96. The proposed introduction of statutory ACDs supports the Independent Review's first principle of choice and autonomy by encouraging patients and service users to set out, in advance, choices relating to their care and treatment, which will be used to inform their treatment if they are detained and lack the relevant capacity to express their wishes and preferences. when detained and lacking capacity. The White Paper will propose that the legislation will require ACDs to be offered to people who have been previously detained, and that guidance will state that anyone who is at risk of detention should also be offered the opportunity to make an Advance Choice Document. The White Paper describes the proposed standard content for ACDs, which will include information about the individual's preferences such as treatment preferences and non-medical therapeutic approaches and is consulting on this. It is therefore not yet defined what form and content the ACD could take, and how and which professional groups would be involved, so we are not presenting costs estimates for ACDs in this IA.

New detention criteria

97. The Government is proposing to change the detention criteria to set out that the detention is required to elicit a therapeutic benefit for the individual, and that care and treatment provided under the MHA should promote recovery and facilitate patients to get better, and promoting discharge as soon as possible. It is also proposing to amend the detention criteria so that, for someone to be detained, it must be demonstrated that there is substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person.

98. These changes are expected to bring a reduction in the number and length of detentions, as detentions will not be justifiable when the patient is no longer considered to pose a significant risk and where treatment or detention ceases to have a therapeutic value. There is no available evidence of how much detentions could be reduced or shortened following changes in detention criteria, so we are unable to present quantified costs in this IA, and will seek to present these estimates in the final IA.

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

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

Learning Disabilities and Autism

99. The Government is proposing to revise the MHA to be clearer that, for the purposes of the Act, autism or a learning disability are not considered mental disorders. Both are lifelong conditions, which can neither be removed or fundamentally improved through treatment. However, many people with a learning disability, autism or both may also require support for a mental illness and the Government wants to ensure that people receive high quality and safe care that is the most appropriate for them. The WP is seeking views on how to do this, so specific policy interventions are still not defined and, therefore, respective costs and benefits cannot be quantified at this stage.

Inpatient physical environments

100. According to the White Paper, the NHS Long Term Plan (LTP) has renewed the Government's commitment to pursue an ambitious transformation of mental health care England and a multi-year capital settlement to tackle backlog maintenance and improve the existing estate is expected to be agreed in the next capital review. As these costs will fall under the implementation of the NHS LTP, we are not presenting them in this IA.

Cultural Change

101. The White Paper sets out the ambition for change, and the forthcoming Bill will make the necessary legal changes for reform. However, legislation alone will not drive changes in the day to day experiences of patients, and staff. Key to any change will be a change of culture, which will be achieved with continued engagement with service users and the profession. Delivering change will require a whole system response and strong leadership from clinicians and experts by experience to turn the ambition for reform into lasting change. While an important component of enabling change, the QI Programme alone will not be sufficient to provide the additional system support to enable both the procedural and cultural changes which are critical to embedding the proposed reforms effectively.

102. As such, Department of Health and Social Care (DHSC) will be working with NHSEI to look at further national support requirements including but not limited to: training on the changes to the MHA and what this means for frontline staff, and supporting meaningful co-production and the development of expert-by-experience leadership roles within providers and local systems.

Familiarisation and transitional costs

103. It is expected that there will be transitional costs to services associated with revising and implementing a new MHA if a large number of organisations such as local authorities, commissioners, and providers will have to update their policies, producers and documentation. It would then be likely that extra training would need to be provided for those organisations whose roles are specifically changing based on the updated Act. Since it is not clear at this stage where some of the proposed changes to the Act are already being used as best practice by organisations and where there is a need for extra support, it is not possible to obtain a clear estimate of what funding would be required, and these costs therefore remain unmonetized. We will assess these costs in future estimates when the policies are clearer and their impact on services can be better assessed.

Training costs for clinical staff

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

Non-Monetised Costs – Justice System

Treatment Choice

105. Recommendation 9 states that patients should be able to appeal treatment decisions at the MHT following a SOAD review. Currently, if a patient wishes to challenge the decision of the RC and SOAD, they have a right to appeal treatment by way of Judicial Review. However, the White Paper accepts the recommendation by the Independent Review that there should be an alternative route to challenge a specific treatment and proposes to introduce the ability for patients to raise this with a single judge of the MHT. The impacts of this recommendation are as yet unmonetized given that further policy development is required. As part of our work to assess the costs, we will take into account the proposal that there shall be a 'permission to appeal' stage prior to cases proceeding to full Tribunal hearing and that cases shall be heard by a single judge sitting alone.

Expanded Powers

106. There are a number of recommendations that have the aim of expanding the powers of the MHT, enabling the MHT panel to make decisions beyond accepting or rejecting an appeal for discharge. These recommendations are discussed below:

Recommendation 18 – Displacement of the Nearest Relative

107. The Independent Review recommended that the County Court power to displace a Nearest Relative, should be replaced by an MHT power to overrule or displace a Nominated Person (NP) as the MHT is better placed to make this decision. The Government agree in principle that this is a sensible approach . To take forward this recommendation and be able to cost it, we need to understand how this change will work in practice and the extent to which it can be implemented. The Ministry of Justice (MoJ) plans to carry out further work before delivering change in this area.

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

109. The Government will also be taking into consideration the implications for the legal aid fund, which currently pays for representatives for patients in these proceedings before the County Court on a means tested basis. Whether legal aid will remain means tested when the proceedings are transferred to the MHT will be considered further as part of the MoJ means test review, which is due to report in 2021.

Recommendation 96 – Additional training for panel members

110. The Independent Review was concerned that the current procedures for the MHT do not accurately reflect the individual needs of the patients, particularly those patients with a learning disability or autism. The Review therefore recommended that training should be developed for MHT panel members in specialisms including children and young people, forensic psychiatry, learning disability, autism, and older people. It further suggested that, once trained, panel members should consequently become 'ticketed' to sit in specialist areas and specifically allocated to sit on cases in which they had gained that specialism.

111. The Goverment agrees in principle with the Review that the individual needs of the patient should be recognised. However, it is the judiciary, through the Judicial College, who are responsible for setting and developing the training for panel members, and this process is independent of Government. Furthermore, the decision as to whether ticketing should be introduced is the

responsibility of the Senior President of Tribunals in consultation with the Chamber President to make.

Recommendation 47 – Power to grant leave or direct transfer to a different hospital

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

Recommendation 135 - Power to direct leave or transfer when deciding not to grant an application for discharge for restricted patients

113. We do not believe it is in line with the principles of the Restricted Patient regime to empower the MHT to direct leave or transfer. However, we are proposing that the MHT is empowered to make a statutory recommendation in relation to community leave or transfer to a different hospital, which the Justice Secretary must consider when taking such decisions.

114. Mental Health Casework teams already action non-statutory recommendations from the MHT. However, moving to statutory recommendations may mean the process around receiving and responding to MHT decisions needs to be adapted, which could lead to an increased burden on staff. There is a possible opportunity cost of other work if these statutory recommendations are prioritised.

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

Recommendation 48 – Breaches of Human Rights MHA

116. The Independent Review recommended that where the MHT believes that conditions of a patient's detention breaches the Human Rights MHA (HRA)1998, it should bring this to the attention of the CQC in England or the Healthcare Inspectorate Wales (HIW). We agree in principle with this recommendation. However, it is important that the MHT does not become an investigatory body when dealing with potential breaches of the HRA as this is not an appropriate function of the MHT.

117. There is already a process in place and the guidance on this is currently being reviewed by the judiciary. This recommendation will be considered as part of this review. Cost estimates can therefore not be provided at this stage.

Recommendation 63 – Changing conditions of CTO

118. The White Paper states that we want to ensure the conditions attached to CTOs are proportionate. The recommendation will be partially accepted. This will mean judges will be able to check the least restrictive option as possible is attached to the patient's CTO. But conditions applied to a CTO will still be determined by the patient's clinical team, who have day to day responsibility for the patient's care and treatment. If the Tribunal finds the least restrictive option is not attached to the CTO, the Tribunal will be able to recommend that the clinical team reconsider its decision.

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

Recommendation 130 – Prisons as places of safety

119. The use of prison as a 'place of safety' is a concept defined in two pieces of legislation:

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

120. We are not yet aware of the scale/impact associated with removing prison as a place of safety for those who meet criteria for detention under the MHA, as relevant data are not currently collected (although we understand numbers are low). However, it is likely to reflect a shift in resource from one area of the system to another (i.e. would require access to health resources at an earlier point in the system – but may ease pressure on prison capacity). MoJ are working with NHS England to better understand the scale of the issue; and ultimately the impact of the recommendation.

Recommendations 131, 132, 140 – Transfers from prisons and Immigration Removal Centres

121. For those whose mental health condition deteriorates in prison to a level whereby they meet the criteria for detention under the MHA, the Independent Review makes three recommendations aimed at ensuring people receive the care they need as quickly as possible:

- Recommendation 131 proposes the creation of a new statutory, independent role to manage transfers to a mental health hospital;
- Recommendation 132 suggests the introduction of a statutory 28 day time limit from the point of referral for a first assessment to a transfer taking place;
- Recommendation 140 extends the recommendation around creating a new statutory transfer manager role to Immigration Removal Centres (IRCs) as well as prisons.

122. The Government is minded to accept recommendation 131 for a new independent role to have oversight of referrals, assessments, transfers and remissions. However, more work is required to scope exactly what the responsibilities of this role should be and how they differ from existing overlapping roles in this space before we can provide estimates on the impact of this recommendation. For example, NHSEI already has a secure transfers management section, which in theory should be carrying out many of the tasks we would want this role to undertake. The Government is considering whether what we need is a reshaping of/more responsibility added to an existing role, rather than creating a completely new one.

123. The scope of the role would also determine where it should sit (with Local Authorities, NHSEI or HMPPS) and how much it will cost. The White Paper is consulting on where a new prison transfers pathway co-ordinator role might best sit and what their remit should be – one around expanding the current Local Authority-employed community role of AMHPs (see also earlier separate section on AMHP implications); the other around a role within NHSEI, which could navigate the process and escalate blockages within the respective organisations. Whatever is agreed would also apply in IRCs (as per recommendation 140).

124. The Government is also minded to accept recommendation 132 around introducing a 28 day time limit for transfers (albeit with a delayed commencement of the statutory element of the

recommendation, to allow time for updated NHSEI guidance setting out the 28 day time limit to be embedded). However, we are mindful of the views shared by various stakeholders (including the Royal College of Psychiatrists) that enshrining the time limit in statute could result in unintended consequences if not carefully managed. For example, clinicians may avoid recommending hospitalisation if they, or their employing authority, are likely to be penalised for not meeting the deadline. As each case is different and complex, there may also be occasions when a longer assessment period is required; we therefore need to be cautious in ensuring that a statutory timeframe does not prevent us from considering the most appropriate placement and treatment that can be provided for individuals. The White Paper is seeking stakeholder views of unintended consequences that a statutory time limit could produce.

125. The costs of accepting this recommendation could be expected to be more around any increased risk of legal challenge to the Government in the case of failing to meet the new time limit, if it were made statutory. In terms of numbers, there are around 1,000 transfers from prison to mental health inpatient settings each year in England, around one third of which meet the current 14 day (non-statutory) target. 50-60% of transfers are within the 28 day window proposed by the Review. In 2018/19, 4% of prisoners waited more than 140 days to be transferred. That said, much work has been done over the past couple of years to improve processes and tackle delays; in addition, it is hoped that the new NHSEI guidance will be released by the end of the year, which should further help.

Recommendation 136 - power to discharge restricted patients with conditions that restrict their freedom in the community

126. The Government agrees with the Independent Review's recommendation that – for a very distinct group of restricted patients for whom the MHA is no longer providing therapeutic benefit from detention in hospital, but who pose such a significant risk to others, that they would need continuous supervision to be managed safely in the community – the MHT should have the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

127. The Government is proposing for consultation the introduction of a discharge with supervision which would allow the MHT to discharge the patient with conditions amounting to a deprivation of that person's liberty, in order to adequately and appropriately manage their risk, subject to annual review by the MHT.

128. The cohort this is applicable to is expected to be small, however data are extremely limited. A marginal increase in MHT caseload can be expected, given the introduction of an additional annual review for these patients. However, a lack of reliable data means this cannot be currently costed. The Government will work to understand the scale of this issue and therefore the impact of this recommendation.

Summary of Costs

129. Estimated additional costs for the policy interventions under Option 2 have been summarised below in table 17[21]. They have been split into costs relating to the NHS, Local Authorities and the Justice System. They are presented at constant 2020/21 prices first (see table 17) and then

[21] Costs may not add up exactly due to rounding

discounted following the HM Treasury Green Book[22] and presented in a similar table for ease of comparison (see table 18).

130. Overall additional undiscounted costs (at 2020/21 prices) for these three areas are estimated at £790 million for the 13-year period. Due to the phased implementation nature of the recommendations, these costs are not evenly split over the ten years starting after legislation changes are assumed to be in place. In the first three years of implementation there will be an increased pressure of between around £68m-£87m per annum. This figure reaches a steady state in subsequent years of approximately £79m per year.

Table 17. Summary of total additional costs (£millions, 2020/21 prices, undiscounted)

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
NHS	-	1	2	47	43	50	48	49	49	51	49	50	50	**490**
Local Authority	-	-	-	20	15	14	13	12	12	12	12	12	12	**133**
Justice System (including legal aid)	-	-	-	12	10	23	16	16	16	19	16	17	17	**163**
Research	4	-	-	-	-	-	-	-	-	-	-	-	-	**4**
Total	4	1	2	80	68	87	77	77	78	82	77	79	79	**790**

131. For each area, overall costs at constant 2020/21 prices are (with breakdowns by specific intervention further down):

- Additional NHS costs are estimated at £490 million for the 13-year period, and vary from £47 million in 2023/24 to £50 million in 2032/33;
- Additional Local Authorities costs are estimated at £133 million for the 13-year period, and vary from £20 million in 2023/24 to £12 million in 2032/33;
- Additional Justice system costs are estimated at £0. 16billion for the 13-year period, and vary from £12 million in 2023/24 to £17million in 2032/33.
- Research costs are expected to be incurred in 2020/21 and are estimated to be £4 million.

132. **NHS and other healthcare resources opportunity costs**. The measurement and valuation of direct health benefits/ costs from a policy intervention is typically performed by estimating the number of Quality adjusted life years (QALYs) generated[23]. QALYs account for impacts on length of life (longevity), and health-related quality of life (QoL). One QALY is equivalent to one year of life in full health or 2 years of life at half of full health. In the Department for Health and Social Care, it is considered that an additional QALY (valued by society at £60,000) can be purchased for £15,000[24]. Where proposed health spending redirects resources from alternative use in the NHS, the opportunity cost of spending is four times the financial cost (£60,000 divided by £15,000 = 4). Therefore, spending for new policies that is met from within existing resources will create an opportunity cost of £4 for every £1 of diverted resources and NHS and other healthcare related costs have been uplifted to reflect the opportunity costs of funding the policy interventions from within existing health and social care resources by multiplying them by a factor of 4. These costs currently

[22] HM Treasury (2018). The Green Book: appraisal and evaluation in central government. Accessed at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent
[23] For a full explanation of the QALY cost/ benefit methodology, please see Annex E.
[24] HM Treasury (2018). The Green Book: appraisal and evaluation in central government. Accessed at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

cover clinical teams and QI programme, which are delivered by NHSEI and SOADs, which are under the CQC's remit.

133. **Discounting.** The summary tables 18-24 for all monetised costs below present discounted costs (also designated as Net Present Value, NPV[25]) and include overall discounted costs accounting for NHS and other healthcare opportunity costs.

134. Overall additional discounted costs including opportunity costs (at 2020/21 prices) for these three areas are estimated at £1.99 billion for the 13-year period, ranging between £210 million and £186 million per annum (between the 10-year period 2023/24 and 2032/33).

Table 18. Summary of total additional costs (including and excluding opportunity costs, £millions, 2020/21 prices, discounted)

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	NPV
NHS and health care costs	-	1	2	45	41	46	44	44	44	45	42	42	42	**438**
NHS and other healthcare including opportunity cost	-	4	8	181	164	186	175	177	175	178	170	169	167	**1,753**
Local Authority	-	-	-	18	13	11	10	9	9	9	9	8	8	**105**
Justice System (including legal aid)	-	-	-	11	9	19	13	13	12	14	11	12	11	**125**
Research	4	-	-	-	-	-	-	-	-	-	-	-	-	**4**
Total excluding opportunity costs	4	1	2	74	63	77	67	66	65	68	62	62	61	**673**
Total including opportunity costs	4	4	8	210	185	217	198	199	196	201	190	189	186	**1,988**

135. For each area, overall discounted costs at constant 2020/21 prices are (with breakdowns by specific intervention further down):

- Additional discounted NHS and other healthcare opportunity costs are estimated at £1.8 billion for the 13-year period, and range from £181 million in 2023/24 to £167 million in 2032/33;
- Additional discounted Local Authorities costs are estimated at £105 million for the 13-year period, and range from £18 million in 2023/24 to £8 million in 2032/33;
- Additional discounted Justice system costs are estimated at £125 million for the 13-year period, with a peak in 2025/26.
- Research costs are expected to be incurred in 2020/21 and are estimated to be £4 million.

136. **Costs by Policy Intervention.** Tables 19 to 24 illustrate the costs broken down each intervention area in Option 2: healthcare, Local authority and Justice system. They are represented in both constant 2021/21 prices as well as in discounted opportunity cost.

[25] Net Present Value (NPV) refers to the sum of the future costs of the policy in the 13-year period considered (that have been discounted by the social time preference rate, at 3.5%) to bring them to today's value.

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

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
SOAD	-	-	-	4	4	4	4	4	4	4	4	4	4	**42**
Clinical Teams	-	-	-	39	39	46	44	45	45	47	45	45	46	**441**
QI programme	-	1	2	4	-	-	-	-	-	-	-	-	-	**7**
Total	-	1	2	47	43	50	48	49	49	51	49	50	50	**490**

Table 20. NHS and other healthcare - Additional Cost (£millions, 2020/21 prices, discounted)

	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	NPV
SOAD	-	-	-	4	4	4	4	4	4	4	4	4	4	**38**
Clinical Teams	-	-	-	38	37	43	40	40	40	41	39	39	38	**394**
QI progr.	-	1	2	4	-	-	-	-	-	-	-	-	-	**7**
Total	-	1	2	45	41	46	44	44	44	45	42	42	42	**438**

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
IMHA	10	9	9	8	8	8	8	8	8	8	**83**
AMHP	11	5	5	5	4	4	4	4	4	4	**51**
Total	20	15	14	13	12	12	12	12	12	12	**133**

Table 22. Local Authorities - Additional Cost (£millions, 2020/21 prices, discounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	NPV
IMHA	9	8	7	7	6	6	6	6	5	5	**65**
AMHP	9	5	4	4	3	3	3	3	3	3	**40**
Total	18	13	11	10	9	9	9	9	8	8	**105**

Table 23. Justice System - Additional Cost (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Tribunal Procedures	-	-	-	-	-	-	-	-	-	-	**-**
Automatic Referrals	7	6	19	13	13	13	16	13	14	14	**127**
Treatment choice	5	4	4	3	3	3	3	3	3	3	**33**
Detention Criteria	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	**-2**
Expanded Powers											
Leave and transfer categorisation	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	**4**
Total	12	10	23	16	16	16	19	16	17	17	**163**

Table 24. Justice System - Additional Cost (£millions, 2020/21 prices, discounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	NPV
Tribunal Procedures	-	-	-	-	-	-	-	-	-	-	-
Automatic Referrals	6	5	16	10	10	10	12	9	9	9	**97**
Treatment choice	4	3	3	2	2	2	2	2	2	2	**26**
Detention Criteria	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	**-1**
Expanded Powers	-	-	-	-	-	-	-	-	-	-	-
Leave and transfer categorisation	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	**3**
Total	11	9	19	13	13	12	14	11	12	11	**125**

Benefits

137. Potential benefits from the MHA reforms include reducing detentions, reducing the length of detentions and improving patient experience and outcomes.

138. Improvements in community care and crisis care are expected to lead to a reduction in detentions. These interventions are now covered by the NHS Long Term Plan, so they are not included in the cost and benefit estimates in this IA, but we have illustrated how much a reduction in detentions could potentially save (see Annex A). Advance choice documents are also expected to reduce the number of detentions.

139. Changing the first detention renewal point from 6 months to 3 months and improvements in patient safeguards and patient experience are expected to reduce the length of detentions and improve health outcomes.

140. Due to limited evidence informing on the impact of the policies on reducing detentions and their length and the lack of available evidence on the quantitative benefits of patient experience, we are not presenting monetised benefits in this IA. Instead, a breakeven analysis has been performed to help understand what the non-monetised benefits would need to be equal to in order for the costs of the proposed policy to be completely offset.

Overview of benefits from improved safeguards

141. The improvement of safeguards for people detained under the MHA focusses on increased patient choice, better access to MHTs and care that is more consistently respectful and meets the requirements of the individual. That is, patients would be more likely to feel more engaged with their care and, within the context of compulsory treatment, feel that they have a voice regarding their care decisions. However, the lack of published evidence makes it very difficult to quantify the benefits from these type of interventions in terms of health outcomes and other outcomes for the individual, their families/friends and the wider society.

142. For example, NICE guidance on patient experience on adult NHS services[26], which covers areas such 'knowing the patient as an individual' and shared decision making, admit that:

> *"While in some cases interventions that improve patient experience may improve 'health' as quantified by QALYs, there is clearly a minimum expectation of what type of patient experience is acceptable, which is not necessarily to do with improving 'health'. For example, a patient and their family have a right to information about their condition and the potential harms and benefits of the treatment they will receive but the aim of this information is not necessarily to improve health. Therefore, the health quality-adjusted life-year will not capture all the benefits of improved patient experience and it is appropriate to take into account other considerations." (p.19)*

143. The research evidence available indicates that benefits associated with patient involvement include:

> *"Increased patient satisfaction and trust, higher patients' quality of life, reduced patients' anxiety and emotions, better understanding of personal requirements, more positive and direct professional's communication with positive and lasting effects on health, patient empowerment and providing better patient health, receiving different opinions of patients about a common subject, planning and decision making improvements through combined opinions of patients,*

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

improvement of monitoring and evaluating services, better decision making due to access to different views, increased trust in services due to increased freedom, knowledge and transparency, a substantial opportunity for dealing with inequalities in health and access to services, encouragement of sense of independent responsibility, career promotion for most staff due to positive feedbacks, reduced possibility of patient dissatisfaction" (Vahdat et al. 2014, p.5)[27]

144. There is also evidence, from a systematic review, that found patient experience for a wide range of disease area settings, including mental health, is associated with a range of patient safety and clinical effectiveness outcomes including mortality, physical symptoms, adherence to treatment, and resource use such as length of stay, readmissions, and primary care use[28]. The Doyle *et al.* systematic review also states that patient engagement and decisions reflecting their preferences have a beneficial impact on health outcomes.

145. Regarding how patient experience benefits could translate into cost savings for services, the NICE Guidance Development Group considers that initial costs may be offset by cost savings (p. 19), and that there may be cost offsets due to improved safety, efficiency and effectiveness of healthcare (p.50)[29]. However, there is no available evidence on these potential benefits for mental health care interventions.

Non-monetised Health benefits for the individual

146. With the proposed changes to the MHA supporting improved patient safeguards and experience and enabling patients to have a say in their treatment and make better, more informed, decisions, it is expected that there will be significant beneficial impacts on wellbeing and health for patients who are detained under the MHA. For example, if patients participate in their CTP, have increased access to IMHAs, AMHPs and SOADs, are automatically referred to the MHT on a more regular basis, then they have more opportunities to voice any concerns and have their detention reviewed by the relevant staff. Also, if they are eligible for discharge at this stage, this could happen sooner than it might otherwise have, reducing demand for hospital beds.

147. These health impacts may be realised in the form of improvements to the patient's original condition as a result of more personalised and targeted treatments or they could be gained through a reduction in the stress or anxiety that patients may face during detentions after the safeguards implemented by the policy improve the overall patient experience. As mentioned above, there is evidence that improvements in patient experience and patient engagement are associated with increased adherence to treatment and have a beneficial impact on health outcomes[30].

148. These improved outcomes would be expected to have some direct health benefits to patients. However, due to the wide range of the conditions and circumstances experienced by patients detained under the MHA, it has been seen as prudent to not attempt to quantify these benefits as a reduction in QALY losses[31].

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[27] Vahdat, S., Hamzehgardeshi, L., Hessam, S., & Hamzehgardeshi, Z. (2014). Patient involvement in health care decision making: a review. Iranian Red Crescent medical journal, 16(1), e12454. doi:10.5812/ircmj.12454

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

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

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

[31] QALYs are explained in Annex E.

Non-monetised benefits for the Healthcare system: potential reduction in the number of detentions, length of detention and potential reduction in readmissions

149. **Some reduction in detentions for those who have set up Advance Choice Documents/Crisis Planning.** Interventions that focus on involving patients in identifying preferences and planning for their care in the event of a future mental health crisis, including ACDs, have been identified as potentially beneficial in reducing the risk of compulsory admissions[32]. A published systematic review estimated the pooled benefit of 5 studies and found a 25% reduction in compulsory admissions (ranging from 39% to 7%) among those receiving crisis-planning interventions compared with those who did not receive the intervention[33]. As not all the studies were England-based and some are not very recent (early 2000s), we would consider estimating a reduction of 7% reduction in detentions for those patients estimated to have set up an ACD in future iterations of this work if no new evidence comes to our knowledge. We would then need to assess whether this reduction in detentions and consequent increase in the number of available beds would cover unmet need or lead to costs savings.

150. **Usage of healthcare.** Once the improved safeguards that allow patients to be more involved in the decision making process are introduced, alongside more opportunities to review and challenge the detention and the replacement of the nearest relative with a nominated person, there is the potential for some detentions to be reduced in length. This may be especially relevant for patients that become 'institutionalised' for large periods in hospitals and for patients where their nearest relative is an inappropriate person to be involved in the decision-making process. As mentioned above, there is some evidence that improvements in patient experience are associated with improved use of resources such as length of stay, readmissions, and primary care use[34].

151. Since longer detentions have a direct cost pressure on NHS budgets, there could be large expected benefits realised if the improved safeguards were to result in a reduction in the average length of a detention. This would mean a cost saving for the NHS which could then be put to use elsewhere in the Healthcare system and generate further direct health benefits in the form of QALYs elsewhere in the economy.

152. This benefit has not been monetised due to the lack of clear evidence on exactly whether or how much length of stays are likely to be reduced by following the introduction of the policy changes outlined in this IA. However, the breakeven analysis section on p38 explores further the degree to which average detention lengths would need to fall by for the costs of the policy to be offset by this benefit alone.

Non-monetised wider economic benefits resulting from potential improvements in mental health outcomes

153. Under the proposed policy Option 2, it is also expected that there will be significant economic and social gains resulting from the improvements in health and wellbeing of patients detained under the MHA, largely through the improvements in human capital but also through wider impacts on the economy.

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

[33] See reference above.

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

154. The Organisation for Economic Cooperation and Development (OECD) has published a series of reports on the social and economic burden that arises as a result of mental ill-health in society[35] [36] [37]. The reports find that mental disorders contribute significantly to unemployment, sickness absence and lost productivity at work; people with severe mental illness also die up to 20 years younger, have a much higher rate of unemployment and are poorer than the general population.

155. The research consistently finds that healthier people contribute substantially more to the economy, acting through a variety of channels such as: greater investment in human capital due to expectations of a longer working life[38], greater labour market participation with increased retirement age and reduced absence from work[39], greater productivity and wages[40, 41], and greater savings rates[42] (also giving rise to greater capital investment).

156. There is evidence to support that higher numbers of health risks and health conditions are associated with lower levels of productivity[43]. Thus, it is expected that mental health patients formerly detained under the MHA would contribute more to the economy due to better mental (and likely physical) health outcomes and overall improved wellbeing.

157. The Independent Review recommendations are expected to improve labour and economic outcomes as improved wellbeing allows individuals to contribute more substantially to the economy through increased workforce participation, reduced absence and increased productivity. These impacts apply both to the healthier patients (with or recovering from mental health issues) and their families and carers, producing benefits to the individual in terms of earnings, and to the Exchequer in terms of income tax and National Insurance contributions. There could also be potential cost saving (to the Department for Work and Pensions, DWP) if some patients were able to stop claiming out of work benefits. Official data show that, in May 2018, approximately 39% (over 21,000 out of over 55,000) of people on incapacity benefits reported a diagnosed mental health condition[44].

158. There is also evidence on the effectiveness of improving population mental health, built through experimental trials, observational studies, and modelling, which provides a strong economic case for promotion and early intervention[45].

159. An economic case for the prevention of mental illness has collated evidence demonstrating that mental health problems have negative impacts on an individual's family, peers, employers, and wider society[46]. There is evidence that families of those with a range of physical health conditions, particularly those who are informal carers, are more likely to experience absenteeism or presenteeism, leading to reduced work productivity, poorer physical activity leading to a reduction in

[35] OECD (17 January2012). Sick on the Job? Myths and Realities about Mental Health and Work. Mental Health Work. Accessed: http://www.oecd.org/els/mental-health-and-work-9789264124523-en.htm
[36] OECD(8 July 2014). Making Mental Health Count. The Social and Economic Costs of Neglecting Mental Health Care. Accessed at: https://www.oecd.org/publications/making-mental-health-count-9789264208445-en.htm
[37] OECD (4 March 2015). Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work. Mental Health Work. Accessed at: http://www.oecd.org/employment/fit-mind-fit-job-9789264228283-en.htm
[38] Kalemli-Ozcan, S., Ryder, H.E. and Weil, D.N. (2000) Mortality decline, human capital investment and economic growth. Journal of Development Economics, 62: 1–23. Accessed at: https://www.sciencedirect.com/science/article/abs/pii/S0304387800000730
[39] WHO Commission on Macroeconomics and Health (2001) Macroeconomics and Health: Investing in Health for Economic Development. Geneva: World Health Organization. Accessed at: https://www.who.int/pmnch/knowledge/topics/2001_who_cmh/en/
[40] Bloom, D., Canning, D. and Sevilla, J. (2002) Health, Worker Productivity and Economic Growth. Pittsburgh, PA: School of Public Policy and Management, Carnegie Mellon University
[41] Health Systems, Health, Wealth and Societal Well-being Assessing the case for investing in health systems, European Observatory on Health Systems and Policies (2012), http://www.euro.who.int/__data/assets/pdf_file/0007/164383/e96159.pdf
[42] Alsan, M., Bloom, D. and Canning, D. (2004) The Effect of Population Health on Foreign Direct Investment, working paper no. 10596. Cambridge, MA: National Bureau of Economic Research
[43] Mitchell, R.J. & Bates, P. (2011). Measuring Health-Related Productivity Loss. *Population Health Management*, 14(2): 93–98. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128441/
[44] Department of Work and Pension statistics. Incapacity Benefit and Severe Disablement Allowance: by ICD medical condition, May 2018. Accessed at: https://www.gov.uk/government/statistics/dwp-benefits-statistical-summaries-2018
[45] McDaid, David, Park, A-La and Wahlbeck, Kristian (2019) The economic case for the prevention of mental illness. Annual Review of Public Health, 40. pp 373-389. https://doi.org/10.1146/annurev-publhealth-040617-013629 (also accessed at: http://eprints.lse.ac.uk/100054/1/McDaid_economic_case_prevention_mental_illness.pdf; https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-040617-013629)
[46] As above.

overall wellbeing and greater incidence of anxiety and depression[47,48]. If this is also true of family members of some of those with mental health conditions, implementation of the recommendations that improve mental health outcomes could have significant benefits for patients' families and wider networks as well as societal benefits through human capital.

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

Non-monetised economic benefits of health research and improvements in data

161. Following the Independent Review recommendations on the need for research on the uses of the MHA, the National Institute for Health Research Policy Research Programme (NIHR PRP), on behalf of the DHSC launched an open call for research proposals to address these gaps in the evidence base as mentioned in the section 'Research on ethnicity and the Mental Health Act'. This additional and improved research should lead to non-monetised benefits as, according to the literature, improved healthcare research could produce a range of wider benefits through 5 broad categories of impact: (1) 'primary research-related impact', (2) 'influence on policy making', (3) 'health and health systems impact', (4) 'health-related and societal impact', and (5) 'broader economic impact' [49,50].

162. The benefits associated with improvements in health and justice data are difficult to monetise. These are long term benefits that are likely to be instrumental to making the right decisions around patient care and treatment, for example, by having a better understanding of the relationships between individuals' protected characteristics and the likelihood of them responding in positive ways to particular types of care and treatment, and in particular by being better able to identify risks around specific groups who may have more difficulty accessing the correct level of care and ending up 'falling through the cracks'.

Other non-monetised benefits

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

164. The White paper accepts the recommendation to introduce a new Organisational Competency Framework, which will support NHS mental healthcare providers work with their local communities to improve the ways in which patients access and experience treatment. This should be addressed by the NHS Long-Term Plan's commitment to develop a Patient and Carer Race Equality Framework

[46] Mazanec, S. R., Daly, B.J., Douglas, S.L. and Lipson, A.R. (2011). Work Productivity and Health of Informal Caregivers of Persons With Advanced Cancer. Research in Nursing & Health Nurs Health, 34(6): 483–495. doi: 10.1002/nur.20461 (also accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4381346/)

[47] Alzheimer's Disease International and Karolinska Institutet (4 July 2018). Global estimates of informal care. Accessed at: https://www.alz.co.uk/news/global-estimates-of-informal-care

[49] Cruz Rivera S, Kyte DG, Aiyegbusi OL, Keeley TJ, Calvert MJ (2017). Assessing the impact of healthcare research: A systematic review of methodological frameworks. PLoS Med 14(8):e1002370. https://doi.org/10.1371/journal. (also accessed at: https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002370)

[50] Kuruvilla, S., Mays, N., Pleasant, A. & Walt, G. (2006). Describing the impact of health research: a Research Impact Framework. BMC Health Services Research, 6:134. Accessed at: https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-6-134

(PCREF) in line with the findings of the Independent Review with the goal of improving access, experience and outcomes for black and minority ethnic people[51].

Summary of Benefits – Unit Costs and Breakeven Analysis

165. The benefits associated with the proposed policy option are likely to be significant. However, due to the absence of quantitative evidence for these impacts, we were not able to monetise them. Instead, we estimate how large these non-monetised benefits need to be in order for the costs of the policy to be offset by them and illustrate them using required reductions in length of stay, reductions in readmissions and improved quality of life.

166. To summarise our approach: we first estimate the base cost of a length of stay using NHS Reference costs[52] and add on the additional estimated policy costs associated with detentions in Option 2; then we divide this total cost by the number of detentions to give an indication of the new average cost of a detention following the implementation of the policy.

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

168. Once we subtract the BAU cost of a detention from the policy cost of a detention, we estimate how large the non-monetised benefits need to be to offset the extra cost – e.g. if the additional cost per patient is £100 then we would need benefits valued at around £100 to offset this cost.

169. The average costs per detention is presented below.

Table 25. Average costs per detention (£, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Average
Option 1. BAU	26,650	26,590	26,540	26,490	26,440	26,440	26,440	26,430	26,430	26,430	**26,488**
Option 2. Policy	27,360	27,260	27,420	27,280	27,220	27,220	27,250	27,220	27,220	27,220	**27,270**
Detention Difference	710	670	890	790	780	780	810	780	790	790	**780**

170. The estimated additional average unit cost of a detention across the 10 year legislation period increases by around 3% or around £800 (undiscounted cost) after the policy implementation.

171. To put this breakeven analysis into perspective, the current average length of a detention is roughly estimated to be 53.5 days[53], and the average daily cost of a detention is estimated at around £495 under BAU (£26,488 divided by 53.5) and at around £510 after the implementation of the policy (£27,270 divided by 53.5). This would suggest that, if the only benefit that is realised after the introduction of the policy was a reduced length of stay in the average detention by 2 days (around £800, the difference between cost of a detention under BAU and under the policy, divided by the estimated dayly cost of a detention under BAU at £495 then rounded up) and the subsequent increase in available beds for other patients, then the policy costs would be offset by the benefits –

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

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

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

see Annex F for further detail. This could be achieved through the deinstitutionalisation of patients who previously were subjected to long-term detentions but now have better access to appeals and care treatment plans and therefore a higher chance of discharge.

172. Similarly, improved patient safeguards and involvement in decision making could also lead to improved treatment adherence and, in turn, a reduction in the number of people with repeated detentions. Currently, 15.5% of people are detained more than once in a year – under 6,500 people in 2018/19[54]. Dividing the additional annual cost of the policy (see Table 17) by the estimated cost of a detention (see Table 25) produces the required reduction in the number of detentions to make the policy cost effective – this is estimated at around 2,600 per year on average during the 10-year period. Assuming in the absence of intervention, the proportion of repeat detentions would remain constant at 15.5% for the 10 year legislation period, we estimate that this would need to fall to 12.7% for the costs of this policy to be completely offset by the savings gained from a reduction in the number of repeat detentions – see Annex F for further detail.

173. There may also be so some potential benefits linked to changing the first detention renewal point from 6 months to 3 months which may help to disperse the spike in discharges currently seen at 6 months, potentially saving over 25,000 detention days per year, equivalent to around 0.25 days per detention,.This alone would not offset the costs of the policy but is another example of the potential ways that the Independent Review recommendations could lead to potential monetary savings in the form of reduced detention lengths. Annex F contains further detail of this calculation.

174. Alternatively, benefits may be realised in terms of direct health improvements, which materialise either after detained patients respond better to treatment (where they are more involved) or simply through patients experiencing less stress and anxiety resulting from a poor experience whilst being detained. For these health benefits to completely offset the costs of the policy in each year, we divided the additional cost each year by £60,000 to work out the number of QALYs this would be equivalent to. Then this was divided by the number of people detained (i.e. some with repeated detentions) in each year to work out the health gains that would need to be gained per detention. It is estimated that each detention would need to provide a health improvement (reduction in health loss) equal to 0.04 QALYs for the costs of the policy to be offset. This may seem small, but would suggest that, illustratively, the person would need to experience perfect health for around 14.6 days in the year following treatment (0.04*365 days = 14.6 days).

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

[54] NHS Digital, Mental Health Act Statistics, Annual Figures 2018-19, accessed at https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures

Risks and Assumptions

176. This section explores how sensitive the estimated total discounted costs over a 13-year period (i.e. the Net Present Value, NPV) are to potential variations in key input variables or assumptions. These are presented separately for the Health and Social Care system and for the Justice system.

Sensitivity Analysis – Health and Social Care System

177. We present in the table 26 below the key assumptions in each model for the central scenario and for alternative scenarios – a best and worst case scenario (these are the highest and lowest possible costs estimates). The different models for detentions and CTOs are explained in their respective annexes; for the other models, in the absence of other evidence, various logical ranges have been applied to try and understand how costs (NPV) will change if the central estimates that have been used are not as accurate as anticipated.

178. Due to the complexity of the modelling, we have limited this section to the assumptions that have the greatest impact on costs – see table 26 below. We then present the impact on costs when each key assumption varies and all the other remain constant under a central scenario. This is followed by a summary section covering two scenarios where we vary some key assumptions simultaneously and assess the impact on total costs.

Table 26. Summary of key assumptions and sensitivities

Models	Assumption	Central scenario	Best case scenario	Worst case scenario
Detention population	Growth factor	6% increase per year	2% increase per year	10% increase per year
	Decrease due to the NHS LTP	10% decrease per year (on top of the 6% increase above, so 4% decrease overall)	15% decrease per year (on top of the 6% increase in the central scenario, so 9% decrease overall)	0% decrease per year (on top of the 6% increase in the central scenario, so 6% increase overall)
CTO population	Growth factor	1.2% increase per year	-6% increase per year	9% increase per year
	Decrease due to recommendations	40% decrease over 5 years (on top of the 1.2% increase in the central scenario)	50% decrease over 5 years (on top of the 1.2% increase in the central scenario)	0% decrease over 5 years (on top of the 1.2% increase in the central scenario)
IMHAs	IMHA uptake	40%	20%	60%
	Salary unit costs (including oncosts and overheads)	£49,822	-20%	+20%
AMHPs	Additional workload due to recommendations	30.3 hours	-20%	+20%
	Salary unit costs (including oncosts and overheads)	£72,592	-20%	+20%
SOADs	Rate of SOAD visits per Detainee type (Refusal, Incapable, ECT, CTO)	0.09-1.86	-20%	+20%
	Unit costs per visit	£375	-20%	+20%
Clinical teams	Additional workload due to recommendations	Central estimates across different staff types	-33%/-50%	+33%/+50%

179. **Detentions**. In the central scenario we assume that detentions would increase 6% per year in the absence of any policy changes. This assumption is based on historical data that are not directly comparable as the official data source for MHA changed in 2016/17 (see Annex G), and the new dataset is still improving in quality and coverage. To account for this, we assume that the increase may range from 2% (which is based on average changes year on year for providers submitting good quality data to the Mental Health Services Dataset since 2016/17)[55] to 10%, which is the highest yearly change observed in the last few years (in 2014/15).

180. The impact of the NHS Long Term Plan, which includes ambitions to improve mental health community services and crisis care is assumed to lower detentions by an approximately 10%. However, the exact impact of the LTP is not known and we are assuming a range of 0% change (worst case) or 15% decrease (best case).

181. **CTOs**. In the central scenario, the number of CTOs is assumed is to grow 1.2% each year of the forecast based on historical trends (average from 2010/11 to 2015/16). This a volatile time series with an increase in one year followed by a decrease in the following year in general (see Annex B.II). We assume a 7.6% percentage point change around this estimate (this is the standard deviation of the average of 1.2%) – from -6% to 9% (rounded to nearest whole number). We also assumed that impact of the Independent Review recommendations would lower the number of CTOs – in the absence of evidence we assume a decrease of around 40% in the central scenario, which is aligned with the expectations of the Review, with a range from 0% (worst case) to 50% decrease (best case).

182. Using the assumptions in table 26 at the start of this section, our estimates are in table 27 below. They show that the clinical teams and SOAD models are both sensitive to the forecast of detentions, with the clinical teams costs possibly increasing or decreasing by over £600m based on the two scenarios that have been tested. On the other hand, the cost of AMHPs is similarly sensitive to alterations made to the assumptions that forecast CTOs, with costs increasing by over £50m if CTOs were to increase by 9% a year.

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

Table 27. Impact of varying assumptions for detentions and Community Treatment Orders (CTOs) on Net Present Value (NPV) relative to the central scenario (2020/21 prices, discounted, including opportunity cost)

Assumption	Scenario	IMHAs		AMHPs		SOADs		Clinical teams		Total effect	
		Change in NPV (£m)	% change in NPV	Change in NPV (£m)	% change in NPV	Change in NPV (£m)	% change in NPV	Change in NPV (£m)	% change in NPV	Change in NPV (£m)	% change in NPV
Model: Detentions											
Growth factor	Central 6%	£64.5m	-			£151.0m	-	£1,575.4m	-	£1,763.2m	-
	2%	-£21.4m	-33.2%			-£41.5m	-27.5%	-£419.4m	-26.6%	-£482.4m	-27%
	10%	+£31.7m	+49.2%			+£55.2m	+36.6%	+£621.5m	+39.4%	+708.4m	+40%
Decrease due to the NHS LTP	Central – 10%	£64.5m	-			£151.0m	-	£1,575.4m	-	£1,763.2m	-
	0%	+£5.6m	+8.7%			+£14.2m	+9.4%	+£110.4m	+7.0%	+£130.3m	+7%
	15%	-£2.8m	-4.3%			-£7.1m	-4.7%	-£55.2m	-3.5%	-£65.1m	-4%
Model: CTOs											
Growth factor	Central 1.2%	£64.5m	-	£40.4m	-	£151.0m	-	£1,575.4m	-	£1,831.3m	-
	-6%	+£6.7m	+10.4%	-£20.4m	-50.5%	+£3.1m	+2.0%	-£66.1m	-4.2%	-£76.7m	-4%
	9%	-17.7m	-27.4%	+£52.1m	+128.9%	-£6.7m	-4.4%	+£171.1m	+10.9%	+£198.9m	+11%
Decrease under the MHA Review recommendations	Central 40%	£64.5m	-	£40.4m	-	£151.0m	-	£1,575.4m	-	£1,831.3m	-
	0%	+£4.1m	6.3%	+£16.6m	+41.0%	+£5.5m	3.6%	+£54.7m	+3.5%	+£80.9m	+4%
	50%	-£1.0m	-1.6%	-£4.1m	-10.1%	-£1.4m	-0.9%	-£13.7m	-0.9%	-£20.2m	-1%

Professional groups: IMHAs, AMHPs, SOADs and clinical teams

183. Using the assumptions in tables 26 and 27 at the start of this section, our estimates are in the table below. The first key impact to highlight is the clinical teams' increase in hours following the implementation of the recomendations, as flexing these times by between 33% and 50% could increase or decrease costs by around £600 million. The overall costs of SOAD visits are also quite sensitive to changes in the rate of visits and unit costs associated with these visits, where an illustrative increase or decrease of 20% could lead to an increase or decrease of almost £30m in costs.

Table 28. Impact of varying assumptions for professional groups on the Net Present Value (NPV) in relation to the central scenario (2020/21 prices, discounted, including opportunity cost)

Assumption	Scenario	Profession		Total effect
		Change in NPV (£m)	% change in NPV	% change in NPV
IMHAs				
	Central	£64.5m		
Uptake (Central: 40%)	20%	-£4.4m	-7%	0%
	60%	+£4.4m	+7%	0%
Salary unit costs (including oncosts and overheads) (Central: £49,822)	-20%	-£12.8m	-20%	-1%
	+20%	+£12.8m	+20%	+1%
AMHPs				
	Central	£40.4m		
Additional workload (Central: 30.3 hours)	-20%	-£7.1m	-18%	0%
	+20%	+£7.2m	+18%	0%
Salary unit cost (including oncosts and overheads (Central: £73,592)	-20%	-£7.3m	-18%	-0%
	+20%	+£7.3m	+18%	+0%
SOADS				
	Central	£151.0m		
Rates of SOAD visits (Central: 2017/18 rates: 0.09-2.20)	-20%	-£30.2m	-20.0%	-2%
	+20%	+£30.2m	+20.0%	+2%
Unit costs (Central £385)	-20%	-£29.7m	-20.0%	-2%
	+20%	+£29.7m	+20.0%	+2%
Clinical teams				
	Central	£1,575.4m		
Additional workload (Central)	-33% to -50%	-£611.2m	-38.8%	-33%
	+33% to +50%	+£611.2m	+38.8%	+33%

Sensitivity Analysis – Justice System

184. Due to the uncertainties in this type of analysis, sensitivity analysis has been conducted on each individual recommendation.

185. Some of the key assumptions, and the range of uncertainty being used for the scenarios have been listed below, with some additional detail for the automatic referral recommendations in Annex D:

- Recommendation 46c (on detention periods): range in expected increase of section 3 applications between 25% and 50%, with central scenario using the median 37.5;
- Recommendation 53 (on automatic referrals for Part III patients): range in expected increase of section 71(2) referrals between 380% and 460% due to varying methodologies with central scenario using a 430% increase;
- Recommendation 137 (on automatic referrals for people on conditional discharge): the modelled volumes of referrals profiled vary depending on the assumed success rate of achieving absolute discharge (no conditions attached, i.e., the criteria for detention are no longer met)[70] for the cohort of patients being automatically referred in previous years. These success rates differ depending on the duration spent on conditional discharge (includes conditions such as meeting healthcare staff, taking medication, living at a particular place)[71] at the time of the tribunal. At the two year point the success rate varies between 3% and 7%, with the central scenario using 5%. At the six year point the success rate varies between 30% and 36%, with the central scenario using 33.3%;
- Recommendations 61 and 64 (on automatic referrals for CTO patients): range in reduction of CTO volumes from 50% in low cost scenario to 0% reduction in the high cost scenario, reflecting the assumptions used in the Health and Social Care system sensitivity analysis;
- Recommendation 46e (on the certifying 10 days in advance of a tribunal hearing that a section 3 patient continues to meet the criteria for detention): the estimated benefits are dependent on the assumption that in 50% of future cancellations, the panel can be reallocated and thus there are no cancellation fees to be claimed, saving half of the current expenditure (which for section 3 patients is 37% of the total claims);
- Unnumbered recommendation CTP (treatment choice): the costs are generated by the expected increase in hearing times from considering the statutory CTP which subsequently impacts on the hearings per sitting day ratio being used (extra time ranging between 20 mins and 60 mins with a central scenario of 40 mins generated by HMCTS operational experts);
- Recommendation 133 (on leave and transfer of restricted patients): varying rate of wage inflation for HMMPS staff ranging from 1%, 2%, 3% for the low, central and high cost scenarios, respectively. The MoJ has been funded for a 1% increase but the Independent Pay Review Board is likely to recommend a higher rate.

186. Sensitivity analysis has been modelled using three plausible scenarios (low cost, central cost, high cost). These have been aggregated in tables 29 and 30 across all of the recommendations to summarise the range of possible impacts.

187. Therefore, the total overall cost to the Justice system could range between around £110m and £260m, though based on our central forecasts and assumptions, it is more likely to be around £160m.

[70] https://www.mind.org.uk/information-support/legal-rights/courts-and-mental-health/section-3741/

[71] As above.

Table 29. Low Cost scenario impacts (£millions, 2020/21prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	39.0	38.7	38.4	38.1	37.8	37.5	37.2	36.9	36.6	36.4	**376.6**
Option 2. Policy	46.1	£44.3	55.5	48.6	48.5	48.4	51.0	47.4	48.0	47.8	**485.6**
Additional cost	7.1	£5.5	17.1	10.5	10.7	10.9	13.8	10.5	11.3	11.5	**108.9**

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Option 1. BAU	39.0	38.7	38.4	38.1	37.8	37.5	37.2	36.9	36.6	36.4	**376.6**
Option 2. Policy	56.9	55.2	71.7	64.4	64.9	64.8	67.4	63.8	64.2	64.1	**637.4**
Additional cost	17.8	16.5	33.3	26.3	27.1	27.3	30.2	26.9	27.6	27.7	**260.8**

Summary of Sensitivity Analysis

188. Table 31 below shows the impact on the NPV from combining all the high and low assumptions made in best and worst case scenarios respectively. The analysis suggests that, if all the assumptions made throughout the IA were to be the worst cases, then the NPV of the costs of Option 2 could rise to £4.4 billion; on the other hand, if the assumptions took on their best cases, costs could fall to £0.9 billion.

Table 31. Summary of scenario analysis impacts (£millions , 2020/21 prices, discounted, including NHS opportunity costs)

Policy area	Central cost estimate NPV	Worst case cost scenario NPV	Best case cost scenario NPV
IMHAs	65	138	37
AMHPs	40	198	13
SOADs	151	333	69
Clinical Teams	1,575	3,504	698
Automatic Referrals	97	155	71
Treatment choice	26	41	13
Detention Criteria	-1	-1	-1
Leave and transfer categorisation	3	6	1
Research	4	4	4
QI	27	27	27
Total	**1,988**	**4,405**	**932**

Private Sector Costs

189. If the burden in the private sector is above £5 million in each year, then an Impact Assessment requires consideration by the Regulation Policy Committee (RPC, an independent advisory committee) and clearance by the Reducing Regulation Committee (RRC, a Cabinet Sub-Committee). For reassurance that the accepted recommendations in the Independent Review of the MHA will not impose a substantial burden in the private sector, the cost estimates for the private sector are presented below for:

- the Health and Social Care system – see Annex H for detail on the method;
- the Justice system.

Health and Social Care System

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

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

192. The acute and secure mental health hospital bed capacity can be split by sector (public or independent sector supply) and by type of funding (public or private funding). In 2018, NHS beds are estimated to account for 67.5% of MH bed provision (public funding/public supply), whilst 29.6% of bed capacity is for services outsourced by the NHS to the private sector and only 2.9% of bed capacity represented privately funded services in independent hospitals[72].

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

194. To estimate the costs for private funding and independent sector supply, we applied the 2.9% market share to the overall estimated cost in each year and that provides an estimate of around £1.1m per year over the period – this is below £5m in each year (see table 31 below).

Table 31. Estimated additional monetised costs for the private sector (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	Total
Total additional clinical team costs	39.3	39.5	46.0	43.6	44.8	45.	46.6	45.	45.4	45.6	**440.8**
Assuming 2.9% of these costs are for the independent sector/ private patients											
Discounted	1.1	1.1	1.3	1.3	1.3	1.3	1.4	1.3	1.3	1.3	**12.8**

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

Justice System

195. The Independent Review recommends that patient and families should have non-means tested Legal Aid under specific conditions. Legal Aid is provided by legal firms/ solicitors, but it has not been presented as a direct cost to business as it is not a regulatory provision and is excluded from the Small Business, Enterprise and Employment MHA (SBEE) [s22 (4) (c)] [73] .That is, private sector impacts for the Justice system are considered not to have direct cost to business under these considerations.

Summary and preferred option

196. Overall, Option 2 is considered to be the preferred option as the implementation of the Independent Review's recommendations is expected to help achieve the policy objectives and make the MHA more fit for purpose. The recommendations are expected to bring significant benefits to patients interacting with the MHA through increasing patient choice and autonomy over their treatment, ensuring they are treated with dignity and respect, improving inpatient therapeutic environments and promoting equality throughout the process.

197. Over the 13 year policy period, the discounted costs (including health opportunity costs) are estimated to be £1.988 billion. Whilst no benefits have been monetised at this time, the evidence on the cost effectiveness of improving mental health outcomes suggests that there would likely be considerable benefits associated with a policy that specifically improves safeguards and the patient journeys of people with mental health disorders. Option 2 is therefore expected to be an overall net benefit when compared to the counterfactual, Option 1.

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

Annex A. Estimating the cost savings of improvements in community and crisis mental health care in the NHS Long Term Plan (LTP)

1. We expect that improvements to mental health community and crisis care as set out in the NHS LTP would lead to a fall in the number of detentions, which in turn, should lead to a fall in secondary care costs relating to detained patients.

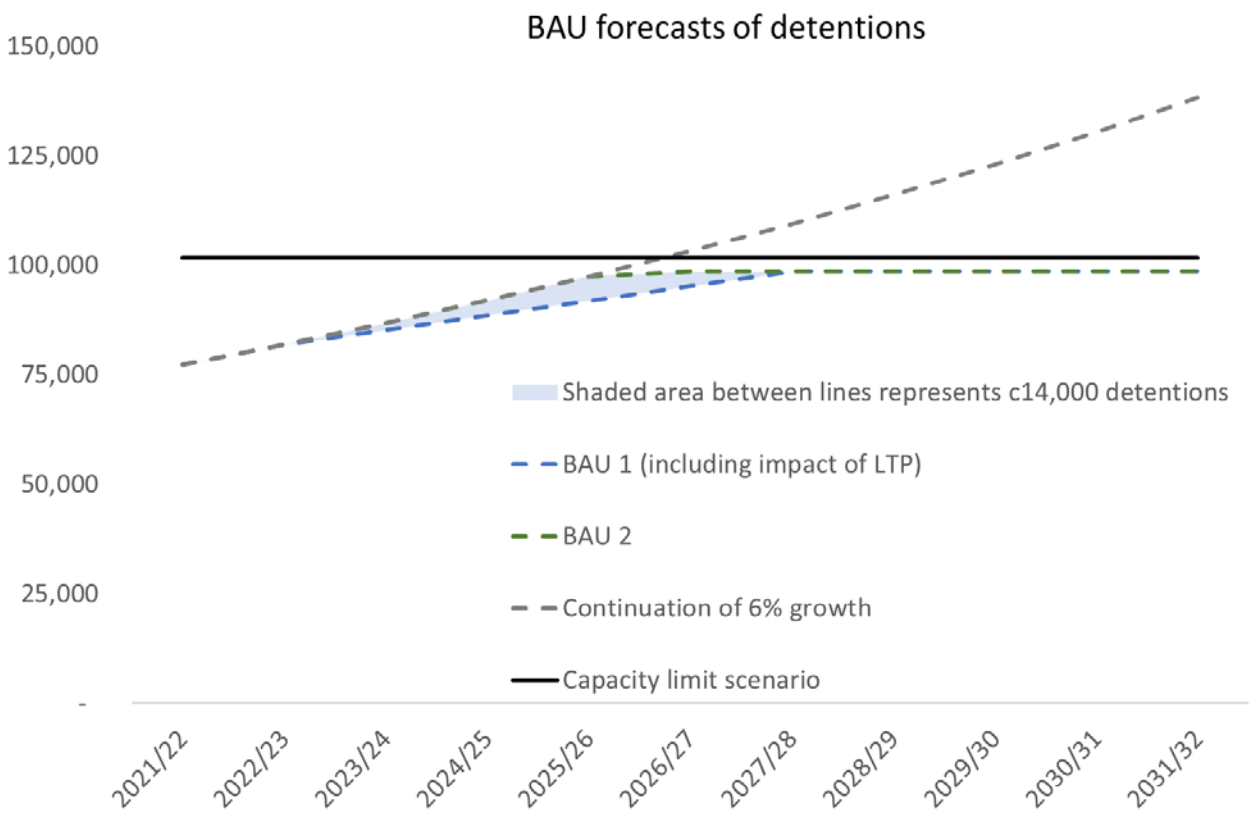
2. The NHS LTP will be implemented independently of the White Paper, and the effects are therefore considered under the Business As Usual in the Impact Assessment.

3. The current BAU (Option 1 or BAU1 in this section) approach for detentions is set out in Annex B.1 and assumes that:

    - If no policy improvements took place detentions under the MHA would increase by 6% per year (based on historical changes) until being constrained by inpatient capacity.
    - We then assume in our central scenario that this trajectory will decrease by 10%, from improvements in mental health community care services and crisis services delivered through the LTP.
    - This 10% reduction is assumed as a phased decrease over 5 years from 2023/24 to 2027/28, after which the number of detentions remains flat.

4. If these policy improvements were not included in the NHS LTP and had been instead considered a policy option following from the White Paper, then the assumed reductions in detentions would have been included under the benefits following from policy implementation.

5. To illustrate this possibility, we consider a second scenario designated as BAU2 where the LTP has no impact on reducing detentions. That is, there is no 10% reduction included in the forecast and consequently the number of detentions reaches the capacity constraint earlier. The graph below demonstrates the difference between BAU1 and BAU2 in terms of the detentions forecast – around 14,000 detentions for the period 2023/24 to 2026/27 after which the number of detentions remains flat and is identical to BAU1):



6. Despite the difference between the two BAUs looking small, this change in the number of detentions is the equivalent of around £300m across the 10-year policy period, which might be overlooked when the full impact of the NHS LTP is considered. This means that if we assumed that BAU2 was used in the IA and we still assumed the reduction in detentions in the policy scenario, then costs would fall by around £300m.

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

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

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

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

3. In brief, the BAU approach assumes that:

    - Detentions under the MHA would increase by 6% per year (based on historical changes) if no policy improvements took place.
    - Then, we assume in our central scenario that detentions would decrease by 10% per year, following improvements in mental health community care proposed and implemented within the NHS Long Term Plan[74]; this reduction is in line with the expectations in the Independent Review.
    - This is modelled as a 10% phased decrease over 5 years from 2023/24 (i.e. reaching 10% decrease on 2027/28), with a flat projection after five years reflecting bed/capacity limitations.

Purpose	To estimate the number and cost of detentions during the policy period for BAU, split by MHA section.
Main outputs	Number of detentions Estimated cost of a length of stay (i.e. excluding MHA assessments)
Main data sources	Two data sets for number of detentions (see Annex H): KP90 data, the official data source for the uses of the MHA until 2015/16, covers 2008/09 to 2015/16 Mental Health Services Data Set (MHSDS), from 2016/2017
Data caveats	The KP90 and MHSDS datasets are not directly comparable. The KP90 data double count transfers between hospitals. The Mental Health Services Data Set (MHSDS) data are still improving and undercounts detentions. Estimated increase in detentions from the previous year for 2016/17 and 2017/18 is based on a subset of providers providing good quality data in 2015/16 (KP90), and in 2016/17 and 2017/18.
Main assumptions – Option 1 (BAU)	**Baseline number of detentions;** The baseline is set at 2015/16 and is estimated at 54,400 detentions. We adjusted the number of detentions in 2015/16 (KP90) for double counting by removing 15% of these detentions – we assumed this to be the proportion of detentions that were 'transfers on section' in the 2016/17 MHSDS. **Annual increase in detentions** is assumed to be 6% − this is the weighted average of the percentage change year on year from 2012/13 to 2017/18, with

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

	lower weights for the last two years to account for poorer coverage of providers. Weights for previous years assumed to be 1, or 100% coverage of providers. **Then, this increase in detentions is countered by a reduction in detentions.** The NHS Long Term Plan is assumed to contribute to a reduction in the number of detentions from 2023/24, which we estimated to be a gradual reduction of 10% over 5 years. From the fifth year and onward the forecast for detentions is assumed to be flat – we assume that the stable number of inpatients in mental health services (annually around 103,500 on average since 2011/12)[75] reflects bed/capacity limitations (central scenario).
Cost of length of stay	The cost of the length of stay in hospital was calculated by multiple the mean unit cost per bed day (£422) by the mean length of a detention (53.5 days). The cost was then inflated to 2020/21 prices using a GDP deflator. The cost of the length of stay in a hospital during a detention in 2020/21 prices is £24.8k.

Data sources and baseline

4. Data published prior to 2016/17 were collected using the KP90 data collection, which was an aggregate data collection[76] (see Annex H). The 2016/17 MHA Statistics publication[77] was the first to use the Mental Health Services Data Set (MHSDS) alongside the 'Annual uses of the Mental Health Act 1983 in English acute trusts' (Acute) collection for 2016/17 and 2017/18[78] (which are not in scope for MHSDS[79]).

Data caveats

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

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

[75] NHS Digital (28 November 2019). Mental Health Bulletin 2018-19 Annual Report. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2018-19-annual-report

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

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

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

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

Option 1. BAU Model

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

8. Detention baseline:
   - The baseline is calculated as the 2015/16 KP90 count adjusted for double counting, by using the percent of transfers on section in 2016/17'[80]: 63,622 detentions * (100%-15%) ≈ 54,000.
   - There are limitations associated with this approach. We are assuming that all 'transfers on section' were double counted in KP90 figures, and that these 2016/17 figures are applicable to 2015/16. From the 2017/18 and 2018/19 data we know that this proportion is consistent. All data caveats that apply to the MHSDS data also apply to this adjustment.
   - This baseline will be projected forward using the growth assumption.

9. Growth rate:
   - Given our uncertainty around the quality of the MHSDS data, we have used a weighted average of the growth rates from 2012/13 to 2017/18, where the weight assigned to each rate corresponds roughly to this uncertainty – see table below.
   - We have estimated the quality of the MHSDS data to be equal to the proportion of detentions captured in the 'high quality' data subset in 2017/18. We have calculated this by looking at these percentage of detentions as at 31 March each year. Because this is based on a single point in time, there is greater uncertainty around these figures. However, the factors for 2016/17 and 2017/18 are relatively constant, which gives confidence in these results. The weights are shown below, based on the last seven years of data, i.e., six years of growth.
   - The weighted average of the growth over the last six years produces a yearly growth rate of 6%. We have assumed that the data quality of KP90 is at 100%, that is, giving equal weighting to all KP90 growth rates and placing much less emphasis on the MHSDS growth figures. The annual growth rate of 6% is applied from the year 2016/17.

Table BI.1. Number of detentions in England, percentage increase and weights used in the weighted average (DHSC calculation)

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	KP90	KP90	KP90	KP90	MHSDS	MHSDS	MHSDS	MHSDS
Number of detentions	50,408	53,176	58,399	63,622				
Percentage increase year-on-year	3.7%	5.5%	9.8%	8.9%	2.0%	2.4%	2.0%	0.8%
Weights	100%	100%	100%	100%	54%	53%		

Notes:
- The published number of detentions in 2016/17 and 2017/18 (45,864 and 49,551, respectively) were considered an undercount and were not used. Instead, we used the estimate increase published by NHS Digital in their annual MHA Statistics for these years[81,82].
- The percentage increase in detentions in 2018/19 in relation to 2017/18 has not been included in the calculations. To estimate yearly changes, NHS Digital uses a subset of providers who have provided good quality data since 2015/16, the last year of KP90, and this number has been decreasing from 35 in 2016/17 to 33 in 2017/18, and 28[83] in 2018/19. We took a conservative approach and decided not to use

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

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

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

[83] NHS Digital (29 October 2019). Mental Health Act Statistics, Annual Figures: Background Data Quality Report - England, 2018-19 Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures

the change in 2018/19 as it is based on a small number of providers and could potentially bias the average yearly change in detentions to lower values.

- The percentage increase in detentions in 2019/20[84] in relation to 2018/19 was also not included in the calculations, as data quality is still improving. NHS Digital[85] has stated that "The headline detention figures for 2019/20 are up 1.8 per cent from last year. This does not represent the true change in detentions due to changes in data quality. MHSDS data quality (as the main data source) has improved whilst that from Acute providers making separate ECDS [Emergency Care Data Set] returns has declined. In order to provide a like-for-like comparison to last year's figures, we have limited our analysis to a smaller group of 24 providers (23 NHS and one independent). These providers all submitted data to KP90 in 2015-16. They all remained open to 2019-20, and submitted 12 months' data about the Act to the MHSDS during each annual period. In addition our ongoing investigations did not reveal any significant data quality issues in their MHSDS data about the Act. Using this methodology, our estimate for the true change in detentions from 2018-19 to 2019-20 is an increase of 0.8 per cent." (p.11)

10. **Reduction in detentions following improvements in services.** The Independent Review expects that if its recommendations are accepted then detentions under the MHA will decrease. It acknowledges that there is "no clear single driver for the rising rates of detention, similarly there is there no simple solution to addressing them" (p. 103)[86]. It also acknowledges that there is not sufficient evidence on the drivers for detentions and that improved research and evaluation should cover alternatives to detention in inpatient settings, interventions to prevent crisis or the escalation of crisis, and the social factors that lead to crises.

11. Their consultation/collection of evidence on what could reduce detentions is summarised by the recommendations below (p.109)[87]:

- Improved mental health crisis and community-based mental health services, aiming at increasing access to all and to "different disadvantaged groups, including but not limited to LGBTQ+, ethnic minority communities, people with learning disabilities or autism, and asylum seekers and refugees." (p. 106)
- Research into service models and clinical social interventions that prevent detentions, and consequent policy development of alternatives to detention and crisis prevention.
- A "concerted, cross-organisation, drive to tackle the culture of risk aversion."

12. The first recommendation above on improved crisis and community services is being taken forward as part ofaddressed by the NHS Long Term Plan[88], published on January 2019. It is further detailed in the NHS Mental Health Implementation Plan 2019/20 – 2023/24[89], published in July 2019, which informs that:

- From 2019/20, local services are expected to "stabilise and bolster current core community services" (p.26).
- By 2023/24, there will be 100% coverage of 24/7 age-appropriate crisis care, including (p.30):
    - "24/7 Crisis Resolution Home Treatment (CRHT) functions for adults (…);
    - 24/7 provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions (…)

[84] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019-20. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures

[85] NHS Digital (27 October 2020). Mental Health Act Statistics, Annual Figures 2019-20: Summary Report V1.1. Accessed at: https://files.digital.nhs.uk/99/3916C8/ment-heal-act-stat-eng-2019-20-summ-rep%20v1.1.pdf

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

[87] As above.

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

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

    - A range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways;
    - A programme for mental health and ambulances, including mental health transport vehicles, training for ambulance staff and the introduction of nurses and other mental health professionals in Integrated Urgent Care Clinical Assessment Services."
- Also, by 2023/24, all general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults.

13. The Independent Review also recommends further research into service models and clinical social interventions that prevent detentions and actions to tackle the culture of risk aversion. We consider that development into these areas will take longer and will not affect significantly the number in detentions in the near future in a way that we are able to include them in our estimates of the reduction in detentions.

14. In line with the Review's expectations, we assume that these improvements could lead to a reduction in detentions of around 10%. This reduction is assumed to start in 2023/24, the first year of full implementation of the improvement in crisis care services in the NHS Long Term Plan – we assume this to be a 10% phased decrease over 5 years from 2023/24 (i.e. reaching 10% decrease on 2027/28), with flat projection after five years to account for an assumed stable number of mental health beds.

Average cost of a length of stay (not including Mental Health Act assessments)

15. In summary, the average cost of a length of stay was calculated by multiplying an estimated mean unit cost per bed day (£422) by the mean length of a detention (assumed to be 53.5 days). The cost was then inflated to 2020/21 prices using a GDP deflator. The cost of detention in 2019/20 prices is estimated at around £23.4k. This estimate was used in the breakeven analysis of costs/benefits.

16. Limitations:
    - The length of stay is underestimated, at least in the shorter stays, as it only covers spells in the same provider and does not include the total number of days when patients are transferred to another provider due to the complexity of the data extraction. This underestimates the detention costs, and the scale of this underestimate is not known.
    - These estimates do not include the costs of MHA assessments.

17. The method is explained in more detail below.

18. **Bespoke data extract.** This analysis is based on a bespoke (and unpublished) NHS Digital data extract from the MHSDS[90] showing number of hospital spells by the number of days detained (in five-day bandings and summary statistics) for 2016/17. This extract only covers spells in a single provider, as total lengths of stay for those transferred between providers are not calculated due to the complexity of the algorithm; it also does not include detentions in acute providers.

19. **Average length of stay.** The mean length of stay of all detentions in the data extract is 53.5 days and the median is 25.0 days. Both the mean and the median are likely underestimates – this is because the length of stay is underestimated, at least in the shorter stays, as total length of stay for those transferred between providers is not included as explained in the paragraph above. To take a more cautious approach, the higher of the mean or median length of stay has been used to calculate costs - weused the mean.

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

20. **Comparing with MHA statistics.** The number of hospital spells that ended and are therefore included in the data extract is around 40,000. There were 45,864 detentions recorded during 2016/17 in the MHA Statistics[91], almost 6,000 more than the number which ended in the year.

    - The data extract only uses MHSDS data and therefore excludes detentions in acute providers; and only includes detentions in a single provider (i.e. excludes transfers between providers).
    - The data extract only includes detentions that ended before 1st April 2017 and the 2016/17 MHA Statistics reports detentions starting in the year.
    - Note also that 2016/17 has incomplete coverage (first year of the MHSDS collection, still experimental data) and may undercount measures.

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

Table BI.2. NHS reference costs per bed day by mental health care cluster, 2018/19

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

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

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

[91] NHS Digital (10 October 2017) *Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics*. Accessed at: https://digital.nhs.uk/catalogue/PUB30105

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

Table BI.3. Estimated cost of a detention under the MHA, 2018/19 (deflated to 2020/21 prices)

Length of stay, days (all detentions)		Cost (in 2020/21 prices, rounded to the nearest thousand)		
		Lower estimate, £417	Mean, £464	Upper estimate, £511
Mean	53.5	£22.000	£25,000	£27,000

Notes:

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

23. Sensitivity analysis – see Risks and assumptions section.

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

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

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

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

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

Purpose	To estimate the number of CTOs during the policy period for BAU and for the policy option
Main outputs	Number of CTOs Workforce costs relating to CTOs (includes responsible clinicians, nurses, and care co-ordinators. Potential cost savings from the reduction of CTOs.
Main data source	KP90 data, cover 2008/09 to 2015/16 Note. The MHSDS data on CTOs were not considered to be of sufficient quality to allow analysing changes in the time series, so not used.
Data caveats	See section on detentions above.
Main assumptions – Option 1 (BAU)	Start date of policy is assumed to be 2023/24, once legislation is expected to be in place. CTO BAU forecast assumes an annual rate of increase of 1.2% based on the average rate of increase over the past seven years data from 2010/11 to 2015/16 (excluding the MHSDS dataset) Following advice from clinicians, we assumed that contact time (assessment and total contact time for a new patient) for each CTO is as follows: 3 hours for consultants and 27 hours for care co-ordinators Hourly costs for consultants and care co-ordinators are estimated to be £108 and £32.5 respectively in 2017/18 prices, and inflated to 2020/21 prices (£114 and £34, respectively)
Main assumptions – Option 2 (Policy)	**CTOs are assumed to reduce gradually by 40% from 2023/24 up to and including 2026/27 and thereafter this lower number will increase by 1.2% per year in line with historical changes** Contact time with clinical staff: • Current responsibilities use the same contact time as BAU • Additional responsibilities – for ease, these estimates were done in the clinical teams model (see Annex B.VI)

Option 1. BAU Model

5. To estimate the annual changes in CTOs the average of the previous seven years data was taken (excluding MHSDS data)[92] – equivalent to an annual increase of 1.2% – see table below.

Table BII.1. Number of Community Treatment Orders and percentage annual increase (2010/11 to 2015/16)

	KP90 2010/11	KP90 2011/12	KP90 2012/13	KP90 2013/14	KP90 2014/15	KP90 2015/16	**Average**
Number of CTOS	3,834	4,220	4,647	4,434	4,564	4,361	
% annual increase	-6.6%	10.1%	10.1%	-4.6%	2.9%	-4.4%	**1.2%**

6. Staff costs for RCs include salary, oncosts and overheads and were estimated based on the costings for a hospital-based consultant in psychiatry, with the total cost per hour estimated at £108 (in 2017/18 prices); staff costs for nurses and care co-ordinators were assumed to be the same and were estimated based on the average unit costs per hour (includes salary, oncosts, and overheads) for bands 4 and 5 hospital-based nurses (£32.5 per hour, in 2017/18 prices)[93]. All costs were inflated to 2020/21 prices using a GDP deflator[94].

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

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

Option 2. Policy Model

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

10. **Limitations:** Our estimates are based on an annual number of forecast CTOs and do not distinguish between new CTOs (initial period of 6 months), reviews of CTOs (at 6 months and at 12 months). This approach may underestimate the number of CTOs.

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

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

[94] HM Treasury (1 October 2019) GDP deflators at market prices, and money GDP September 2019 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-september-2019-quarterly-national-accounts

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

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

    - Advocacy will move towards an opt-out service model where service users would be proactively approached by an IMHA.
    - Advocacy entitlement will widen to cover all mental health hospital patient admissions[95].
    - The workload of an IMHA will increase.

2. The table below summarises key assumptions and outputs of the model. These assumptions are based on our broad assessment of additional responsibilities and were discussed with stakeholders and service providers. They will need to be refined for future improved cost estimates.

Purpose	To forecast the number and costs relating to IMHAs as a result of the White Paper proposals. Advocacy will become opt out and will cover all mental health inpatients.
Main outputs	Number of people entitled to IMHA support, numbers of people taking up services, number of staff required, and cost of providing and training IMHAs.
Main data sources	• Detention and CTO scenario forecasts flow through from the DHSC models. • Conditionally Discharged Restricted Patients forecasts are aligned with the MOJ model. • Advocacy providers for information on uptake, caseload, salary and potential additional workload.
Main assumptions – Option 1 (BAU)	• Current levels of advocacy uptake are 40%. • IMHA salaries are £25k per year, and costs to train new IMHAs are £1.5k. • An advocate has a caseload of 100 people per year. • Detention, and CTO forecasts feedthrough from their respective models. • Conditionally discharged restricted patients increase by 4% per year, up until 2024/25, there after annual change varies between -14% and 10% based on estimates from MoJ forecast modelling. • Those subject to guardianship fall by 7% per year. • Section 57 and 58A treatment and ECT remain constant at 5 and 1 cases per year.
Main assumptions – Option 2 (Policy)	• Advocacy uptake remains at 40% for those currently entitled to an IMHA and also for informal mental health inpatients. • The salary and cost of training an IMHA remain the same. • An IMHA's caseload increases by 12 hours per CTP (only 6 hours for Section 2 detainees), 6 hours per SOAD interaction, 12 hours per CTO case and 6 hours per tribunal. • Detention and CTO forecasts flow from the respective models. • Conditionally discharged restricted patients forecast is aligned with MOJ modelling. • BAU forecasts are maintained for guardianship, serious mental health surgery, and ECT. • Mental Health inpatient numbers are assumed constant at 2016/17 levels, and voluntary patients are assumed to be the difference between inpatients and detainees.

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

Eligibility

3. Under the current MHA, those who are eligible[96] to use IMHA services are:

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

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

5. Offender Management statistics[97] show that the population of restricted patients currently conditionally discharged from hospital increased by an average of 4% per year between 2014 and 2018. We therefore use 4% annual growth in the forecast for BAU. There are a number of White Paper proposals that will impact on this group, including those relating to automatic referrals. Consequently the forecast for these patients is aligned with the modelling outputs from the MOJ model.

6. Public data on Guardianship under the MHA were obtained from NHS Digital[98], with annual figures available up until the year 2015/16. Estimates from 2016/17 onwards use the mean annual decrease of 7% seen between 2003/04 and 2015/16. We do not expect the White Paper proposals to impact this group so the BAU forecast holds post implementation.

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

8. The number of courses of ECT in England in 2016/17 was 2,153[99]. The rate of 1.08 courses per patient for the UK and Ireland was applied to the England courses of ECT to derive an estimate of 2 patients. However, only 0.1% of ECT patients are under 18, and 52% are informal. We therefore assume that only 1 patient is captured in this cohort and this is consistent in BAU and the policy scenario.

9. The White Paper accepts the recommendation that the statutory right to an IMHA should be extended to include all mental health inpatients. Although it does not explicitly state so in the recommendations,

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

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

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

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

here we assume only inpatients with a length of stay greater than 72 hours will be offered an IMHA (in line with current procedures for detainees under the MHA).

10. Data from NHS Digital[100] indicate that the number of mental health inpatients over recent years has been fairly consistent. We therefore assume that the number of mental inpatients remains fixed at 2016/17 levels of around 103,000. We assume that voluntary patients are equal to the difference between total inpatients and detentions. That is, we assume that there is no increase in mental health inpatient beds in the future.

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

Uptake

12. No official data are available on the number of detainees who use IMHA services. Therefore, we looked to published academic literature on IMHAs for estimation. We found two studies that reviewed IMHA quality − Newbigging et al. (2012)[101] and Newbigging et al. (2015)[102]. A rounded average uptake of 40% was derived from these two studies and this estimate was supported in discussions with providers of IMHA services.

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

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

Additional Workload

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

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

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

[101] Newbigging, K., et al. (2012) The Right to Be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England. Accessed at: https://www.uclan.ac.uk/research/explore/projects/the_right_to_be_heard.php

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

Additional Workload aspect	Additional hours required
CTPs for section 3 detainees	12
CTPs for section 2 detainees	6
SOAD interaction	6
CTOs	12
Tribunal	6

Caseload

17. The average caseload of an individual IMHA is assumed to be 25 cases at any one time, with the majority of cases being open between one and three months, based on data from Newbigging et al. (2015) assessing advocacy services in England[103]. Based on this, an annual caseload of 100 is assumed (25 cases every three months = 100 in 12 months).

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

Salary

19. The annual salary of a FTE IMHA is estimated as £25,000 in 2019/20 prices using feedback from service providers. Salary is assumed to account for 51% of total costs, with oncosts and overheads accounting for the remaining 49%. This is in line with approaches for other staff groups and gives a total cost of £49,822 (in 2020/21 prices).

20. Training costs for IMHAs are assumed to be £1,539 (2020/21 prices) based on a professional training company, Advocacy Training[104].

Sensitivity Analysis

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

22. The key assumption is the assumed level of uptake for IMHAs once the recommendations are implemented. Under the policy scenario, the assumption is that 40% of people would use IMHA services. However, this is an uncertain estimate, despite considered reasonable by stakeholders and so this is increased and decreased to 60% and 20% in the sensitivity analysis respectively.

23. The cost of providing IMHA services is also an influential assumption. We have been provided with a salary estimate of £25,000 from advocacy providers, which is scaled to estimate a unit cost. These salaries are uncertain over long time scales.

[103] Newbigging, K. et al. (2015) "When you haven't got much of a voice": An evaluation of the quality of Independent Mental Health Advocate (IMHA) Services in England. Accessed at: http://clok.uclan.ac.uk/10968/1/When%20you%20haven%27t%20got%20much%20of%20a%20voice.pdf
[104] Advocacy Training. Accessed 23/08/19. Accessed at: http://advocacytraining.org.uk/courses/qia-core-units/ and http://www.inclusiveaccess.org.uk/Advocacy_Training_and_Qualifications

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

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

2. Under the Review, recommendations were made on areas where it was believed AMHPs could play a larger role. To support the White Paper, and after consulting with professionals, we assumed that the recommendations around detentions would need further policy thinking; so they are not being costed. We also assumed that the additional support would occur mainly at specific points of the pathway, specifically with impacts relating to Community Treatment Orders (CTOs).

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

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

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

Purpose	To forecast the number and costs relating to AMHPs (FTEs and training for headcount) as a result of the recommendations of the Independent Review being implemented.
Main outputs	Number of additional AMHP staff required (FTEs and headcount) and related additional costs.
Main data sources	CTO model data flow through to this model.
Main assumptions – – Option 1 (BAU)	Uses figure of 140,000 assessments a year[105]. Number of assessments assumed to be flat across the policy period.
Main assumptions – – Option 2 (Policy)	Start date of policy is assumed to be the year MHA legislation changes should be in place – 2023/24. Workload increases by 30.3 hours per CTO.

Option 1. BAU Model

6. **Number of assessments.** These are assumed at 140,000 assessments a year[106], and to be flat across the policy period.

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

[106] As above.

7. **Salary, oncosts and overheads:** based on £38,100 salary (2018 prices)[107] inflating this to £39,810 (2020/21 prices), then adding oncosts and overheads (assumed at 48% of total costs) using the proportion of these costs in the salary of the social worker in adult services[108].

8. **Full Time Equivalents (FTEs).** The number of FTE AMHPs for 2018/19 was estimated to be around 1,200. This was estimated by taking the current estimated number of assessments carried out by AMHPs (140,000) and multiplying by the time taken to perform an assessment (the sum of 12 hours per assessment plus an average travel time of 1.4 hours, see section on policy model below). This figure is divided by the standard working hours in a year (1,685) to estimate the number of FTE AMHPs in England.

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

Option 2. Policy Model

10. **Salary, oncosts and overheads for professionals during training:** based on estimates from the PSSRU report on Unit Costs of Health and Social Care 2018, the annual salary for a social worker is used as a proxy for the salary of the professional training as an AMHP – this is £34,008 in 2017/18 prices[109]. We also estimated oncosts based on published costs for social worker in adult services[110]. Oncosts were estimated to be £9,348, which gives a total cost of £43,356 (in 2017/18 prices). Next, we assumed training time is six months, giving a total training cost of £21,678 (in 2017/18 prices. Finally, total costs were inflated to 2020/21 prices (£23,081 in 2020/21 prices) using two GDP deflators[111] (2017/18 to 2018/19 prices) [112] (2018/19 to 2020/21 prices).

11. **Additional working hours per patient.** AMHPs will be required to perform extra assessments for each patient on a CTO and this is expected to result in an increase in overall workload. Through engagement with professionals, we have assumed an approximate number of hours required for each new responsibility. For each CTO:

    - Two additional assessments at 6 and 12 months into CTO – each estimated to be 12 hours (2 * 12 hours)
    - One additional meeting with the patient, Nominated Person and the community team before the CTO is finalised – estimated to last 2 hours.
    - Average travel time per assessment/meeting is assumed to be 1.4 hours (4.3 in total for the two assessments and the additional meeting)
    - In total, we estimate that additional AMHP support required would be around 30.3 hours (24 + 2 + 4.3) for each CTO.

12. **Travel time.** To account for travel time, and in the absence of good evidence on the proportion of AMHPs who are placed locally or who need to travel, we are assuming that AMHPs would need to

[107] Department of Health and Social Care & Skills for Care (November 2019). The Approved Mental Health Professional Workforce in the adult social care sector. Accessed at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf
[108] Curtis, L. & Burns, A. (2018) Unit Costs of Health and Social Care 2018, Personal Social Services Research Unit, University of Kent, Canterbury. https://doi.org/10.22024/UniKent/01.02.70995
[109] As above.
[110] As above.
[111] HM Treasury (1 October 2019) GDP deflators at market prices, and money GDP September 2019 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-september-2019-quarterly-national-accounts
[112] Office for Budget Responsibility (14 July 2020) Fiscal sustainability report – July 2020. Accessed at: https://obr.uk/fsr/fiscal-sustainability-report-july-2020/

travel to meet 50% of the patients in a CTO. From these, we are assuming that[113,114]:

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

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

- Additional working hours per CTO = number of CTOs multiplied by 30.3h;
- These additional hours allowed estimating extra FTE = Additional hours / standard working hours per year; 30.3*1,685.

14. **Headcount.** To estimate training costs, we converted the 81 estimated FTEs in year 1 (2023/24) into headcount by taking into account that:

15. 25% of active AMHPs are estimated to have a single AMHP role whilst 75% are in a combined role (based on numbers of active AMHPs)[115];

16. As most AMHPs are social workers, we use our estimated rate for social workers: 90,000 social care FTE in LAS to 112,200 jobs – rate of conversion is 80%[116].

17. To estimated total headcount, we combined these two conditions, obtaining an estimated 162 AMHPs across single and combined roles[117].

18. **Training unit costs.** The training cost per head is estimated at under £29,000 in 2020/21 prices, which includes:

- average training cost around £5,000 for a 6-month period (based on average training costs from online professional adverts and confirmed by professionals);

- post backfill (social worker salary, oncosts, and overheads) estimated at under £24,000 (6

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[113] Department for Environment, Food & Rural Affairs (21 June 2016). Department for Environment, Food & Rural Affairs. 2011 Rural-Urban Classification of Local Authorities and other geographies – Lookup for 2011 Rural Urban Classification of Local Authorities. Accessed at: https://www.gov.uk/government/statistics/2011-rural-urban-classification-of-local-authority-and-other-higher-level-geographies-for-statistical-purposes

[114] There are 6 urban/rural classifications, defined as follows:

- "major urban: districts with either 100,000 people or 50% of their population in urban areas with a population of more than 750,000
- large urban: districts with either 50,000 people or 50% of their population in one of 17 urban areas with a population between 250,000 and 750,000
- other urban: districts with fewer than 37,000 people or less than 26% of their population in rural settlements and larger market towns
- significant rural: districts with more than 37,000 people or more than 26% of their population in rural settlements and larger market towns
- rural-50: districts with at least 50% but less than 80% of their population in rural settlements and larger market towns
- rural-80: districts with at least 80% of their population in rural settlements and larger market towns"

Source: Office for National Statistics (no date). Rural/urban local authority (LA) classification (England). Accessed at: https://www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications/2001ruralurbanclassification/ruralurbanlocalauthoritylaclassificationengland

[115] Department of Health and Social Care & Skills for Care (November 2019). The Approved Mental Health Professional Workforce in the adult social care sector (p.6). Accessed at: https://www.adass.org.uk/national-findings-amhps-mental-health-act-assessments-the-mental-health-social-care-workforce

[116] Skills for Care (October 2019). The state of the adult social care sector and workforce in England September 2019 (p. 30, table 3). Accessed at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

[117] To demonstrate these calculations: (a) converting 81 FTEs into headcount (81*0.8) produces 101.25 headcount; (b) if 40% of these are single role AMHP, we obtain 40.5 headcount (unrounded); (c) these are supposed to account for 25% of the headcount, so extrapolating to 100% (40.5/0.25), we obtain an estimated total 162 headcount.

months).

19. **Training costs.** We multiplied headcount by the costs of training per head to obtain overall training costs – under £5 million in 2023/24.

Sensitivity Analysis

20. The two assumptions tested are (see Risk and assumptions section for further detail):

- additional working hours – the AMHPs model is mainly driven by assumptions on additional working hours, which were defined following discussions with professionals;
- salary (including oncosts and overheads) estimates, which are derived from the assumption that all AMHPs are employed as adult social workers (around 95%[118] of the workforce are social workers); the salary is assumed to remain the same throughout the forecast.

[118] Association of Directors of Adult Social Services & Benchmarking Network (April 2018). AMHPs, Mental Health Act Assessments & the Mental Health Social Care workforce: National Findings -England.

B.V. Estimating the impact on Second Opinion Appointed Doctors

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

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

Purpose	To forecast the number of SOAD visits and associated costs due to changes in the number of detentions and CTOs, and changes in the use of SOADs.
Main data sources	• Section 3 Detentions and CTO forecasts from the relevant models. • CQC Management Information: SOAD visits, Service Costs and SOAD Workforce and Caseload, 2018-19. • NHS Digital bespoke dataset*:* Number of days detained under the MHA per single-provider hospital spell, 2016-17.
Main assumptions	**Breakdown of SOAD visits:** 81% of SOAD visits are to review medication – 11% for refusals and 70% for those lacking capacity. 11% of SOAD visits are in relation to ECT and 8% for CTOs. **Rates of SOAD Visits per Detainee:** There are 0.4 visits for refusals per Section 3 Detainee, 2.2 visits for those lacking capacity, 0.09 visits for ECT and 0.24 visits for CTO. **Length of Stay (LOS):** 31% of Section 3 detainees have a stay of 3 months or more. 62% have stays between 15 days and 3 months, and 16% have stays between 2 months and 3 months. The model assumes the same proportions in future years. **Time between notification and SOAD visit:** There is an assumed 14 days between notification to the CQC and the SOAD visiting. This time lag alters the proportion of Section 3 detainees to 26% for those notifying at 3 months or more, 50% for those between 15 days and 3 months, and 11% for those between 2 months and 3 months. **Cost of a SOAD Visit:** Each SOAD visit is assumed to cost £85 in 2020/21 prices. **Caseload:** A SOAD conducts a mean of 109 visits per year. **Training:** Training of new SOADs is short, and it is assumed that SOADs needed in year Y are trained in year Y. As well as mandatory training, there is optional training – it is assumed that 50% take up of the optional training.
Option 1 (BAU) Model	Models the number of SOAD visits and associated costs for those currently eligible: • Section 3 Detainees refusing medication (length of stay beyond 3 months) • Section 3 Detainees lacking capacity (length of stay beyond 3 months)

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

Model Description

3. The model estimates the demand for SOADs due to forecasted changes in the number of detainees and CTOs following proposed changes to the MHA.

4. The BAU model estimates the number of SOAD visits, SOADs and costs, based on the modelled number of Section 3 detainees and CTOs from the DHSC models. BAU covers Section 3 detainees who have lengths of stay longer than 3 months; CTOs and ECTs.

5. The policy scenario model explores changes to the usage of SOADs as a result of the proposed changes to provision set out in the White Paper. These are: extending SOAD provision to section 3 detainees for refusals from 14 days and for those lacking capacity from 2 months; reduced CTO numbers from the CTO model; there is no change in modelled ECT numbers.

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

7. The main model input is the forecast number of Section 3 detentions drawn from the DHSC Detentions model. The model also draws on the estimated number of CTOs from the DHSC CTO model.

Option 1. BAU Model

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

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

Number of SOAD visits *equals*:

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

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

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

Length of Stay

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

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

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

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

*Proportions may not sum due to rounding

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

Rates of SOAD Visits

14. The average proportion of SOAD visits for each type of SOAD visit was calculated from available CQC data across 2014/15 to 2017/18. Approximately 81% of SOAD visits are for medication reviews (11%

for refusals, 70% for those lacking capacity to consent). 11% of SOAD visits were for ECT and 8% for CTOs.

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

Type of SOAD Visit	Visits per Section 3 Detention
ECT	0.09
CTO	0.24
Medication Review - Refusals	0.36
Medication Review – Lacking Capacity	2.20

SOAD Caseload

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

Option 2. Policy Model

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

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

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

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

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

Length of Stay

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

Rates of SOAD Visits

20. In the absence of any other information, it is assumed that the current rates of SOAD visits are the same for all detainees regardless of their length of stay. These rates may be an overestimate of potential SOAD usage, particularly for shorter lengths of stay.

Costs

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

22. The CQC have provided a high level breakdown of the cost of running the SOADs provision for 2018/19. These have been averaged over all 14,354 visits in 2018/19 to calculate a unit cost per visit[119]:

	2018/19 Cost	**Cost per SOAD Visit**
SOAD Fees	£3,376,839	£235
Management and Support	£452,471	£32
Travel & Subsistence	£218,501	£15
Other General Supplies and Services	£40,683	£3
Overheads and Indirect Costs	£954,444	£66
From April 2019:		
- Additional employer pension contribution		£15
- Management employer pension contribution		£2
	£5,042,938	£368
2020/21 Unit Cost of SOAD Visit		**£385**

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

Appraisals

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

25. The average total cost of all of the elements above has been calculated as £533 per SOAD in 2020/21 prices. CQC data indicate that 45% of SOADs were appraised in 2018/19 and this proportion is assumed constant in future years and applied to the total number of SOADs needed in each year. It is assumed that appraisers can be absorbed into the existing workforce rather than needing extra SOADs to act as appraisers.

[119] Care Quality Commission (2020). Monitoring the Mental Health Act in 2018/19. Accessed at: https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201819

Training of Additional SOADs

26. Training of new SOADs is short, but the model assumes that SOADs needed in year Y are trained in year Y. Mandatory training consists of a one day course at a cost of £805 in 2020/21 prices. There is also optional training at a cost of £836 at 2020/21 prices. It is assumed that 50% of new SOADs take up the optional training.

Sensitivity Analysis

27. The SOAD model is mainly driven by two assumptions: the rates of SOAD visits per detainee (in particular the rate for those lacking capacity); and changes in the unit cost of a SOAD visit (essentially has a proportional change in overall costs).

B.VI. Estimating the impact on Clinical Teams

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

2. Under the Business As Usual (BAU) option, which pertains to the status-quo with no new national policies implemented, we assumed that clinical teams support for tribunal hearings challenging detention remains flat alongside tribunal hearings, and that most patients (80%) already have a CTP [120]. Proposed policy options on increasing clinical teams working hours under the MHA can be compared against the BAU option (the counterfactual) to estimate additional costs, staff requirements, etc. associated with these options.

3. The table below summarises the main assumptions and outputs of the model

Purpose	To estimate the impact on clinical teams during the policy period for BAU and for the policy option (accepted recommendations set out in the White Paper).
Main outputs	Staff time and costs (can be viewed separately for type of staff and by section under the MHA).
Main data sources	Tribunal receipts were provided by the MoJ. Receipts were provided separately for sections 2, 3, 37, and for CTOs. Detentions and CTOs models flow through this model.
Main assumptions – Option 1 (BAU)	Tribunal numbers are assumed to remain the same (at 2018/19 levels) for all sections. Staff: • Three staff assumed to be potentially present at each tribunal: a responsible Clinician (RC), nurse, and care co-ordinator – this is considered to be worst-case-scenario because usually only the RC and a nurse **or** a care co-ordinator will attend, not both • 7.5 hours (including: tribunal, travel, and report writing) of staff time per tribunal – same number of hours assumed for RC, nurse and care co-ordinator • Staff costs can be adjusted to GDP year – 2020/21 year prices currently selected
Main assumptions – Policy option	Assumes that different staff times all increase by specific amounts post policy implementation. These amounts were agreed with NHSEI as reasonable increases. Assumes that 80% of patients already have CTPs as stated by a 2018/19 CQC report.[121]

Data sources

[120] Care Quality Commission (2020). Monitoring the Mental Health Act in 2018/19. Accessed at: https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201819

[121] Care Quality Commission (2020). Monitoring the Mental Health Act in 2018/19. Accessed at: https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201819

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

Option 1. BAU Model

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

6. Staff costs for RCs include salary, oncosts and overheads, and they were estimated based on the costings for a hospital based consultant in psychiatry [122]. The total cost per hour is estimated to be £108 (in 2017/18 prices). Staff costs for Nurses and care co-ordinators were assumed to be equal and were estimated based on the average unit costs per hour (includes salary, oncosts, and overheads) for bands 3 and 5 hospital-based nurses (£32.50 per hour, in 2017/18 prices)[123].

7. All costs were inflated to 2020/21 prices using a GDP deflator[124].

Option 2. Policy Model

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

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

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

Section 3			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
CTP Set Up	Responsible Clinician	Any S3 with stays beyond 7 days	4
CTP Review	Responsible Clinician	Any S3 with stays beyond 14 days	4
Contact with SOAD	Responsible Clinician	Increased Visits	1.5
Contact with SOAD	Nurse	Increased Visits	1.5

[122] Curtis, Lesley A. and Burns, Amanda (2018) Unit Costs of Health and Social Care 2018. Accessed at: https://kar.kent.ac.uk/70995/
[123] As above.
[124] HM Treasury (1 October 2019) GDP deflators at market prices, and money GDP September 2019 (Quarterly National Accounts). Accessed at: https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-september-2019-quarterly-national-accounts

Contact with SOAD	Non-Nurse	Increased Visits	1.5
Renewal	Responsible Clinician	S3 with stays beyond 3 months	4
Certification for Tribunal	Responsible Clinician	All S3 receipts (MOJ Costs)	0.3
Tribunal	Responsible Clinician	Tribunal Hearings	6
Tribunal	Nurse	Tribunal Hearings	6
Tribunal	Care Coordinator	Tribunal Hearings	6
CTO			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
Application	Community Supervising Clinician	All CTOs	4
Renewal	Additional Clinician	CTOs over 6 months	4
Tribunal	Responsible Clinician	Tribunal Hearings	6
Tribunal	Nurse	Tribunal Hearings	6
Tribunal	Care Coordinator	Tribunal Hearings	6
Other sections			
Area of pathway	**Staff Type**	**Cohort**	**Extra hours**
Tribunal	Responsible Clinician	Tribunal Hearings	6
Tribunal	Nurse	Tribunal Hearings	6
Tribunal	Care Coordinator	Tribunal Hearings	6

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

Sensitivity Analysis

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

Annex C. Analytical approach for Justice system impacts

Counterfactuals (BAU) for analytical inputs

Receipt and Hearing Volumes

1. One of the key inputs used to determine the impact of the recommendations on the justice system were Mental Health Tribunal (MHT) receipts and hearing volumes. These were taken from the MARTHA data system. We used the receipts and hearings for the latest full year available (2018/19) and a flat forecast for all case types between the start of the implementation period (2023/24; when legislative changes are expected to be in place) until the end of the appraisal (2032/33), as advised by our expert operational colleagues at Her Majesty's Courts and Tribunals Service (HMCTS). This methodology was used because MHT workload, as measured by receipts, has been steady for the past few years, despite the increase in the number of MHA detentions. As such, it is apparent that the relationship between detentions and MHT workload is not a simple linear relationship. These receipts are presented in figure 3 earlier in this document.

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

Unit costs

3. The first key unit cost to discuss is the unit cost of an average MHT sitting day. Average sitting day unit costs have been used in line with advice from HMCTS on how best to model the costs of an additional hearing/receipt. These sitting day costs have been taken from the 2019/20 HMCTS cost card, which averages the total cost of a sitting day based on estate costs, judicial salaries/fees and pensions and other staff costs.

4. The unit cost used for a MHT sitting day was £2,262 for 2019/20. From 2020/21 onwards, the deflators are used to increase costs per year. .

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

6. Legal aid unit costs are derived from actual spend and are split by the category of work relating to the section of the MHA the patient is currently detained under. Future unit costs are expected to be the same as current unit costs in nominal terms because the fees paid to providers are from a fixed fee scheme, as set out in the provider's contract, with rates set out in regulations.

Hearings per sitting day

7. This input underpins the costings of all of the automatic referral recommendation and is the basis of the CTP unnumbered recommendation costs. Hearing volumes are divided by the hearings per sitting day ratio, which determines the number of sitting days needed to sit a given workload of cases. The unit cost for a sitting day is then applied.

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

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

Cancellation fees

10. A key input for recommendation 46e, cancellation fees can be claimed by panel members when hearings are cancelled, and panel members have not been able to be reallocated.

11. Cancellation fees by month from May 2013 onwards were provided, broken down by the volume of claims and total claim amount for non restricted judges, medical members and specialist lay members from the MARTHA data system[125]. Actuals were used up to 2019/20, after which the deflators were used to increase costs in subsequent years. .

12. The claim total was then divided by the volume of claims to provide an average for each financial year. This was multiplied by the volume of claims annually and the 50% reduction was then applied to 37% of this claim total, as this is the proportion of claims that for section 3 hearings.

13. Due to recent fluctuations in claims, an average of the last five years (from 2014/15 to 2018/19) for each tribunal member was forecast forward as the counterfactual for annual claim volumes.

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

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

Automatic Referrals

14. In addition to MHT receipt and hearing volumes previously mentioned, the automatic referrals section of the analysis also used the Mental Health Casework Section (MHCS) published statistics[126] as a key input.

15. These statistics present data on the volume of restricted patients detained under part III of the MHA, including the population of patients currently conditionally discharged in the community and the volume of conversions annually from conditional to absolute discharge. Internal MHCS management information regarding the profile of conditionally discharged patients in the past was used to understand the current mean duration of conditional discharge for all patients, and the mean length of time patients were on a conditional discharge section before they were absolutely discharged.

16. The analysis also used Length of Stay data from NHS Digital[127] to estimate the proportion of section 3 patients detained longer than a year.

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

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

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

Annex D. Cost estimates for automatic referrals

1. The recommendations pertaining to automatic referrals are one of the five themes of recommendations considered in the Justice systems impacts, discussed in the section 'Monetised costs – Justice System' .

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

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

4. Given the data limitations around determining what proportion of patients currently go to MHT in the first 4 months, an alternative methodology needed to be devised. Recommendation 46c would mean patients are able to apply three times in their first year of detention as opposed to twice. This would be a 50% increase. Across three years, patients would have an increase from 4 to 5 chances to apply, which is a 25% increase. These ranges were averaged to create the central scenario of a 37.5% increase. Using assumptions over the proportion of section 3 detentions that last longer than 1 year from the Length of Stay data provided by NHS Digital[128], an estimated increase in the volume of actual section 3 applications annually was calculated.

5. Regarding the impact on referrals of recommendation 52, it has been assumed that the move from 6-month to 4-month mandatory referrals will incur a 'bring forward' effect only on the volume of section 3 MHT receipts and subsequent hearings. Thus, the main impact will be from the move from referrals every 3 years to annual referrals, which has been modelled as a 100% increase on the volume of these hearings annually – under section 68(6). The table below illustrates the total costs of implementing recommendations 52 and 46c.

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	**Total**
Option1. BAU costs rec 46c	16.7	16.5	16.3	16.2	16.0	15.8	15.7	15.5	15.4	15.2	**159.3**
Option1. BAU costs rec 52	6.7	6.7	6.6	6.6	6.6	6.5	6.5	6.4	6.4	6.3	**65.4**
Option 2. Policy costs rec 46c	23.9	23.7	23.5	23.2	23.0	22.7	22.5	22.3	22.1	21.8	**228.7**
Option 2 costs rec 52	6.7	6.7	8.7	8.7	8.6	8.6	8.5	8.4	8.4	8.3	**81.7**
Total Option1 Costs	23.4	23.2	23.0	22.8	22.6	22.3	22.1	21.9	21.7	21.6	**224.7**
Total Option 2 Costs	30.7	30.4	32.2	31.9	31.6	31.3	31.0	30.7	30.4	30.2	**310.4**
Total Additional cost	7.3	7.2	9.2	9.1	9.0	8.9	8.9	8.8	8.7	8.6	**85.7**

6. The White Paper proposes to accept recommendation 53 "For part III patients, automatic referrals

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

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

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	**Total**
Option 1. BAU	2.0	2.0	2.0	1.9	1.9	1.9	1.9	1.9	1.9	1.8	**19.1**
Option 2. Policy	2.0	2.0	10.9	10.8	10.7	10.6	10.5	10.4	10.3	10.3	**88.3**
Additional cost			8.9	8.8	8.8	8.7	8.6	8.5	8.5	8.4	**69.2**

7. The White Paper proposal to accept recommendation 137 introduces a completely new right for conditionally discharged patients. The Independent Review states "*There should be an automatic referral for people on conditional discharge to the tribunal after 12 months and at regular intervals after that for patients who have not applied directly*". Currently, such patients are eligible to apply to the MHT once in the first 12-24 month period and then every two years, but there is no automatic referral process. Consequently, there is no real safeguard for such patients, particularly those who may not have capacity to apply, or would only apply if their care team supported absolute discharge. It may be the case that some patients remain subject to conditional discharge for an extended period of time when a Tribunal may have considered them suitable for absolute discharge at an earlier stage.

8. Because this would be a completely new right under the MHA for patients, there is no BAU counterfactual to compare with. There is also no available information on what proportion of receipts might follow through into hearings. Therefore, receipt volumes were used, rather than hearings. The analysis uses data on the length of time previous patients were on conditional discharge before being given absolute discharge on the assumption that the profile of these previous patients is representative of the current sample. Length of detention is not a direct indicator for suitability for absolute discharge as this will depend on individual circumstances (diagnosis, current presentation, potential for risk of harm in the future if relapse occurs, likelihood of relapse). However, it gives an indication of the volume of current conditional discharge patients that could be suitable for immediate absolute discharge.

9. The analysis uses the suggested referral period recommended in the White Paper; note that the White Paper proposes setting the threshold for the first automatic referral after 24 months rather than the 12 months set out in the Independent Review. The analysis then models the number of people who have another automatic referral four years after the first, in line with the White Paper. A steady influx of patients being given a conditional discharge and a stable proportion of direct applications to the MHT is assumed. The current success rate of applications to the MHT under section 75(2) is around a quarter[129]. However, it is felt by operational colleagues that it is very unlikely the majority of patients would meet the criteria for absolute discharge after two years; the mean duration of

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

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

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

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	**Total**
Option 2			5.3	0.1	1.1	1.4	4.5	1.3	2.2	2.4	**18.1**

10. Recommendations 61 and 64 are also being accepted in the White Paper and follow on from recommendations seeking to reduce the volume of CTOs in use. The two recommendations costed here concern the rights of patients released on a CTO to appeal to the MHT. Patients are currently automatically referred after the first 6 months and at 3-year intervals after that. The Independent Review recommendations suggest changing this 3-year referral period to an annual one, much like with section 3 referrals.

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

12. The cross-cutting assumption used for this analysis was a 40% reduction in CTO volumes over five years from 2023/24 (see Annex B.II) and a 75% increase in section 68(6) referral volumes from 2024/25 onwards.

13. Currently, hospital managers must refer a case when a CTO is revoked under section 68(7). The Review states that "government should consider removing this automatic tribunal when a CTO is revoked" (p.138). The table below illustrates the total benefits of implementing recommendations 61 and 64, including the additional cost savings if the unnumbered recommendation regarding section 68(7) receipts were to be taken forward.

Table E4. Estimated monetised overall cost savings for Recommendations 61 and 64 (£millions, 2020/21 prices, undiscounted)

	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	**Total**
Option 1. BAU	10.4	10.3	10.2	10.2	10.1	10.0	10.0	9.9	9.9	9.8	**100.8**
Option 2. Policy	10.0	9.1	5.4	4.8	4.2	4.2	4.2	4.1	4.1	4.1	**54.3**
Difference in costs	-0.4	-1.2	-4.8	-5.4	-5.9	-5.8	-5.8	-5.8	-5.7	-5.7	**-46.5**

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

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

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

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

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

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

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

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

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

The social value of a QALY (£60,000)

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

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

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

Example of an Impact Assessment calculation

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

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

- The costs of the project are the QALYs that would be gained if the funds were used elsewhere in the NHS, but which are foregone if the project is undertaken. Using the standard DHSC estimate that one QALY is gained elsewhere for every £15,000 of funding, this gives an 'opportunity' cost of **1,000 QALYs lost**. Monetising these costs at the DHSC estimate of the social value of a QALY gives a monetary equivalent of **£60m**.
- The benefits of the project are simply the QALYs gained – that is **1,200 QALYs gained**. Monetising these costs using the DHSC estimate of the social value of a QALY gives a monetary equivalent of **£72m**.
- The net benefit of the project is therefore **200 QALYs**, or, expressed in monetary terms **£12m.**

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

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

Annex F. Breakeven analysis – method

Reduction in length of stay

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

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

    - We estimate the average cost of a detention in each year by dividing the total healthcare and justice costs in that year by the forecast number of detentions in that year. For the 10 year period from 2023/24 to 2032/33, this was estimated at an average of around £26,500 per detention under BAU and at around £27,300 under the policy scenario, that is, each detention is estimated to cost an additional £800 under the policy scenario.
    - The current average length of a detention is roughly estimated to be 53.5 days[131] and we assume that this applies to the 10-year policy period.
    - To estimate the daily cost of a detention after the implementation of the policy, we divide the average cost of a detention under the policy scenario by the length of stay (£27,300 divided by 53.5 days), and obtain an estimate of around £510.

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

Reduction in readmissions

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

5. Currently, 15.5% of people are detained twice or more in a year – under 6,400 people in 2018/19[132] – see Table F1 below.

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

[132] NHS Digital, Mental Health Act Statistics, Annual Figures 2018-19, accessed at https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures

Table F1. Number and percentage of repeated detentions in 2018/19

	Number of times person was detained during period								
	1	**2**	**3**	**4**	**5**	**6**	**7 or more**	**Detained twice or more**	
Total people	34,705	5,326	810	165	39	18	13	6,370	
% people	84.49%	12.97%	1.97%	0.40%	0.09%	0.04%	0.03%	15.5%	
When multiplying number of people by number of times detained:								**Out of those detained 2x or more, % detained 2x**	**Out of those detained 2x or more, % detained 3x or more**
Number detentions	34,705	10,652	2,430	660	195	108	91		
% detentions	71.1%	21.8%	5.0%	1.4%	0.4%	0.2%	0.2%	78%	22%

6. Dividing the overall annual additional cost of the policy (see Table 16) by the estimated cost of a detention (see Table 24) produces the required reduction in the number of detentions to make the policy cost effective – this is estimated at around 2,800 per year on average during the 10-year period.

7. We assume that in the absence of policy intervention, the proportion of repeated detentions would remain constant at 15.5% for the 10 year period from 2023/24 to 2032/33. Following policy implementation, we estimate that this would need to fall to 12.7% for the costs of this policy to be completely offset by the savings gained from a reduction in the number of repeat detentions.

8. To illustrate the method, we use a worked example for 2023/24. We estimate that the reduction in repeated detentions required to offset policy costs would be around 2,900 – around 2,300 for those detained twice (around 78% of those people detained twice or more in a year) and around 700 detained 3 or more times (around 22% of those people detained three or more times in a year).

9. **BAU.** In 2023/24, our forecast under BAU is for almost 85,150 detentions (see Fig. 1). Applying the proportion of detainees detained once, twice or 3 times or over in the year (around 72%, 22%, 6%, respectively), we assume that there are around 61,000 detentions for those detained once, 18,800 detentions for those detained twice and 5,400 detentions for those detained 3 times or more.

10. To estimate number of people detained, we divided these numbers of detentions by 1, 2 or 3 detentions respectively and obtained around 61,000 people detained once, 9,400 people detained twice, and 1,800 people detained three times or more; around 72,150 people detained in total. That is, around 15.5% of people are detained twice or more times (9,000+1,700 divided by 69,300).

11. **Option 2. Policy scenario.** In 2023/24, and considering a decrease by around 2,900 repeated detentions, we would have around 82,000 detentions (85,150 minus 2,900):

    - Around 63,200 detentions for those detained once - those already assumed to be detained once plus those people who would have been detained twice under BAU and are now detained once. That is, the estimated 61,000 detentions for those detained once plus 2,200.
    - Around 15,200 detentions for those detained twice – the number of detentions pertaining to those assumed to be detained twice, minus the assumed decrease of 2,200 people (detained twice under BAU and now detained once) multiplied by 2 detentions, plus the 650 people (detained three times or more under BAU and are now detained twice) multiplied by 2 detentions.That is, 18,800 minus 2,400*2 detentions plus 700*2 detentions.
    - Around 3,500 detentions for those detained three times or more – the number of detentions pertaining to those already assumed to be detained three times or over, minus the assumed

decrease of 650 people detained 3 times or more under BAU and now detained twice, multiplied by 3 detentions That is, 5,400 minus 650*3 detentions.

12. The estimated number of people detained would be the same as under BAU but readmissions or repeated detentions would decrease. We divided the number of detentions above by 1, 2 or 3 detentions respectively and obtain 63,200 people detained once, 7,700 people detained twice, and 1,000 people detained three times or more (around 72,000 detainees in total). That is, over 10% of people are detained twice or more times (7,700+1,000 divided by 72,000).

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

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

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

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

16. To illustrate the monetised impact, this reduction is estimated at 23,000 days of detention in 2023/24, which is equivalent to around 0.25 days per detention (23,000 days divided by the forecast of detentions for 2023/24), or around £11.8 million in 2023/24 (23,000 days multiplied by the estimated average daily cost of a detention). As our forecast of detentions includes a flat forecast from 2027/28 to reflect constrains in bed capacity (see Fig. 1 and Annex B.I), free beds would likely be used for unmet need, and we are not presenting this monetised impact in this IA, as we would need to investigate further the potential for cost savings.

Increase in health benefits

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

18. We explained before in the body of the IA that the measurement and valuation of direct health benefits/ costs from a policy intervention is typically performed by estimating the number of quality

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

adjusted life years (QALYs) generated. In Annex E, we said that the value society places on a QALY has been estimated at £60,000.

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

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

21. the overall annual additional cost of the policy in that year is estimated at £193 million (see Table 17), which divided by the social value of a QALY at £60,000, gives an estimated number of over 3,000 QALYs;

22. dividing this number of QALYs by the estimated number of people detained (around 72,000 detainees in total, as explained in the section above) produces an estimate of a health gain per patient at around 0.04 QALYs.

23. In sum, it is estimated that each person detained would need to experience an additional health improvement (reduction in health loss) equal to 0.04 QALYs for the costs of the policy to be offset. This may seem small, but would suggest that, illustratively, the person would need to experience perfect health for around 14.6 days in the year following treatment (0.04*365 days = 14.6 days).

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

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

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

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

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

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

[134] Care Quality Commission (March 2018). Accessed at: https://www.cqc.org.uk/publications/themed-work/briefing-mental-health-act-approved-mental-health-professional-services

[135] Care Quality Commission (January 2019). Monitoring the Mental Health Act in 2016/17. Accessed at: https://www.cqc.org.uk/news/stories/monitoring-mental-health-act-201617-amendments

[136] Care Quality Commission. Second opinion appointed doctors (SOADs). Accessed on 22 August 2019 at: https://www.cqc.org.uk/guidance-providers/mental-health-services/second-opinion-appointed-doctors-soads

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

[138] Source: Laing & Buisson (2018). Healthcare Market Review, 32nd Ed. London

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

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

Source: Laing & Buisson. Healthcare Market Review. London

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

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

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

6. The overall additional cost of clinical teams has been estimated at around £39.3m in 2023/24 to £45.6m in 2032/33 (2020/21 prices, undiscounted) for all detained (patients, that is, including public and private funding for patients in the public and independent sector – see section on clinical teams.

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

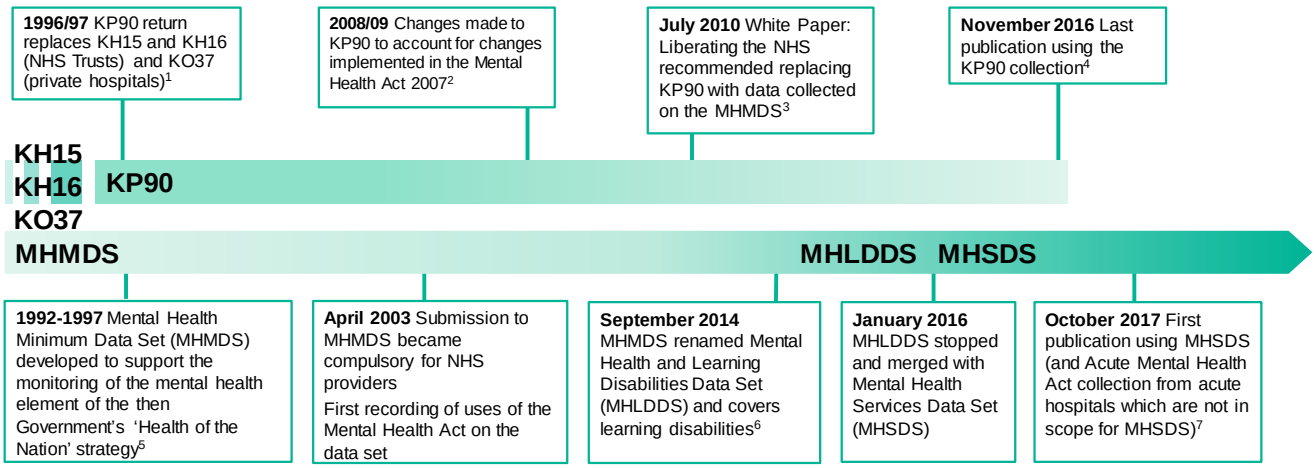
Annex H. Changes in data on the uses of the Mental Health Act

From 1 April 1987, statistics on formally detained patients admitted to NHS facilities and NHS patients using non NHS facilities under contractual arrangements were collected on the aggregate return KH15 on a financial year basis and on the return KH16 on changes in legal status[1]. Following a review of requirements for information on detained patients, a new return, KP90, was introduced for 1996/97. This return replaced returns KH15 and KH16, previously completed by NHS trusts, and KO37, completed by health authorities on behalf of private hospitals in their area[1].

The Secretary of State's Fundamental Review of Returns 2013 recommended that the KP90 collection would be retired once the same information could be produced from administrative sources, namely the Mental Health Services Data Set (MHSDS) and previous versions. These have been reporting data on detentions since 2003, alongside KP90. The MHSDS became the official data source for detentions under the Mental Health Act in 2016/17, and data from KP90 were last published in 2015/16[4,7].

The scope of the administrative data source has gradually increased from covering only NHS mental health services for adults, to including Independent Sector Providers in 2011 together with changing the format to permit analysis of individual uses of The Act, adding learning disability services in 2014 and, in the current MHSDS, introducing Children and Young People services and referral level data in January 2016. This means it now covers the majority of services where The Act is used[7].

The Mental Health Services Data Set became the official source of data for Mental Health Act Statistics in 2016/17 and is not comparable with previous data



1 NHS Digital (26 May 2006). Inpatients Formally Detained in Hospital under the Mental Health Act 1983 - England, 1994-1995 to 2004-2005. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment/inpatients-formally-detained-in-hospital-under-the-mental-health-act-1983-england-1994-1995-to-2004-2005

2 NHS Digital (14 October 2009). Inpatients Formally Detained in Hospitals Under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment - 1998-1999 to 2008-2009. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment-1998-1999-to-2008-2009

3 NHS Digital (2012) Fundamental Review of Returns and the KP90 collection. Accessed at: https://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/media/12646/Fundamental-Review-of-Returns/pdf/KP90_Fundamental_Review_of_Returns_2012_HSCIC.pdf/

4 NHS Digital (30 November 2016). Inpatients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment 2015/16, Annual Figures. Accessed at: https://webarchive.nationalarchives.gov.uk/20180328135613/http://digital.nhs.uk/catalogue/PUB22571

5 NHS Digital (29 October 2008). Mental Health Bulletin, First report on experimental statistics from Mental Health Minimum Data Set (MHMDS) annual returns, 2003-2007. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/mental-health-bulletin-first-report-on-experimental-statistics-from-mental-health-minimum-data-set-mhmds-annual-returns-2003-2007

6 NHS Digital. Mental Health and Learning Disabilities Statistics Data. Accessed at: https://data.gov.uk/dataset/9989e4ee-3cae-4747-9b72-b948d1df9f62/mental-health-and-learning-disabilities-statistics-data

7 NHS Digital (10 October 2017). Mental Health Act Statistics, Annual Figures 2016/17 – Experimental Statistics. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/mental-health-act-statistics-annual-figures-2016-17-experimental-statistics

Other annual publications accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures