The Strategy Unit.

Estimating the impact of the proposed reforms to the Mental Health Act on the workload of psychiatrists

on behalf of the Royal College of Psychiatrists

15 October 2021

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1. Executive Summary

The Government's White Paper, *Reforming the Mental Health Act*, proposes changes to the roles and responsibilities of psychiatrists in relation to patients detained or treated without consent.

This report sets out the methods and results of an assessment of the impact of these changes on the workload of psychiatrists and the additional number of psychiatrists that would be required to meet these new obligations. The assessment was carried out by the Strategy Unit on behalf of the Royal College of Psychiatrists.

Estimating the scale of these impacts is not straightforward. The reforms will have many subtle and varied impacts on psychiatrists' working arrangements. These impacts will evolve and emerge dynamically in response to available capacity, staff and service users' perspectives, and the extent to which other demands compete for time. Estimates are nonetheless required for planning purposes. We focus on those changes whose effects are likely to be substantial and clear cut.

- Reducing the time intervals between Mental Health Tribunal hearings
- Statutory Care and Treatment Plans and Advance Choice Documents
- Earlier involvement of Second Opinion Appointed Doctors
- The introduction of the Nominated Person role
- Expanding the role of Independent Mental Health Advocates
- Increasing the evidence required to justify the use of Community Treatment Orders
- Training

If detentions and Community Treatment Orders continue to grow as they have been in recent years, then we estimate that an additional 335 (5.8%) additional whole-time equivalent (WTE) psychiatrists will be required to accommodate the specific impacts of the proposed reforms by 2023/24. And that a further 185 WTE psychiatrists will be required by 2033/34. We estimate the costs of these impacts at £40m per annum by 2023/24, rising to £63m by 2033/34, at today's prices.

Our analysis suggests that the primary driver of these increases will be the additional time required to prepare and attend Tribunal hearings given the additional obligations placed on psychiatrists as part of the reforms. Increases in the frequency of Tribunal hearings per detention, additional tasks relating to detained patients outside of Tribunal hearings and additional training have a more modest but nonetheless material impact on the numbers of additional psychiatrists required.

Of the Tribunal related impacts by 2033/34, 55% relates to people detained under part 2 - section 3 of the Act, 24% to those detained under part2 - section 2 and 19% to people subject to Community Treatment Orders. The impact of patients detained under part 3 of the Act are more modest.

If the additional psychiatrists mirror the current distribution of psychiatrists by type, then we estimate that 399 (77%) of the additional psychiatrists required by 2033/34 will be consultants.

The results of the analysis do not appear to be particularly sensitive to differing assumptions about detention growth.

It is important to note that these estimates relate only to the impact of the reforms and are in addition to extra staff that may be required to fill existing vacancies, replace retiring psychiatrists or to meet rising demand for mental health care.

2. Introduction and background

Mental health problems affect one in four people at any given time. People with mental health problems may be offered treatment and support by health services and other agencies, but there are some circumstances when a patient can be detained in hospital and treated without their consent. The Mental Health Act (1983) is the piece of legislation that describes the rights of people who are detained or treated without consent in England and Wales and the responsibilities of staff and organisations when detention is deemed necessary. Psychiatrists play a central role in this process and have specific duties and responsibilities under the Act.

In January 2021, the Government published a White Paper, setting out its plans to reform the Mental Health Act. The Government invited views on the paper and in July 2021, it published a summary of the consultation responses and its plans to address the issues raised.

The proposed reforms aim to ensure mental health service users have choice and autonomy wherever possible, that restrictions on service users' freedoms are minimised and that opportunities for therapeutic benefit whilst detained are maximised. The reforms seek to deliver these objectives by altering the rights and responsibilities described in the 1983 Act or by introducing new rights and responsibilities.

This analysis, conducted for the Royal College of Psychiatrists, seeks to estimate the impacts of the Mental Health Act reforms on the workload of psychiatrists and to quantify these impacts in terms of additional whole-time-equivalent staff that will be required.

Estimating the impact of the reforms is a prerequisite to adequately resourcing them. Failure to do so will create implementation risks and may inadvertently displace or interfere with other important aspects of a psychiatrist's role. This issue is particularly important at present when demand for mental health services is high and rising rapidly.

The Mental Health Act and role of the psychiatrist

The Mental Health Act focusses on the care of people who need to be assessed and treated for a mental disorder but cannot or will not consent to be admitted to hospital. The Mental Health Act allows people to be compelled to be detained and treated. The Act has several 'parts' and 'sections' which set out the various arrangements and circumstances under which people can be compulsorily detained or treated.

Anyone who is detained is allocated a responsible clinician. The Responsible Clinician has overall responsibility for the care and treatment of a person being assessed under the Mental Health Act. These responsibilities include making decisions about treatment, reviewing detention, and assessing whether the criteria for renewing a detention are met

The Wessely review, the White Paper and the consultation response

The foundation for the reform of the Mental Health Act is the Wessely report, 'Modernising the Mental Health Act - Increasing choice, reducing compulsion', published in 2018. It proposed four principles should underlie any reform of the Mental Health Act: supporting choice and autonomy, using the least restriction possible, ensuring therapeutic benefit, and that the person should be seen and treated as an individual. The report included a framework for action with a focus on 154 recommendations.

The formal government response was a White Paper, published in January 2021, setting out plans for *'an unprecedented transformation: making mental health services fit for the future'*. The White Paper adopted the four principles of the Wessely Report and many of its recommendations.

The Department of Health and Social Care consulted widely, seeking the views of those who might be impacted by the planned reforms, including service users, their families and carers, mental health clinicians and professionals, and experts in mental health and mental capacity legislation. in July 2021, it published a summary of the consultation responses and its plans to address the issues raised.

The 2021 Spending Review and the NHS Long Term Plan

Decisions about the adoption of the reforms are subject to funding considerations, in particular, during the Government's 2021 Spending Review[1]. The Department of Health and Social Care published an impact assessment estimating the costs and benefits of the proposed changes to support these funding decisions.

This analysis provides an alternative, independent assessment of the impact of the proposed reforms, specifically relating to the impacts on psychiatrist's workload and the associated workforce implications.

Funding decisions related to the Mental Health Act reforms must be seen in the wider context of prior Government commitments to increase investment in mental health services. In its Long Term Plan, NHS England pledged to increase funding for mental health services by £2.3bn by 2023/24. This pledge predates the proposed reforms to the Mental Health Act, and so did not include anticipated cost pressures associated with the reforms.

[1] This is due to take place in September and October 2021.

What is not in scope of this work?

The report does not seek to assess the impact of the full extent of the reforms, only those that might impact on the workload of psychiatrists, and the number of additional psychiatrists that might be required to fulfil these new obligations.

Moreover, the report does not seek to assess the additional psychiatrists required as a result of other factors; filling existing vacancies, replacing psychiatrists lost through retirement or turnover, or meeting increases in demand for mental health care.

The 2007 amendments to the Mental Health Act 1983 enabled different professional groups, psychologists, nurses, occupational therapists, and social workers, who have been suitably trained to become Approved Clinicians and take up the role of Responsible Clinician in addition to Psychiatrists.

Whilst this analysis focuses on the impact of the reforms on the workload of psychiatrists, a parallel analysis, conducted by the Strategy Unit on behalf of the National Workforce Skills Development Unit, addresses the impact on multi-professional Approved Clinicians.

This analysis focuses on the impacts on psychiatrists who form part of the NHS workforce. The reforms are likely to impact on psychiatrists working for other agencies such as the Second Opinion Appointed Doctors service overseen by the Care Quality Commission, and the Mental Health Tribunal that forms part of the HM Courts and Tribunal Service, an executive agency of the Ministry of Justice.

3. How will the reforms impact on the workload of psychiatrists?

The proposed reforms are substantial and wide-ranging. This paper does not aim to assess the merit of these changes, but rather to estimate their impact on the workload of psychiatrists. These impacts are likely to be numerous and varied. We highlight here some of the more specific and substantial factors at play. Many, more nuanced impacts are also likely.

Reducing the time intervals between Mental Health Tribunal hearings

If a patient is detained under the Mental Health Act or subject to a Community Treatment Order, but feels that this is unfair or unnecessary, then they can appeal to the Mental Health Tribunal. The Tribunal will establish a panel to take evidence and determine whether the detention or Community Treatment Order should be terminated, now or at some point in the future, and whether changes should be made to the treatment plan.

Patients and their representatives can appeal to the Tribunal at various time intervals during their detention or treatment. These time points vary according to the part and section of the Mental Health Act under which they are detained. In addition, patient detentions are automatically referred to the Mental Health Act Tribunal for review in some circumstances. When a patient's case is considered by the Mental Health Tribunal, then the psychiatrist, acting as the Responsible Clinician must prepare for and attend tribunal hearings.

The proposed reforms alter the time intervals when a patient can appeal to the Tribunal and when automatic referrals take place. These proposals seek to reduce the time interval between appeals and automatic referrals.

Statutory Care and Treatment Plans and Advance Choice Documents

Whilst care plans are routinely developed when patients are detained in hospital, the proposed reforms will put these documents on a statutory footing. A Care and Treatment Plan will "*document the specific risk that justifies detention and how detention will deliver therapeutic benefit*". These documents will be considered at Tribunal hearings where a Responsible Clinician will be required to justify "*why the patient continues to meet the detention criteria.*"

The reforms also propose the roll-out of Advance Choice Documents to allow service users to set out their treatment preferences should they be detained at some point in the in future. Such documents are in use in many services already, but the reforms will alter the status, profile and structure of these documents.

Psychiatrists will play a pivotal role in developing Care and Treatment Plans and Advance Choice Documents. The reforms will increase the significance and the complexity of this process.

Earlier involvement of Second Opinion Appointed Doctors

When a detained patient refuses or is unable to consent to treatment, the Second Opinion Appointed Doctor (SOAD) service, managed by the Care Quality Commission can be used to determine whether the treatment is clinically defensible. The proposed reforms will make the service available earlier in the detention process. The engagement of the SOAD service has modest workload implications for psychiatrists acting as Responsible Clinicians.

The introduction of the Nominated Person role

The Mental Health Act (1983) confers rights on one of a detained patient's family members. This individual, known as the Nearest Relative, can for example, object to or apply for a patient's detention, appeal to the Mental Health Tribunal on the patient's behalf and must be given information if a patient is detained. The proposed reforms seek to widen the range of individuals that might act in this capacity, outside of the patient's family, so that patients can choose who represents them. Furthermore, the rights available to this Nominated Person, will be extended to include consultation on statutory care and treatment plans, hospital transfers, detention extensions and to object to certain treatment arrangements. These changes will likely generate additional tasks for psychiatrists acting as Responsible Clinicians.

Expanding the role of Independent Mental Health Advocates

Independent Mental Health Advocates (IMHAs) are specially trained to advocate on behalf of patients detained under the Mental Health Act. They act independently from mental health services. The proposed reforms will extend the availability of IMHAs to all mental health inpatients, and to increase the scope of the service to cover involvement in statutory care and treatment plans

and to support patients to appeal against their detention. These changes will likely generate additional tasks for psychiatrists acting as Responsible Clinicians.

Increasing the evidence required to justify the use of Community Treatment Orders

The Mental Health Act (1983) permits the use of Community Treatment Orders (CTOs), to enable Responsible Clinicians to discharge a detained patient, but require the patient to continue to receive treatment in a community setting. The proposed reforms will require a greater level of evidence from Responsible Clinicians to justify the use of CTOs.

Training

Given their role within the Mental Health Act, it is critical that psychiatrists have a detailed understanding of its powers and limitations. Substantial changes to the Act, such as the proposed reforms, imply therefore, additional training needs for psychiatrists. Moreover, given that the reforms will increase the complexity of the Act, on-going professional development activities related to the Act are likely to be more detailed and time-consuming.

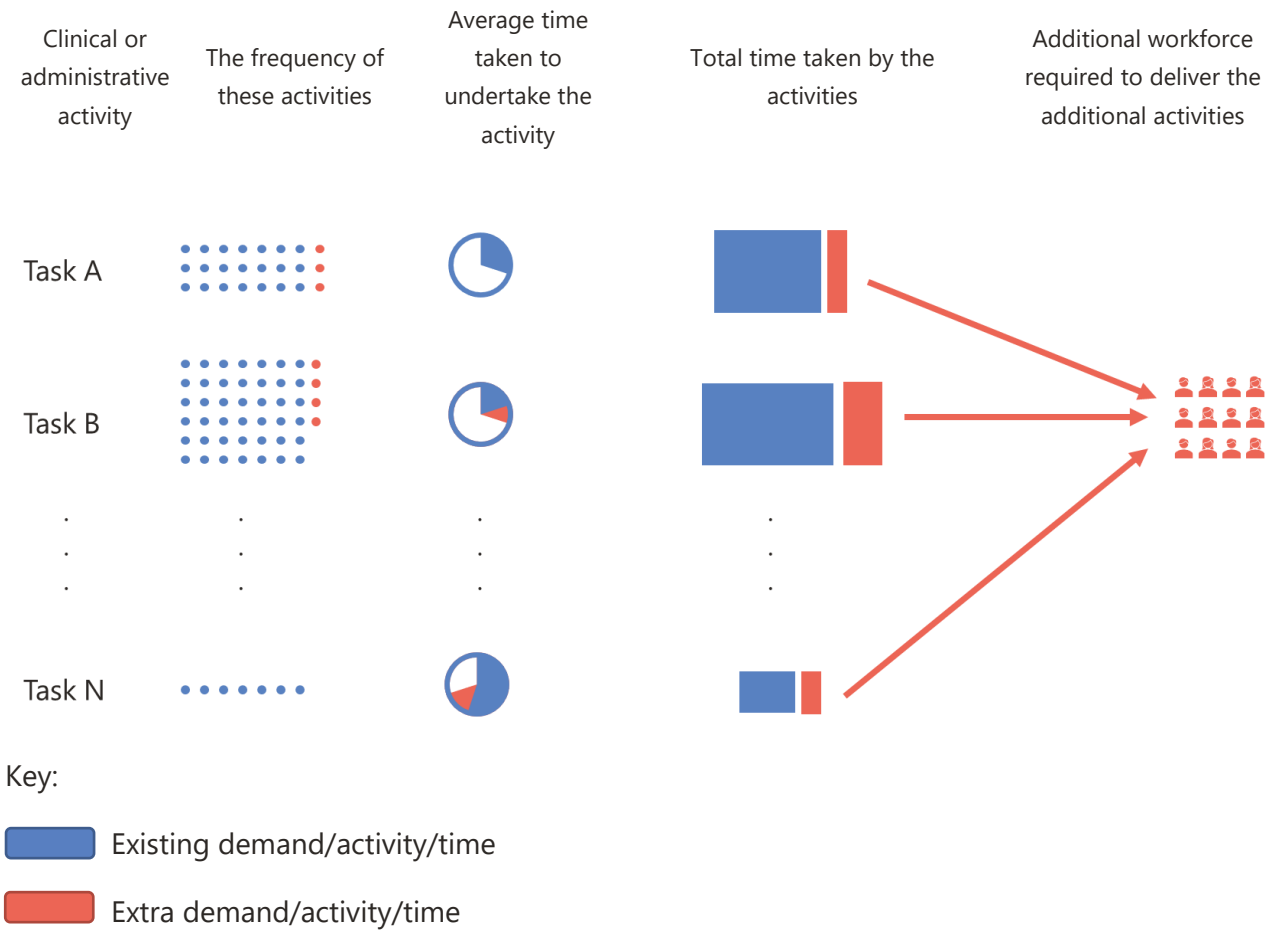
4. Our approach to quantifying these impacts

Estimating the scale of these impacts on psychiatrists' workload is not straightforward. The reforms will have many subtle and varied impacts on psychiatrists' working arrangements. These impacts will evolve and emerge dynamically in response to available capacity, staff and service users' perspectives, and the extent to which other demands compete for time. Estimates are nonetheless required for planning purposes. Our approach focuses on those changes whose effects are likely to be substantial and clear cut. Our approach will rely on assumptions, as any other approach would, but we will be explicit about these assumptions and provide supporting analyses to indicate the extent to which our impact estimates are sensitive to these assumptions.

Our conceptual model

Our conceptual model recognises that the Mental Health Act in its current form, places obligations on psychiatrists to carry out certain tasks and functions: prepare for and attend Tribunal hearings, engage with second opinion reviews etc. The time these tasks take varies, often considerably from case to case, but there is nonetheless an average duration for each task across all psychiatrists and patients. The proposed reforms may alter the frequency and average durations of these tasks and may introduce new tasks. We seek to estimate these changes in frequency and duration and to sum these over all cases in some future year. We can then convert the total additional time required to meet these new obligations into whole-time-equivalent psychiatrists using assumptions about the average working hours of psychiatrists in that year.

Figure 1: Conceptual model



This approach requires data on the baseline frequency and duration of tasks as well as estimates of the impact of these reforms on their future frequency and duration. Some of this data exists in published statistics or can be gleaned from the White Paper and subsequent consultation response. Where gaps in the data required exist, we have relied on expert opinion. We set out below the sources of data that we have used, and the methods used to elicit expert opinion.

Data sources

Historical data on **the number of Mental Health Act detentions and community treatment orders** are published by NHS Digital. The data includes subcategories of detentions by the part and section of the Act that was used. The underlying source of these statistics changed in 2016 from the KP90 statistical returns to the Mental Health Services Minimum Dataset. NHS Digital warn

against comparisons of detention numbers before and after this change. As such we relied on detention and CTOs numbers and trends from 2016/17 onwards.

Alongside data on the counts of detentions and CTOs, NHS Digital also publish data on **the duration of Mental Health Act detentions and CTO**s. In particular data on the median duration, upper and lower quartile durations by part and section of the Act and year.

The Ministry of Justice publish data on **the number of Mental Health Tribunal hearings** carried out each year and the Care Quality Commission publish additional data on the breakdown of these hearings by the section and part of the Act used.

The Care Quality Commission also publish data on **the number of Second Opinion Appointed Doctor reviews** that are carried out each year.

Data on **the number of whole-time-equivalent Psychiatrists** employed by the NHS are published by NHS Digital and this includes a subdivision by grade (e.g., consultant, associate specialist, specialty doctor, staff grade, hospital practitioner and other local doctor grades). **Rates of sickness absence of NHS consultants** are published each month by NHS Digital.

Data on the **minimum intervals between patient appeals to the Mental Health Tribunal and of automatic referrals to the Tribunal**, under the current version of the Act and under the proposed reforms were gleaned from the Act itself, the White Paper and the consultation response.

Eliciting expert opinion

Where no published data was available to support our calculations, we sought expert opinion, using a modified (estimate-review-estimate) Delphi method. The Delphi method is an established and structured method of obtaining estimates from groups of experts.

An online workshop was convened on 10th August 2021. 16 members of the Royal College of Psychiatrists participated in the workshop, representing a range of clinical sub-specialties including general adult psychiatry, intellectual disability, forensic psychiatry, liaison psychiatry, perinatal psychiatry, psychotherapy, child and adolescent psychiatry, old age psychiatry, eating disorders, addiction and rehabilitation.

Over the course of 2 hours, the participants provided estimates for 19 quantities of interest such as the time required, under the current Act to prepare for an attend a Tribunal hearing and the additional time, per tribunal that the proposed IMHA and Nominated Person reforms might entail.

The estimation process followed the following steps:

(1) The Strategy Unit described a quantity of interest.

(2) Each participant was asked to anonymously estimate the quantity. [round1]

(3) Discussion was limited to clarifying the interpretation and definition of the quantity.

(4) Participants were shown the distribution of round 1 estimates.

(5) Participants were asked to anonymously submit a second estimate. [round 2]

This process was repeated until all quantities of interest were addressed.

The median of the round 2 estimates was used to inform this impact quantification process. The distribution of the round 2 estimates was used to inform sensitivity analyses.

The outputs of the Delphi process and the names of the members of the Royal College of Psychiatrists that participated are set out in appendices A and B.

Estimating the impact on Tribunal interval changes on the frequency of tribunal hearings

The reforms propose several changes to the intervals at which patients or their representatives can appeal to the Mental Health Tribunal to bring their detention or treatment to an end and the intervals between automatic referrals to the Tribunal. The extent to which the changes will impact on the number of hearings is a function of both the interval changes and the distribution of detention (and CTO) durations. We fitted time-to-event distributions to the median, upper and lower quartile durations by part and section of the Act, published by NHS Digital and overlaid the time intervals for Tribunal hearings under the current Act and the proposed reforms. This allowed us to estimate the numbers of patients that would be eligible, or automatically referred to the Tribunal before and after the reforms. Further information on this process can be found in appendix C.

Detention & CTO growth assumptions

The extent to which the number of new detentions and Community Treatment Orders changes in the future will have a compounding or dampening effect on the impacts of the reforms on workload of psychiatrists. Predicting detention growth however is not straightforward. Relatively few historical data points exist, and it may be argued that the reforms will alter the trajectory of

detentions and CTOs. For the purposes of this analysis, we estimate the impacts of the reforms under three distinct growth scenarios.

A continuation of recent growth: The recent growth rate was approximated using linear regression on the logged annual detention and CTO numbers by part and section of the Act since 2016/17 and exponentiating the model coefficient for the 'year' covariate.

DHSC assumed growth: The July 2021 Impact assessment published by DHSC, included assumptions about detention and CTO growth. DHSC assumed that the reforms would slow the rate of growth in detentions over a 5-year period.

No growth: This scenario was included to provide an indication of the impacts of the reforms themselves, in the absence of detention growth.

5. Results

In this chapter, we set out the results of our assessment. A file accompanying this report, which includes the detailed calculations is available on request.

We start by setting out our principal estimates. These assume a continuation of recent detention and CTO growth and apply the median of the expert opinions elicited via the exercise described in the previous chapter. We then go on to illustrate the sensitivity of these results to alternative assumptions and opinions.

Principal impact assessment

If detentions and Community Treatment Orders continue to grow as they have been in recent years, then we estimate that an additional 335 (5.8%) additional whole-time equivalent (WTE) psychiatrists will be required to accommodate the specific impacts of the proposed reforms by 2023/24. And that a further 185 WTE psychiatrists will be required by 2033/34. We estimate the costs of these impacts at £40m per annum by 2023/24, rising to £63m by 2033/34, at today's prices.[2]

Our analysis suggests that the primary driver of these increases will be the additional time required to prepare and attend Tribunal hearings given the additional obligations placed on psychiatrists as part of the reforms. Increases in the frequency of Tribunal hearings per detention, additional tasks relating to detained patients outside of Tribunal hearings and additional training have a more modest but nonetheless material impact on the numbers of additional psychiatrists required.

Of the Tribunal related impacts by 2033/34, 55% relates to people detained under part 2 - section 3 of the Act, 24% to those detained under part2 - section 2 and 19% to people subject under Community Treatment Orders. The impact of patients detained under part 3 of the Act are more modest.

If the additional psychiatrists mirror the current distribution of psychiatrists by type, then we estimate that 399 (77%) of the additional psychiatrists required by 2033/34 will be consultants.[3]

It is important to note that these estimates relate only to the impact of the reforms and are in addition to extra staff that may be required to fill existing vacancies, replace retiring psychiatrists or to meet rising demand for mental health care.

[2] Mid-point of consultant salary range + 25% on-costs.
[3] The remainder predominantly being Associate Specialists and Specialty Doctors.

Figure 2: Impact of Reforms by 2023/24 (Principal estimate)

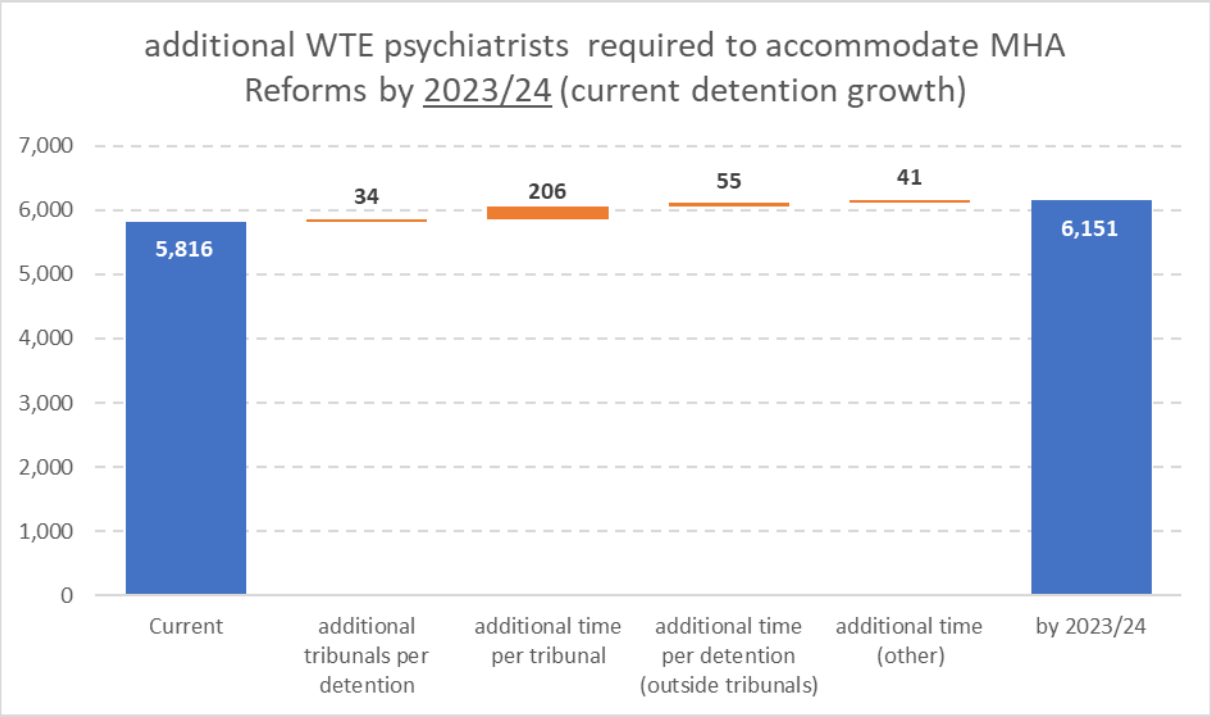
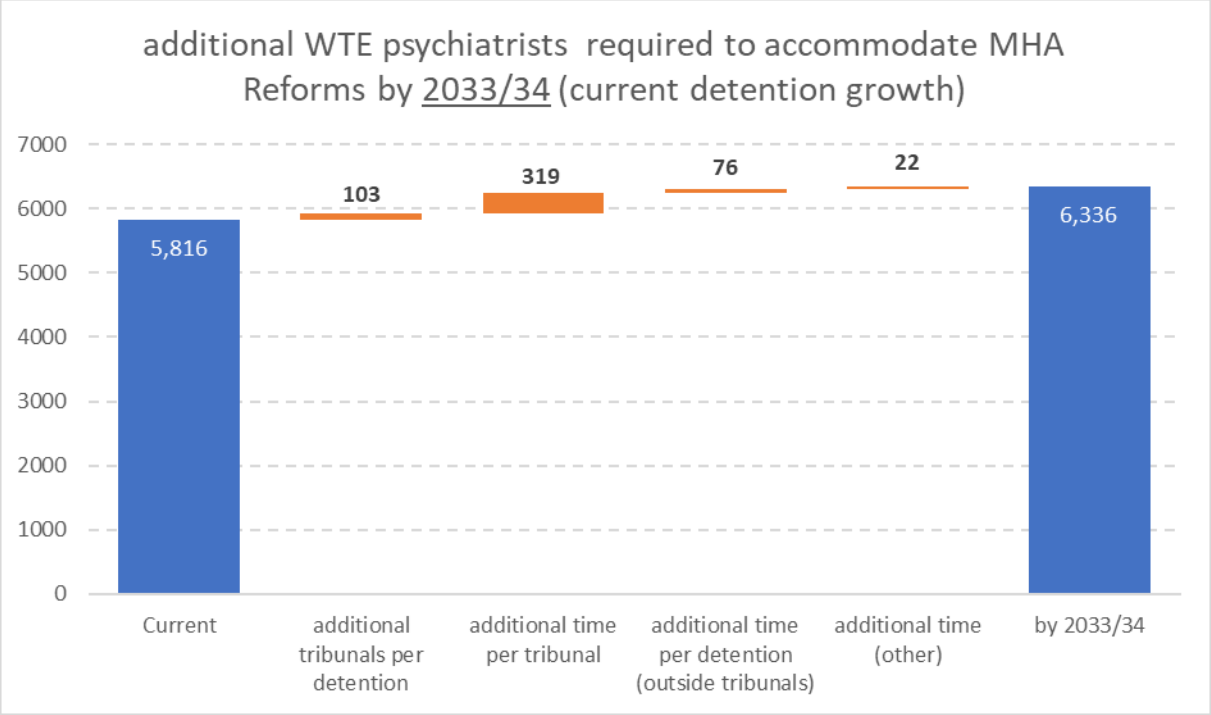


Figure 3: Impact of Reforms by 2033/34 (Principal estimate)



Sensitivity analyses

The impact of detention and CTO growth assumptions on our estimates is not substantial. Our principal estimate, assuming a continuation of current detention and CTO growth, is that an additional 520 WTE psychiatrists will be required as a result of the reforms by 2033/34. Under DHSC's moderated detention growth assumption, this reduces to 494 additional psychiatrists. Indeed, even in the 'no detention growth' scenario, the estimated additional number of WTE psychiatrists reaches 417 by 2033/34.

Table 1: Sensitivity of results to detention & CTO growth assumptions

Detention and CTO growth assumption	Additional WTE career-grade psychiatrists	
	by 2023/24	by 2033/34
Continuation of recent growth [principal]	335	520
DHSC assumed growth	333	494
No growth	325	417

Given that the primary driver of the estimate of additional psychiatrists appears to relate to the amount of extra time required per Tribunal hearing, it is prudent to explore the sensitivity of these estimates to alternative opinions about the impacts of the reforms on this extra time. Our principal estimates are based on the median of the experts' opinions about the extra time required. We set out below how these estimates would have differed if we had instead used the upper and lower quartile of the experts' opinions about the extra time required per tribunal.

Table 2: Sensitivity of results to opinions about extra time required per Tribunal hearing

Expert opinion of extra time per tribunal	Additional WTE career-grade psychiatrists	
	by 2023/24	by 2033/34
Median of opinions [principal]	335	520
Lower quartile of opinions	264	410
Upper quartile of opinions	460	713

Appendix D contains the results of the assessment if the detention growth and increased time per tribunal assumptions are varied simultaneously.

6. Other considerations

Whilst preparing to undertake this analysis, we conducted several informal interviews with members and officers from the Royal College of Psychiatrists and other individuals with perspectives on the proposed reforms and their possible impacts. In addition, at the end of the workshop that was used to elicit expert opinions, several of the participants offered additional contextual perspectives. We set out the main themes from these discussions below.

Overview of act

There was strong support expressed for the ethos and values base of these proposed reforms; that treatment must be therapeutic and the need for treatment to be evidence-based. There was optimism that the new Act could improve clinical processes, giving clinicians the space for positive and creative thinking, with a focus on what clinicians can do rather than what cannot be done. It must not become a new set of yes/no tick boxes.

There was enthusiasm expressed for advanced directives, that could perhaps be completed at the end of an inpatient stay, discussing 'what worked well' during the stay, and to develop relapse and follow up plans.

Impact of timelines

There was strong support for the tighter timelines, but there were concerns about having enough time to carry out a full assessment and having the time to gather evidence/data/analysis of problems. This may be especially relevant in people with a Learning Disability, for people whose first language is not English, and potentially people on the autistic spectrum.

We also need to ensure there is time to consider all aspects of a full assessment. This may include not only the psychological and psychiatric condition, but also co-morbid physical health problems, social needs, etc.

Risk from lack of resources

There was concern expressed that unless the additional resources required with respect to the Mental Health Act were fully met, the increased staff focus/time on people detained under the Act could take attention away from people receiving care under a voluntary basis.

Impact on different services

The resource impact of these changes would not fall equally across all services. Clearly those with a large number of people detained under the Mental Health Act and those with a fast turnover will

have the greatest impact due to the changes to the Act. It was suggested that these would include forensic, secure, rehabilitation, eating disorders and CAMHS services.

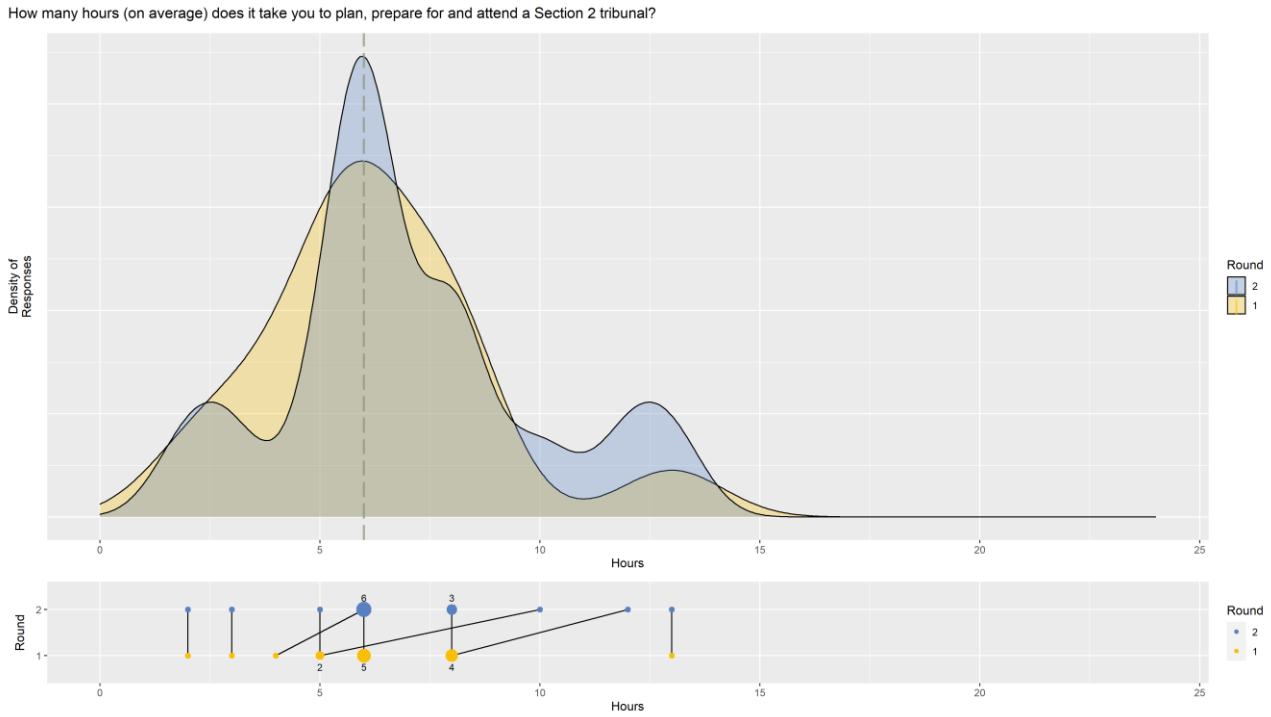
7. Appendices

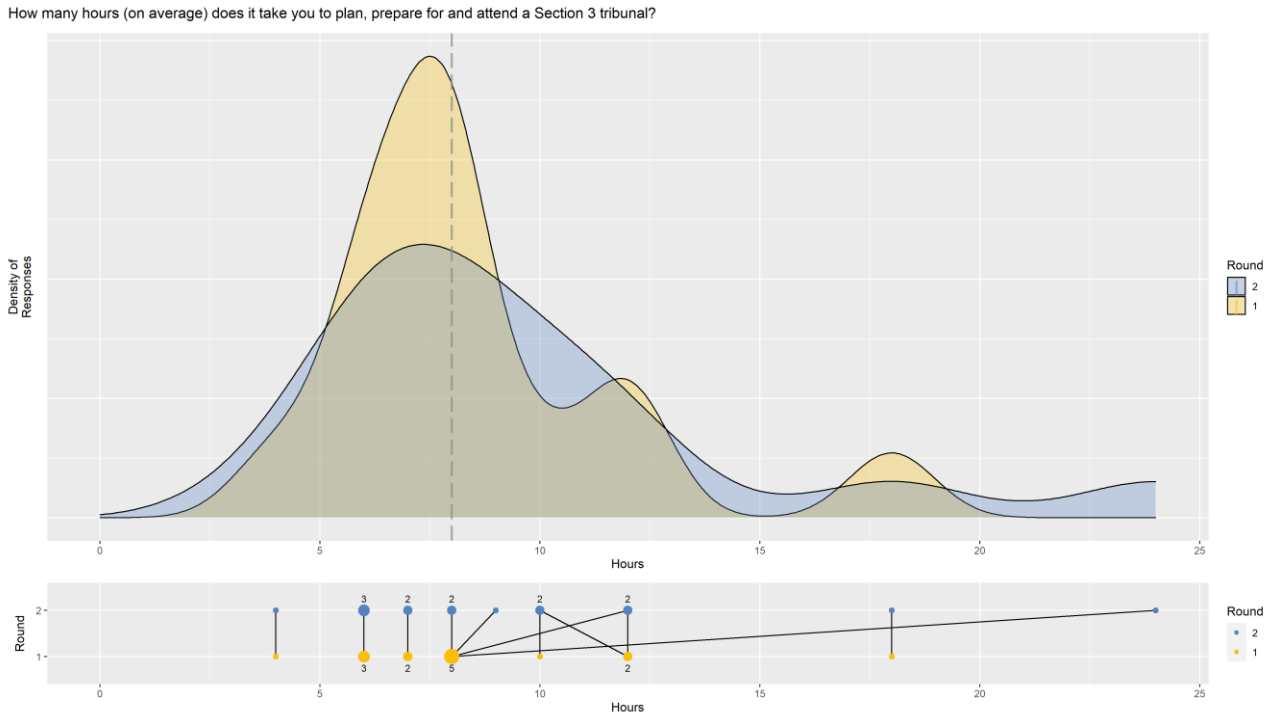
Appendix A – Results of the Expert Opinion Elicitation Exercise

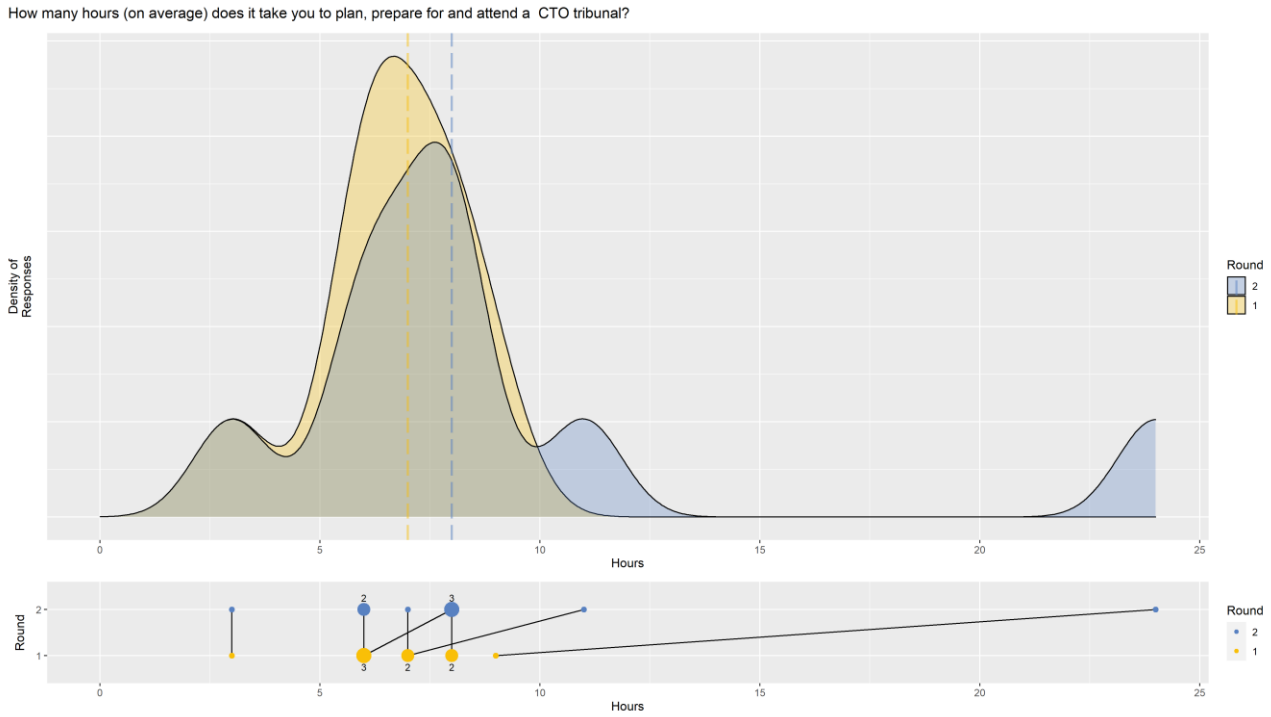
Table 3: Headline results of the Expert Opinion Elicitation Exercise

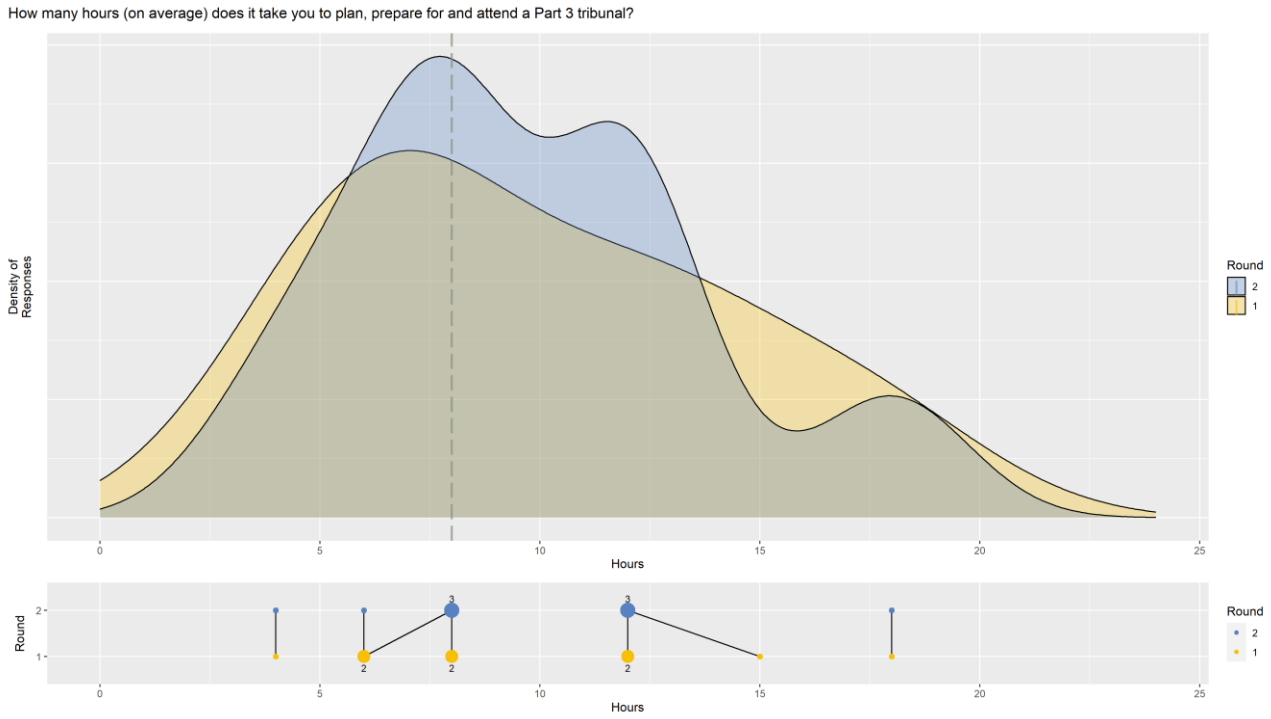
Quantity estimated	Median estimate	[Inter-quartile range]
How many hours (on average) does it take you to plan, prepare for and attend a tribunal?		
Section 2 tribunal	6	[6 to 8]
Section 3 tribunal	8	[6.5 to 11]
CTO tribunal	8	[6 to 8]
Part 3 tribunal	8	[8 to 12]
Part 3 restricted tribunal	12	[10 to 16]
What do you believe is the most likely future growth rate for detentions? (% per annum)	8	[6 to 8]
Care & treatment plan and clinician's justification: How many extra hours might these requirements add to preparing and attending a typical tribunal?		
Section 2 tribunal	4	[2.25 to 5.5]
Section 3 tribunal	5	[2.25 to 6]
CTO tribunal	5	[3.25 to 8]
Part 3 tribunal	6	[6 to 6]
Part 3 restricted tribunal	8	[7to 8]
To what extent might the new requirements reduce the use of CTOs? (% reduction)	0	[-10 to 0]
How many additional hours might be required to prepare and attend a CTO tribunal under these new requirements?	4.5	[2 to 6]
Considering patients who would not otherwise have applied for discharge < 14 days, what proportion will in future apply between 14 and 21 days?	25	[21 to 35]

Quantity estimated	Median estimate	[Inter-quartile range]
How do you expect the number of SOAD requests to change under these new arrangements? (% change)	41	[26 to 50]
How many hours of your time does it add when a second opinion is requested?	2	[1.25 to 3]
How many hours might the IMHA and nominated person reforms add to current workload?		
per MHA tribunal	4	[2.5 to 8]
per detained patient outside of tribunal per year	11	[7.25 to 21.75]
How many hours training do you expect you will need to comply with the MHA reforms in the year after the reforms are introduced?	12	[9 to 14]
How many additional hours training per year do you expect you will need to comply with the MHA reforms in subsequent years?	6	[5 to 8]

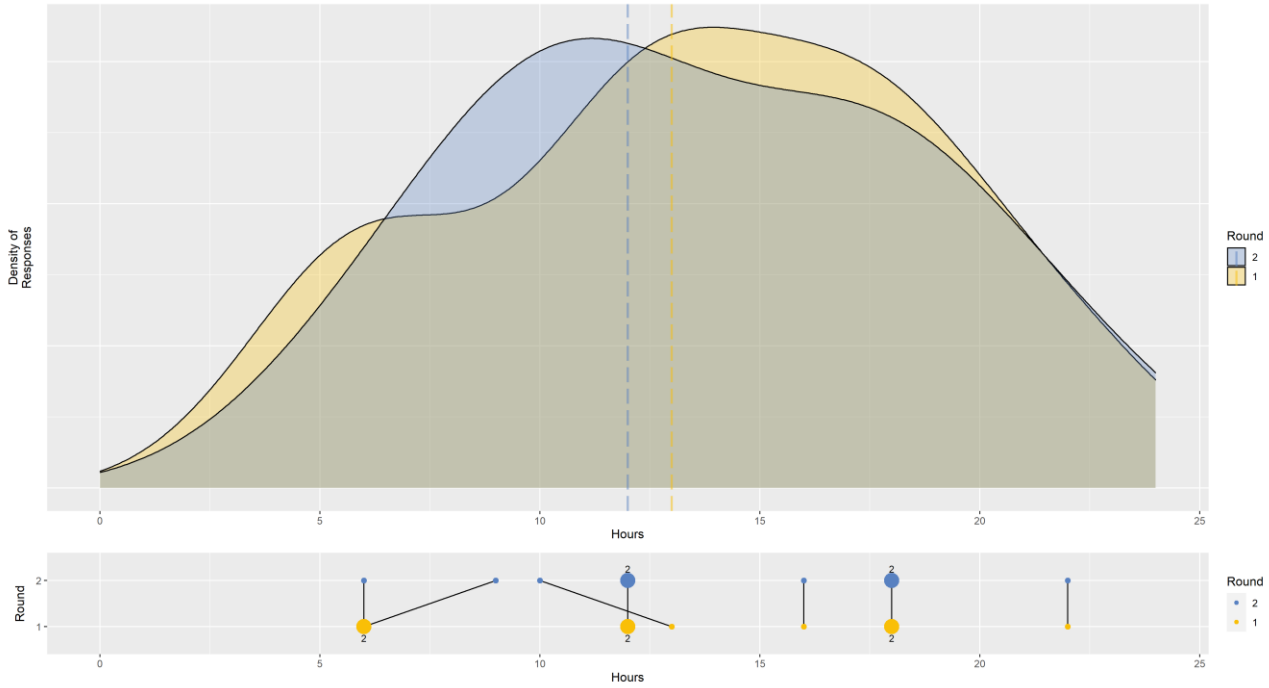

How many hours (on average) does it take you to plan, prepare for and attend a Section 2 tribunal?
Density of Responses
Round
2
1
0
5
10
15
20
25
Hours
Round
2
1
6
3
2
5
4
Round
2
1
Hours


How many hours (on average) does it take you to plan, prepare for and attend a Section 3 tribunal?
Density of Responses
Round
2
1
0
5
10
15
20
25
Hours
Round
2
1
3
2
2
2
2
3
2
5
2
Round
2
1
Hours

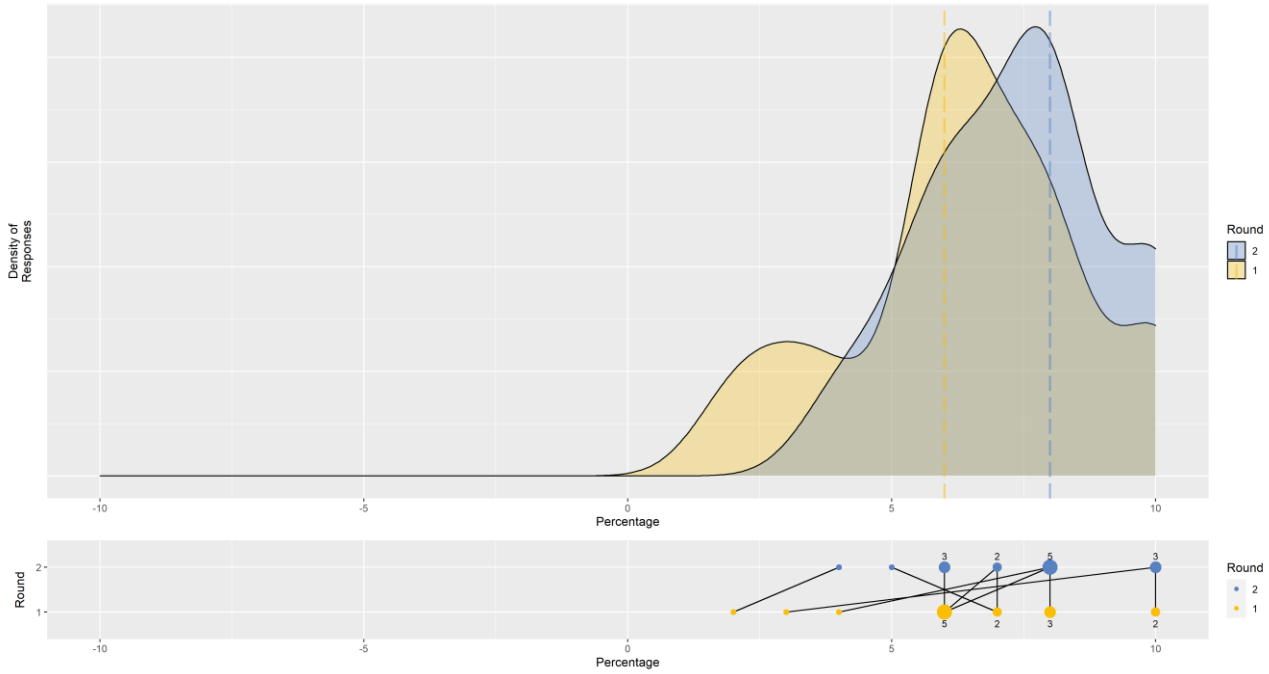

How many hours (on average) does it take you to plan, prepare for and attend a CTO tribunal?
Density of Responses
Round
2
1
0
5
10
15
20
25
Hours
Round
2
1
2
3
3
2
2
Round
2
1
Hours

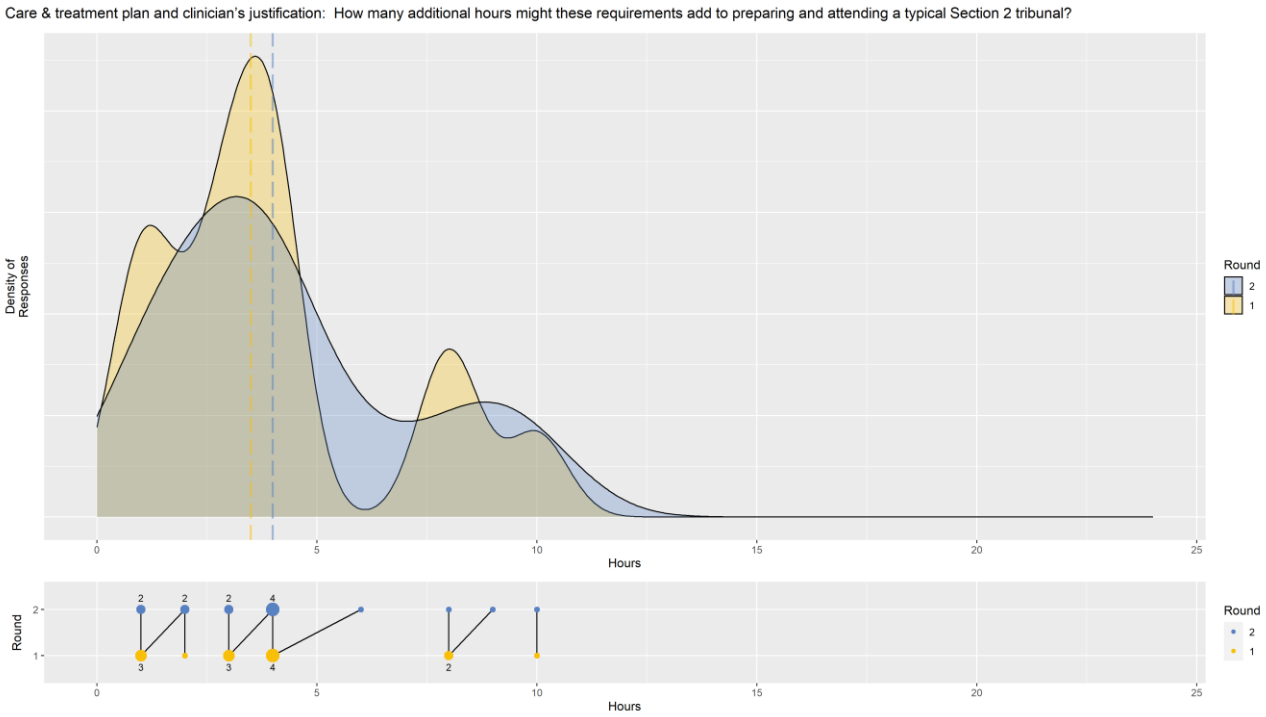

How many hours (on average) does it take you to plan, prepare for and attend a Part 3 tribunal?
Density of Responses
Round
2
1
0
5
10
15
20
25
Hours
Round
2
1
2
3
2
3
2
Round
2
1
Hours

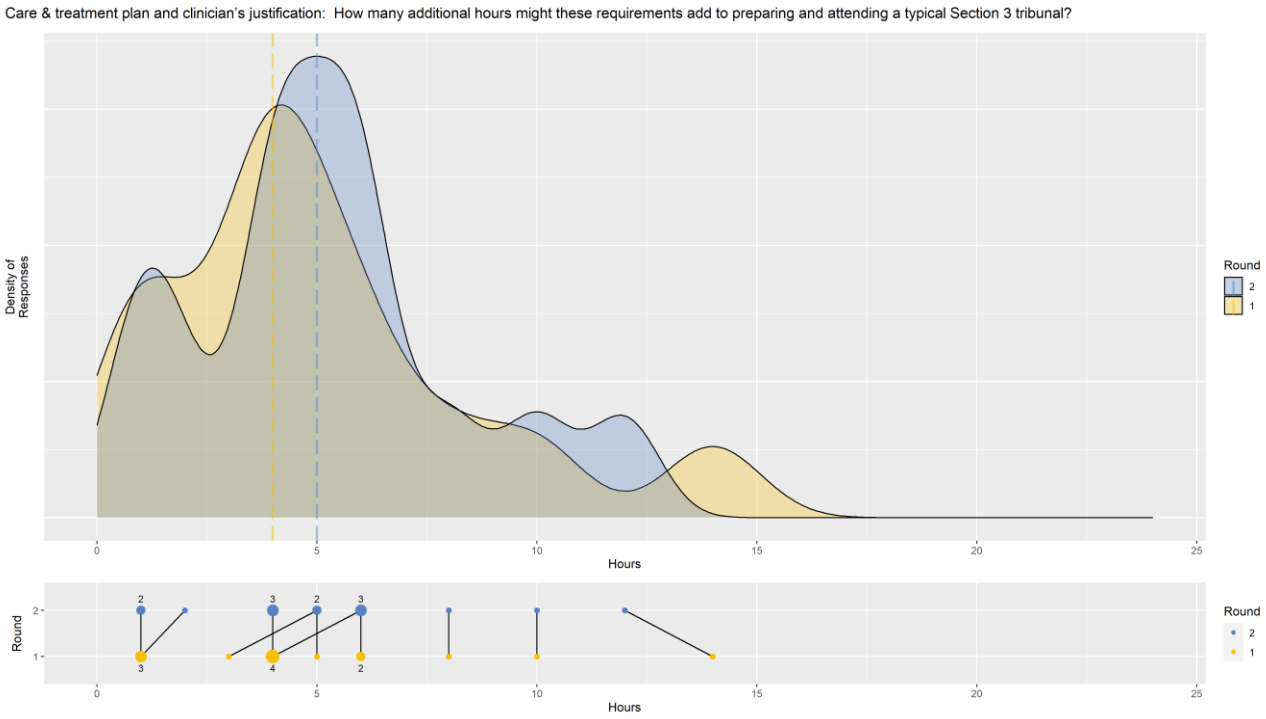
How many hours (on average) does it take you to plan, prepare for and attend a Part 3 restricted tribunal?

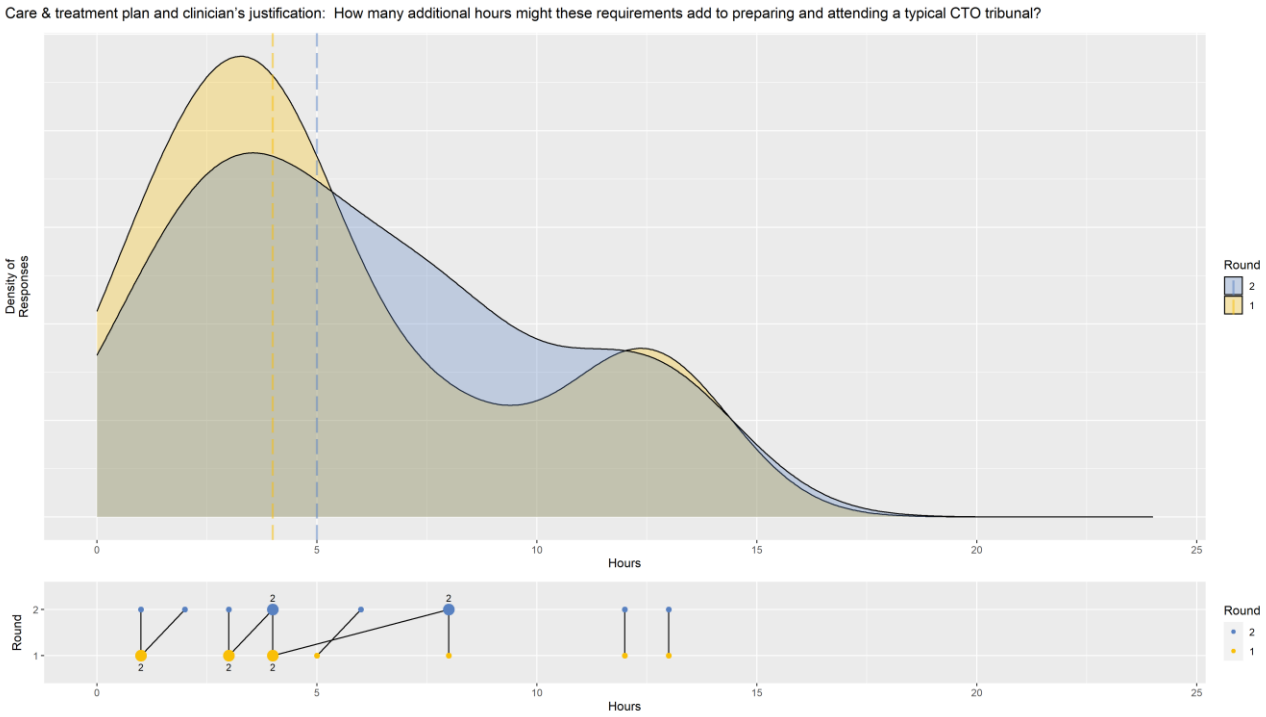


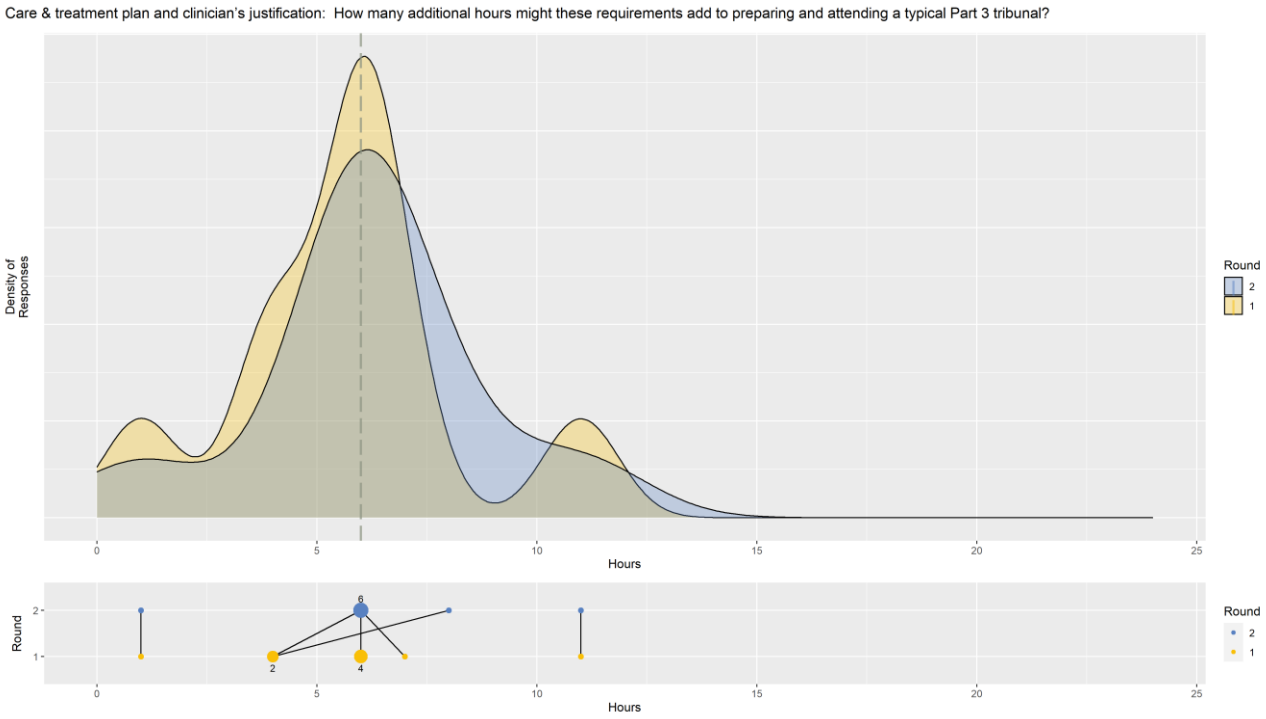
What do you believe is the most likely future growth rate for detentions ? (% per annum)



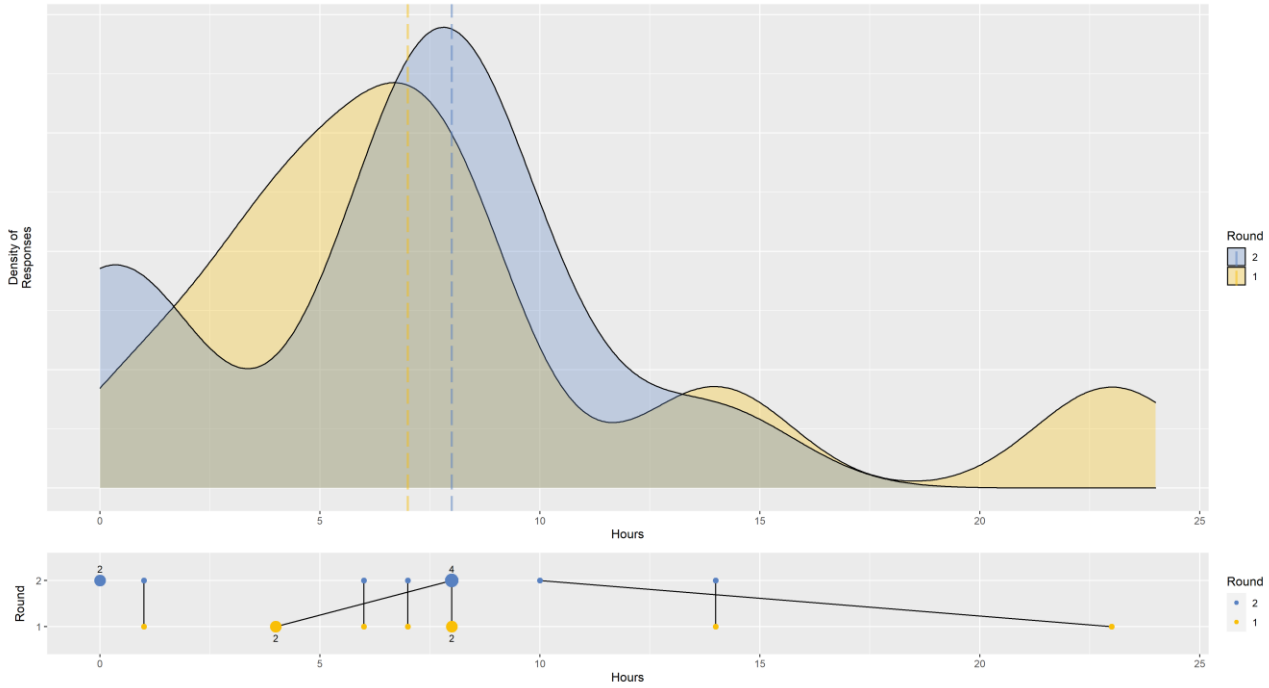

Care & treatment plan and clinician's justification: How many additional hours might these requirements add to preparing and attending a typical Section 2 tribunal?
Density of Responses
Hours
Round
2
1
Round
Hours


Care & treatment plan and clinician's justification: How many additional hours might these requirements add to preparing and attending a typical Section 3 tribunal?
Density of Responses
Hours
Round
2
1
Round
Hours

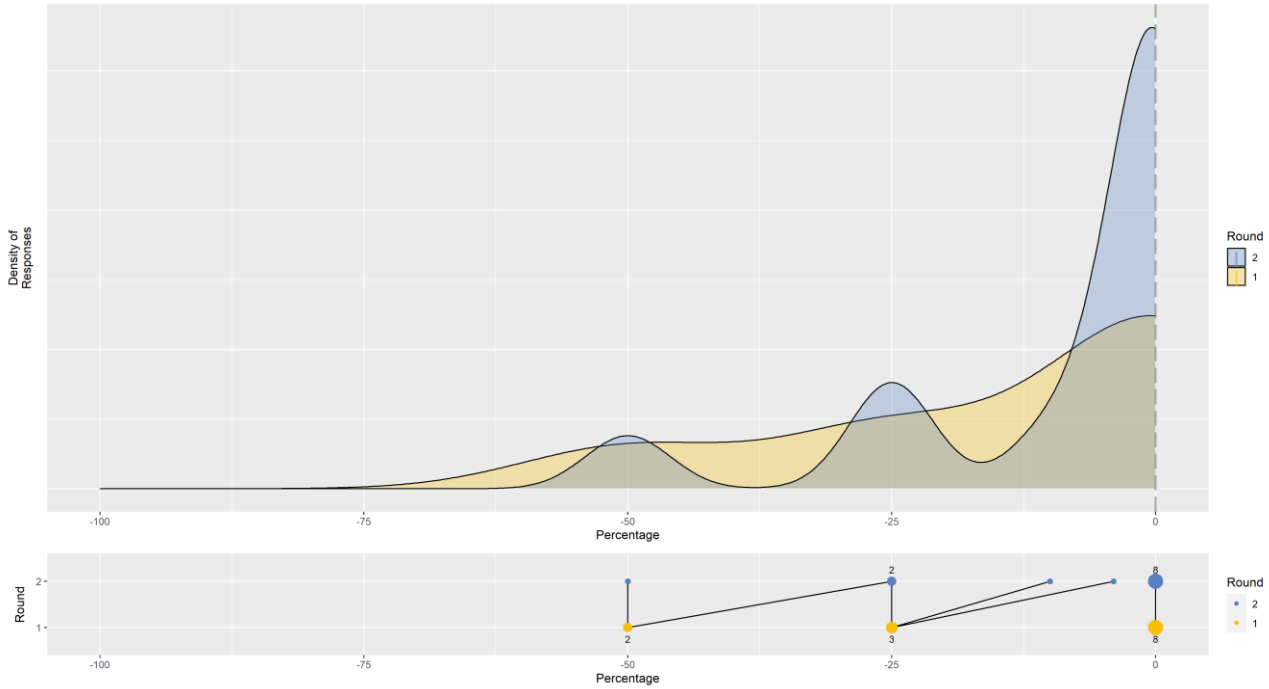

Care & treatment plan and clinician's justification: How many additional hours might these requirements add to preparing and attending a typical CTO tribunal?
Density of Responses
Hours
Round
2
1
Round
Hours


Care & treatment plan and clinician's justification: How many additional hours might these requirements add to preparing and attending a typical Part 3 tribunal?
Density of Responses
Hours
Round
2
1
Round
Hours

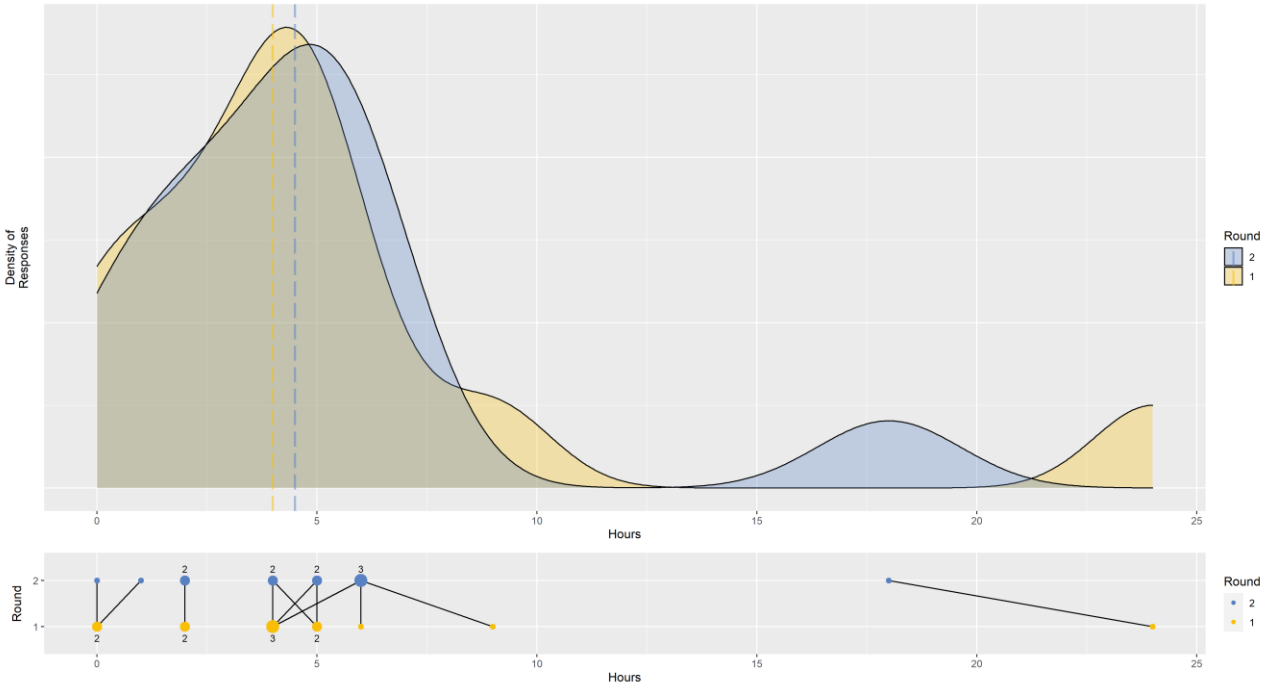
Care & treatment plan and clinician's justification: How many additional hours might these requirements add to preparing and attending a typical Part 3 restricted tribunal?



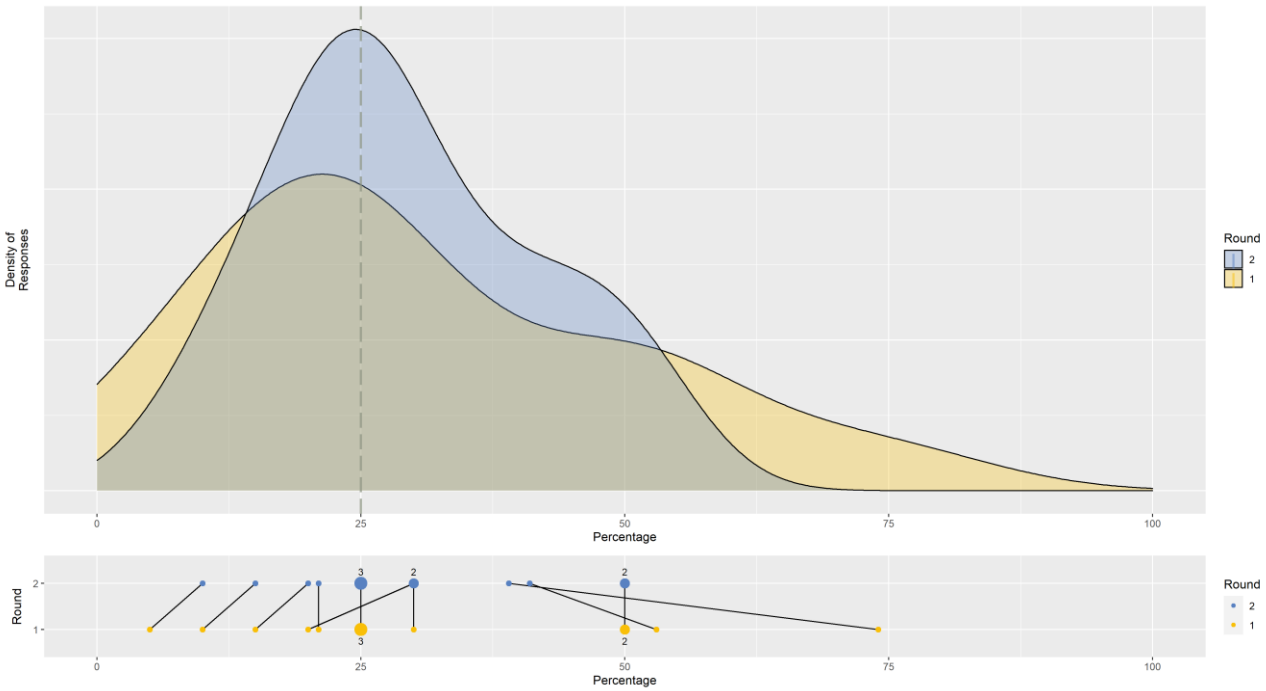
To what extent might the new requirements reduce the use of CTOs? (% reduction)

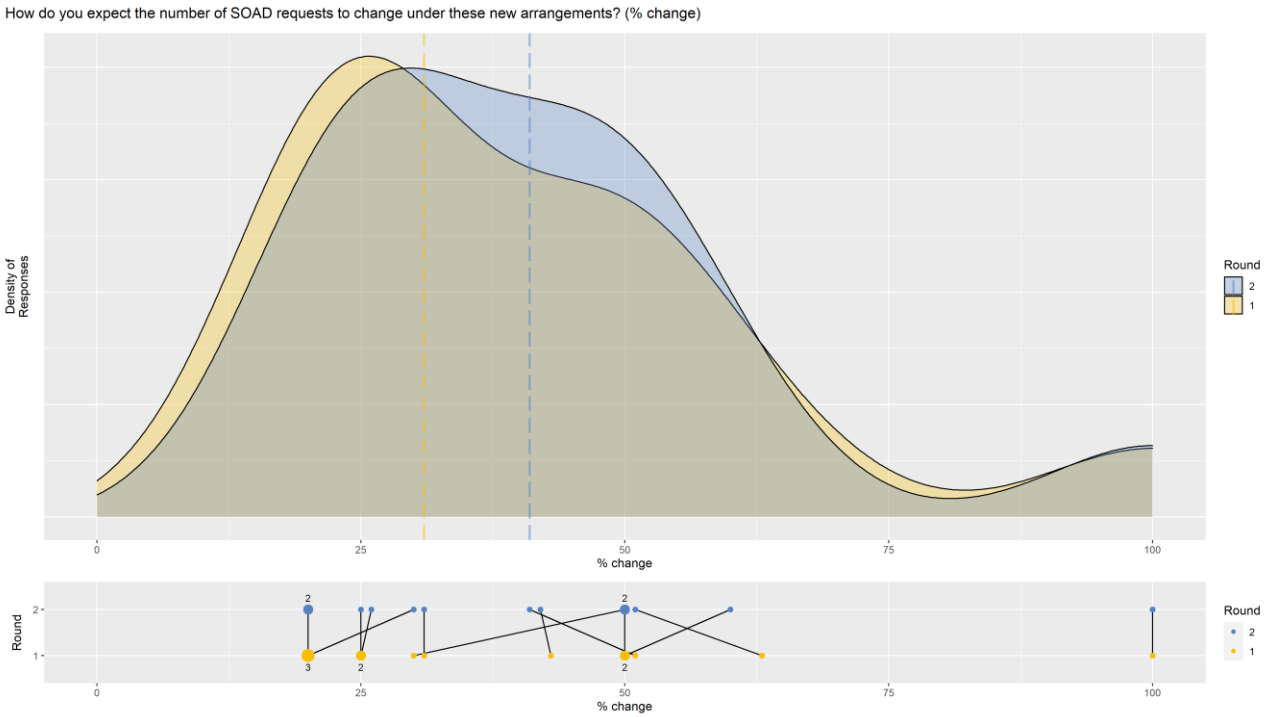


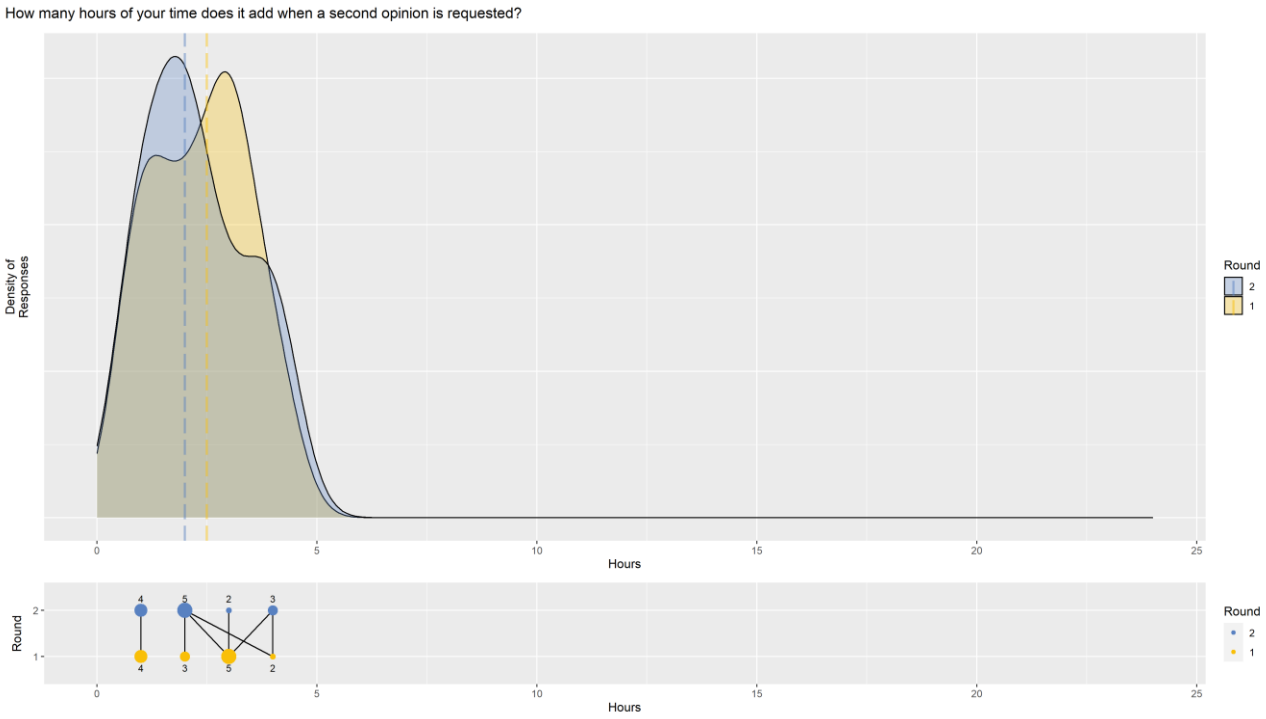
How many additional hours might be required to prepare and attend a CTO tribunal under these new requirements?

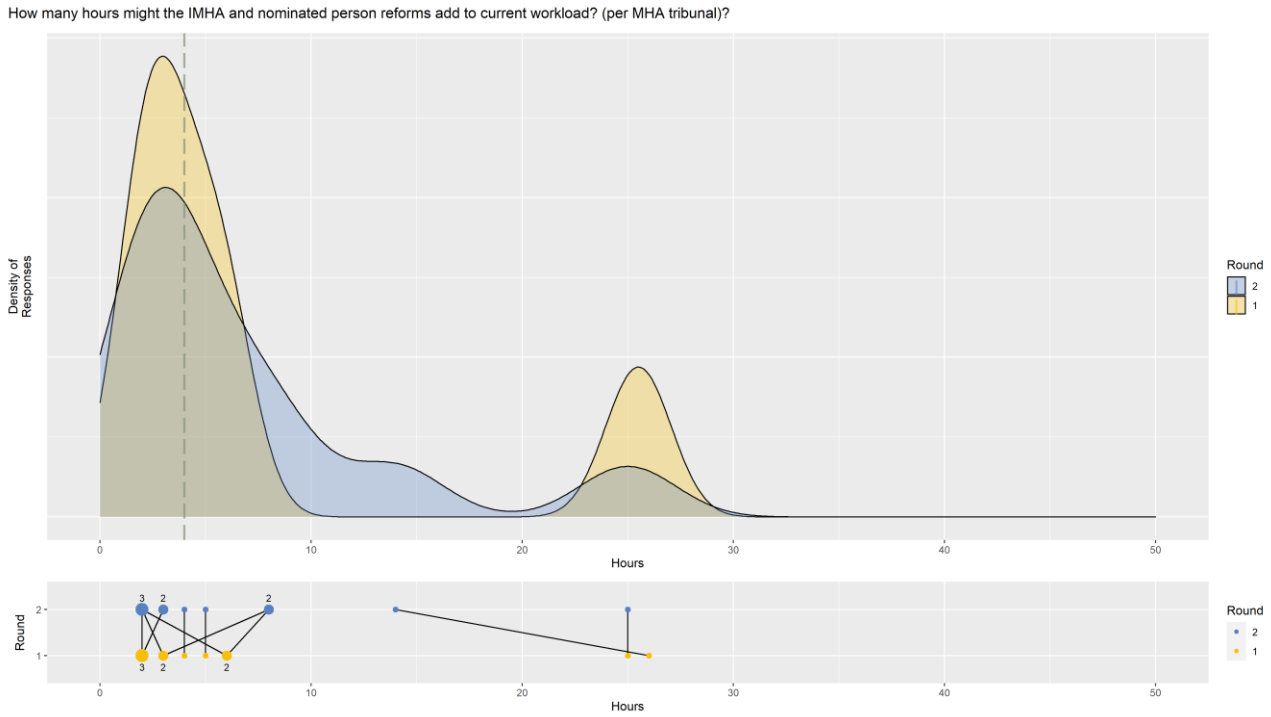


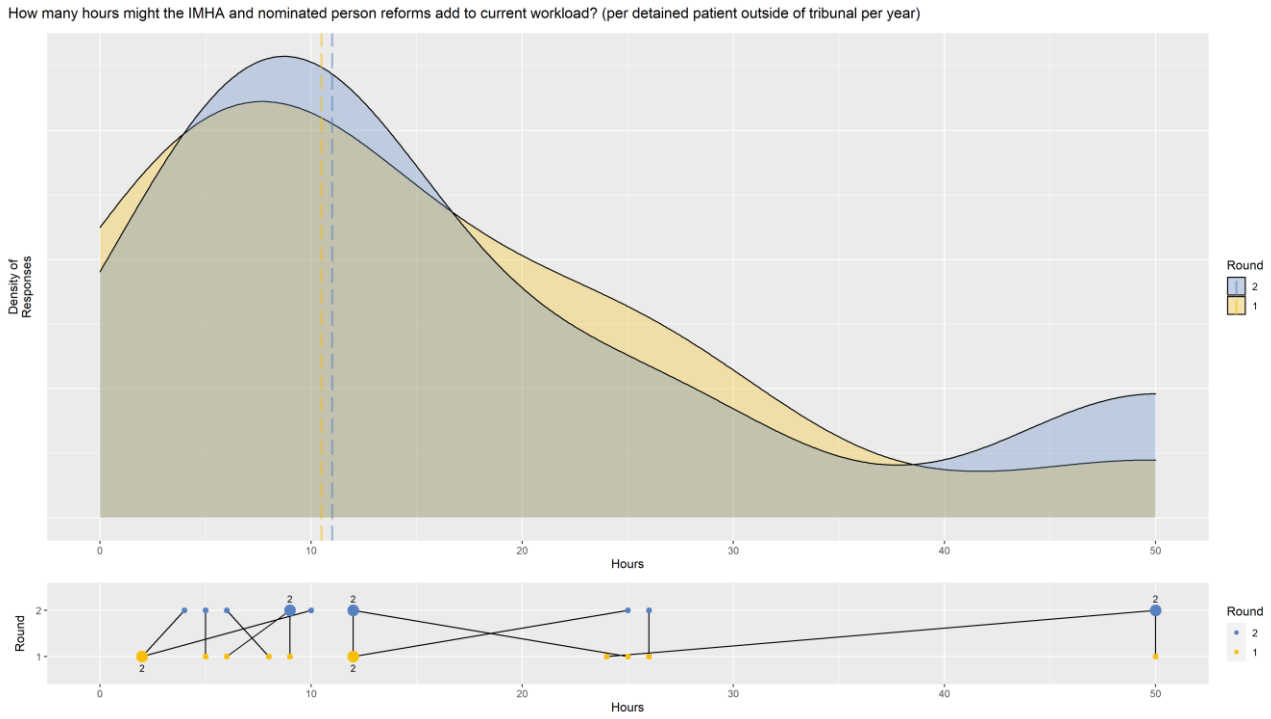
Considering patients who would not otherwise have applied for discharge < 14 days, what proportion will in future apply between 14 and 21 days?



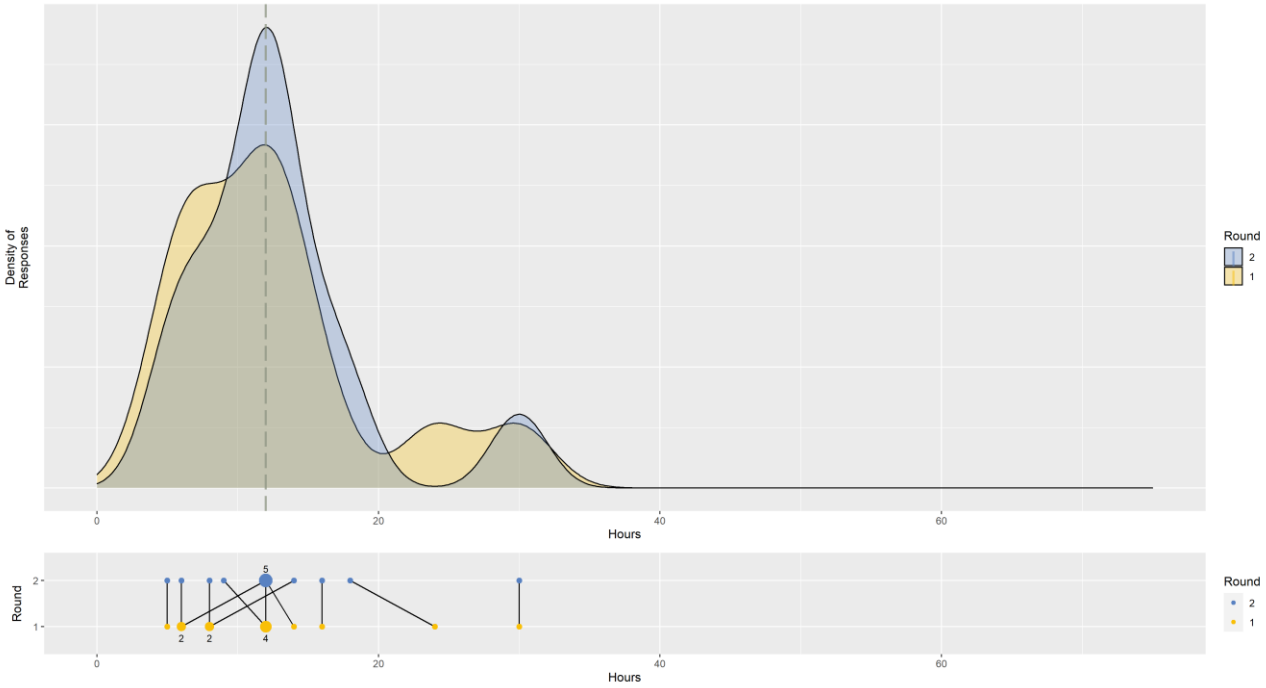

How do you expect the number of SOAD requests to change under these new arrangements? (% change)
Density of Responses
0
25
50
75
100
% change
Round
2
1
Round
2
1
2
3
2
2
2
0
25
50
75
100
% change
Round
2
1


How many hours of your time does it add when a second opinion is requested?
Density of Responses
0
5
10
15
20
25
Hours
Round
2
1
Round
2
1
4
5
2
3
4
3
5
2
0
5
10
15
20
25
Hours
Round
2
1

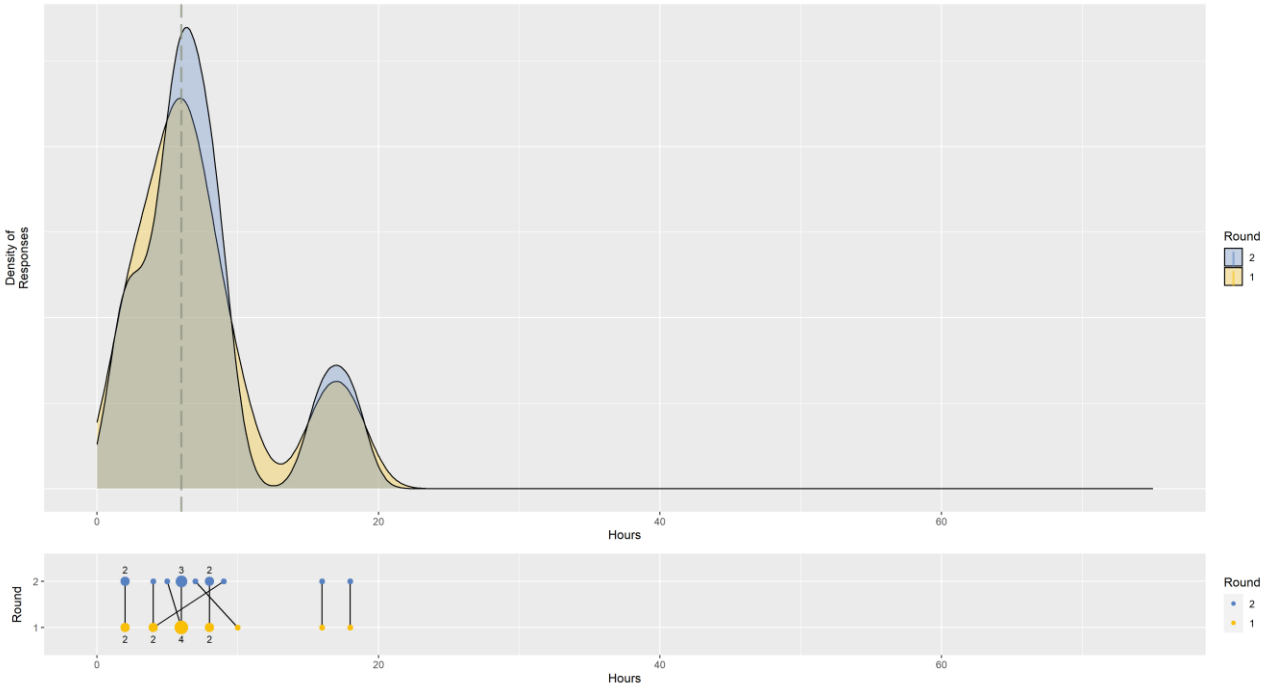

How many hours might the IMHA and nominated person reforms add to current workload? (per MHA tribunal)?
Density of Responses
Round
2
1
0
10
20
30
40
50
Hours
Round
2
1
3
2
2
3
2
2
Round
2
1
0
10
20
30
40
50
Hours


How many hours might the IMHA and nominated person reforms add to current workload? (per detained patient outside of tribunal per year)
Density of Responses
Round
2
1
0
10
20
30
40
50
Hours
Round
2
1
2
2
2
2
2
Round
2
1
0
10
20
30
40
50
Hours

How many hours training do you expect you will need to comply with the MHA reforms in the year after the reforms are introduced?



How many additional hours training per year do you expect you will need to comply with the MHA reforms in subsequent years?



Appendix B – Expert Opinion Elicitation Exercise: List of Participants

Table 4: Expert Opinion Elicitation Exercise: List of Participants

Participant	Facilitator	Observer
Abdi Sanati	Andrew Hood	Ella Robinson
Agnes Ayton	Lawrence Moulin	George Roycroft
Ashok Roy	Steve Wyatt	
Clementine Maddock	Sarah Gilliland	
Ellen Wilkinson	Victor Yu	
Indermeet Sawhney		
Jenny Drife		
Manal El-Maraghy		
Mani Krishnan		
Mayura Deshpande		
Pamela Taylor		
Paul Bradley		
Ross Overshott		
Tina Irani		
Vivienne Curtis		
William Calthorpe		

Appendix C - The impact on Tribunal interval changes on the frequency of tribunal hearings

The following process was used to estimate the impact of changes to the time intervals for patient-led appeals and automatic referrals to the Mental Health Tribunal on tribunal frequency.

(1) We extracted the median, upper and lower quartile distributions for the durations of mental health act detentions by part and section of the Act, published by NHS Digital.

(2) We combined these as necessary to estimate the median, upper and lower quartile of the duration distributions for patients detained under part 2 section 2, part 2 section 3, CTO, part 3 and part 3 (restricted).

(3) We fitted log-normal distributions to the median, upper and lower quartiles using the R programming language[4] and the 'rriskDistributions' R package[5].

(4) We used these fitted distributions to plot the estimated number of patients still be detained against time since detention.

(5) We identified the current and proposed time intervals for patient-led appeals and automatic referrals to the Mental Health Tribunal by section (see tables 5 and 6) and overlaid these intervals onto the plotted duration distributions.

(6) For detentions under part 2 – section 3, CTOs, and part 3 of the act, we estimated the ratio of automatically referred tribunals per detention under the current Act and under the proposed reforms, by comparing the sum of the proportions of people still detained at each of the automatic referral points.

(7) For detentions under part 2 - section 2 of the act, we estimated the ratio of patient-led tribunals per detention under the current Act and under the proposed reforms, by combining:

[4] R Core Team (2020). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL https://www.R-project.org/.
[5] https://cran.r-project.org/web/packages/rriskDistributions/index.html

a. the proportion of patients who appeal to the Tribunal in the first 14 days of their detention
b. the estimated proportion of patients who are detained longer than 14 days
c. the estimated percentage of patients who might be expected to appeal if the timescales for appeal are increased to 21 days, taken from the expert opinion elicitation exercise.

Table 5: Time intervals for automatic referrals to the Mental Health Tribunal by Section

Part / Section	Current Mental Health Act	Proposed reform
Part 2 - Section 3	6, 36, 72 months, etc	4, 12, 24, 36, 48 months, etc
CTO	6, 3, 72 months, etc	6, 12, 24, 36, 48 months, etc
Part 3	36, 72 months, etc	12, 24, 36, 48 months, etc
Part 3 restricted	36, 72 months, etc	24, 72, 120 months, etc

Table 6: Time intervals for patient-led appeals to the Mental Health Tribunal by Section

Part / Section	Current Mental Health Act	Proposed reform
Part 2 - Section 2	Within first 14 days	Within first 21 days
Part 2 - Section 3	Twice in the first 12 months thereafter once a year	Three in the first 12 months thereafter once a year

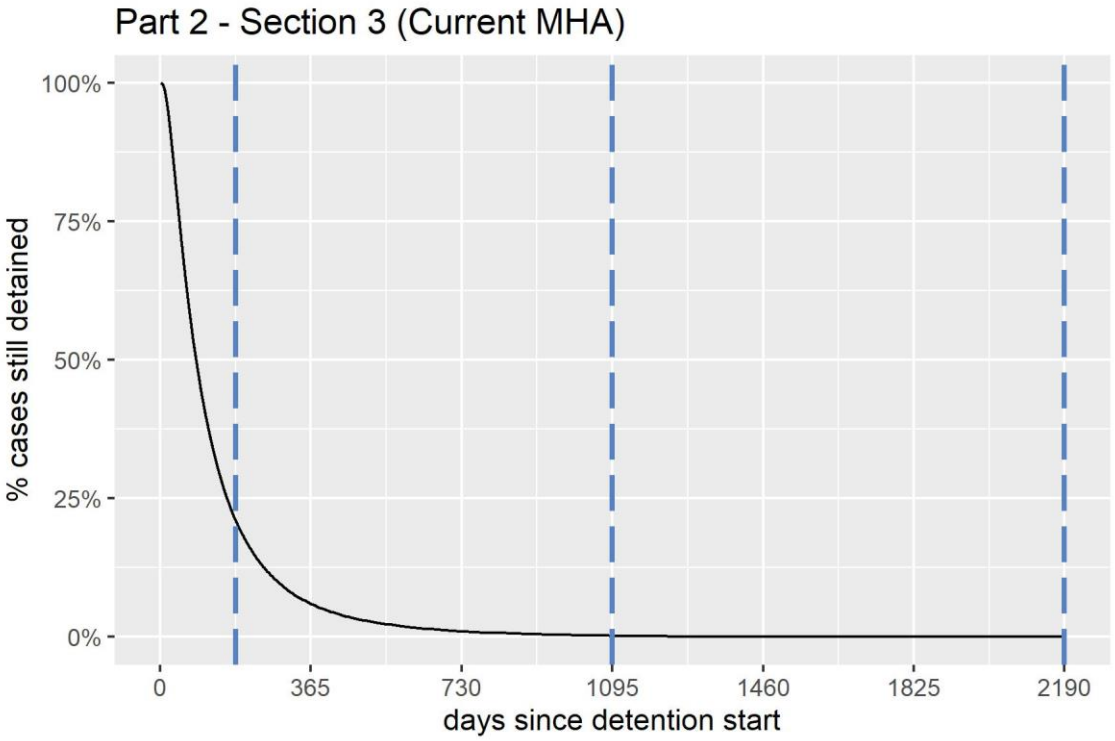
Notes

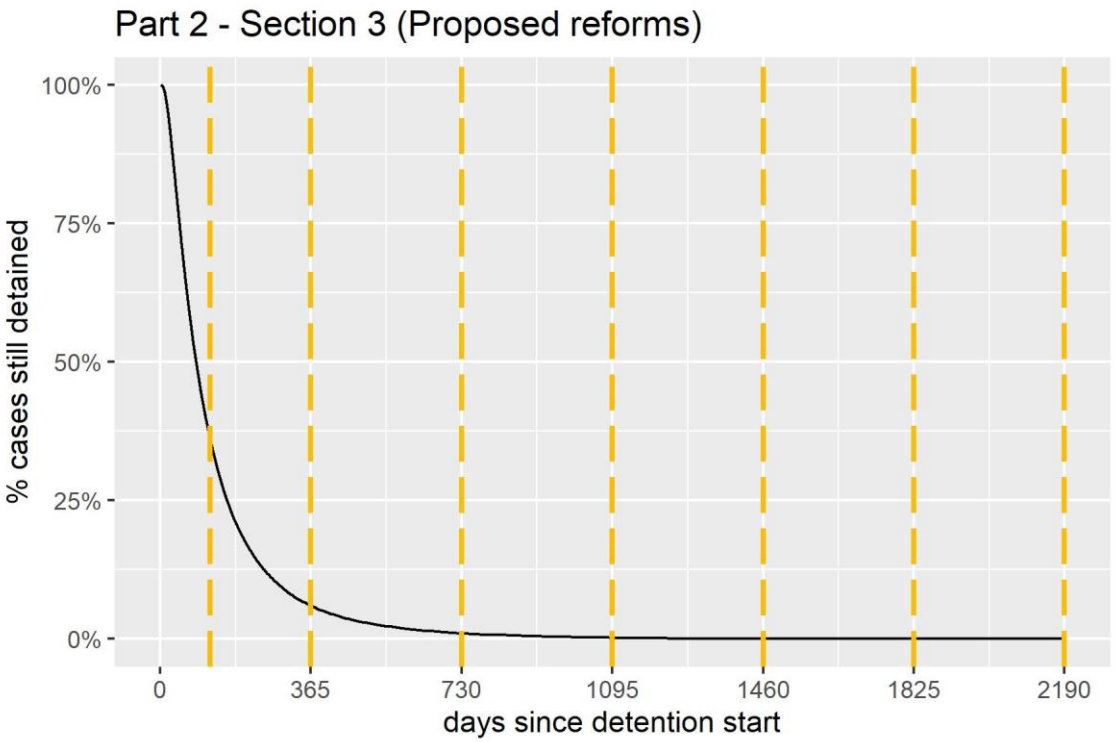
(1) We did not estimate the impact of the increased opportunities for patient-led appeals under part 2 section 3 of the Act, so that we minimised the opportunity for double counting effects relating to changes in automatic referral intervals.

(2) It might be argued that increasing the frequency of Tribunal hearings will change the detention duration distribution. In the absence of data to support this view, we assumed that the detention duration distributions would not be altered by the reforms.

Part 2 Section 3: Detention durations and intervals between automatic Tribunal referrals

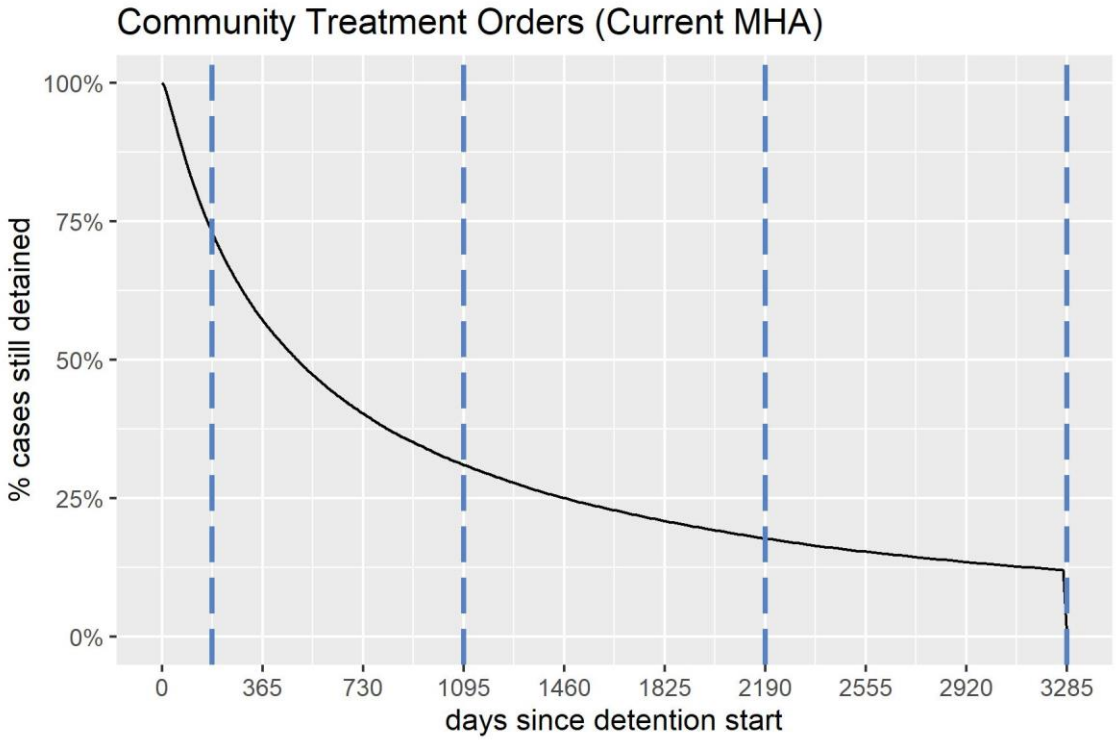
Vertical dotted lines denote points of automatic referral to the Mental Health Tribunal

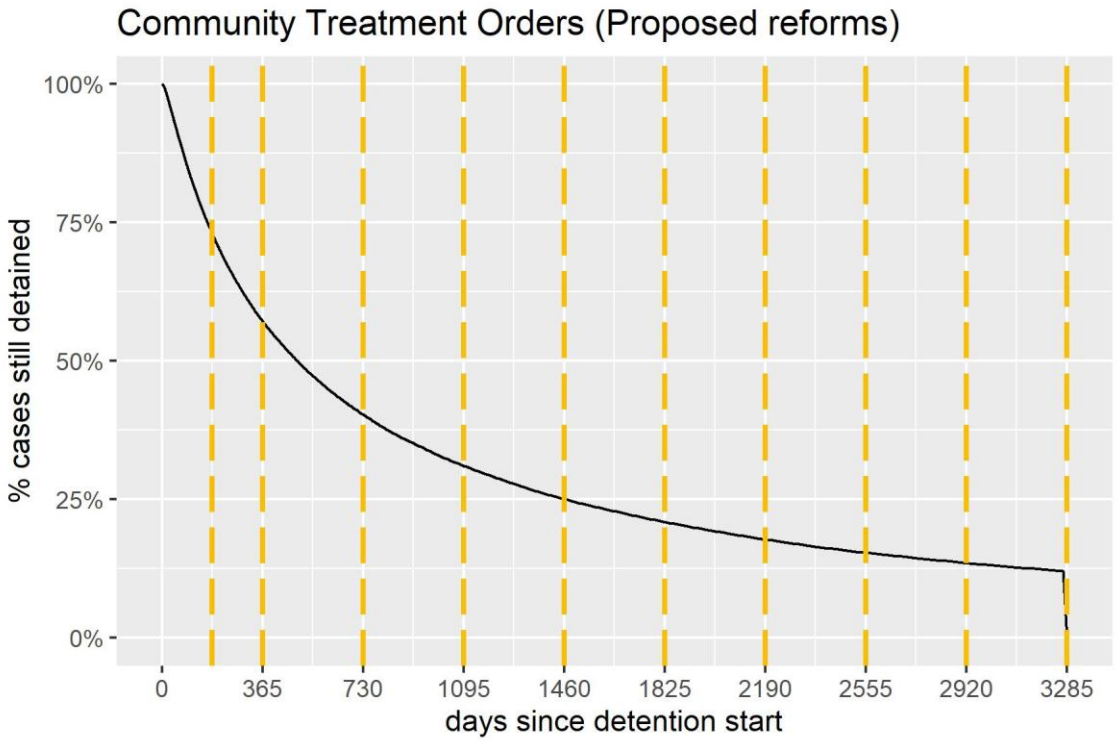




Community Treatment Orders: Detention durations and intervals between automatic Tribunal referrals

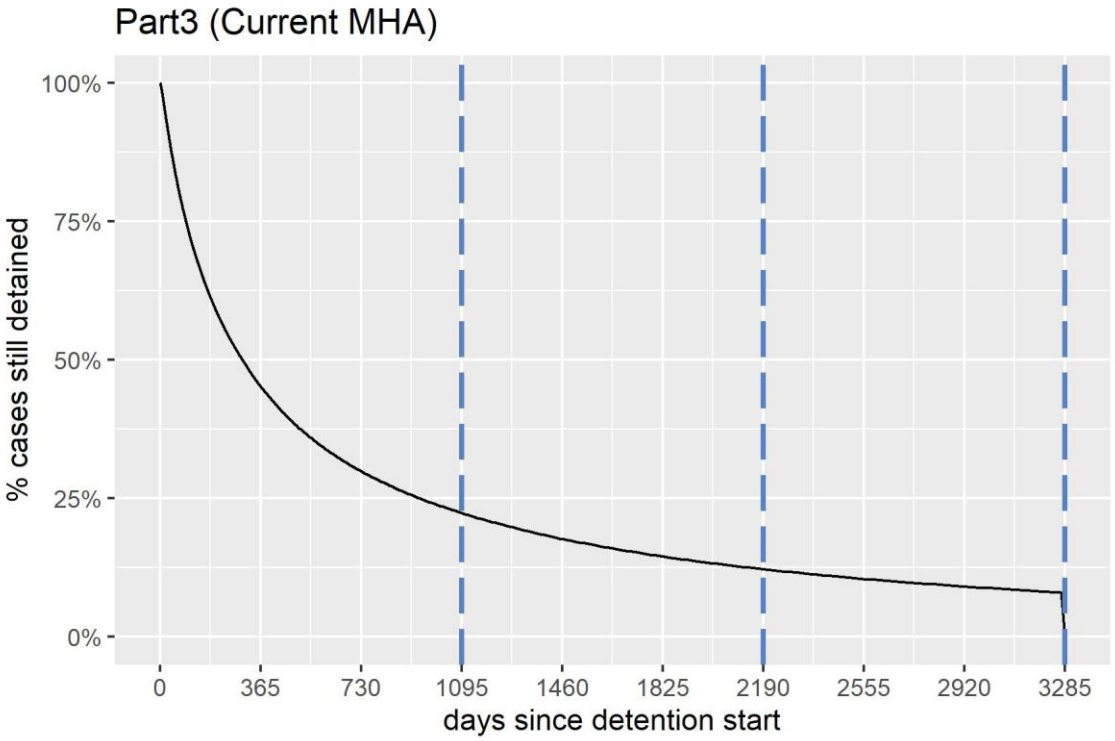
Vertical dotted lines denote points of automatic referral to the Mental Health Tribunal

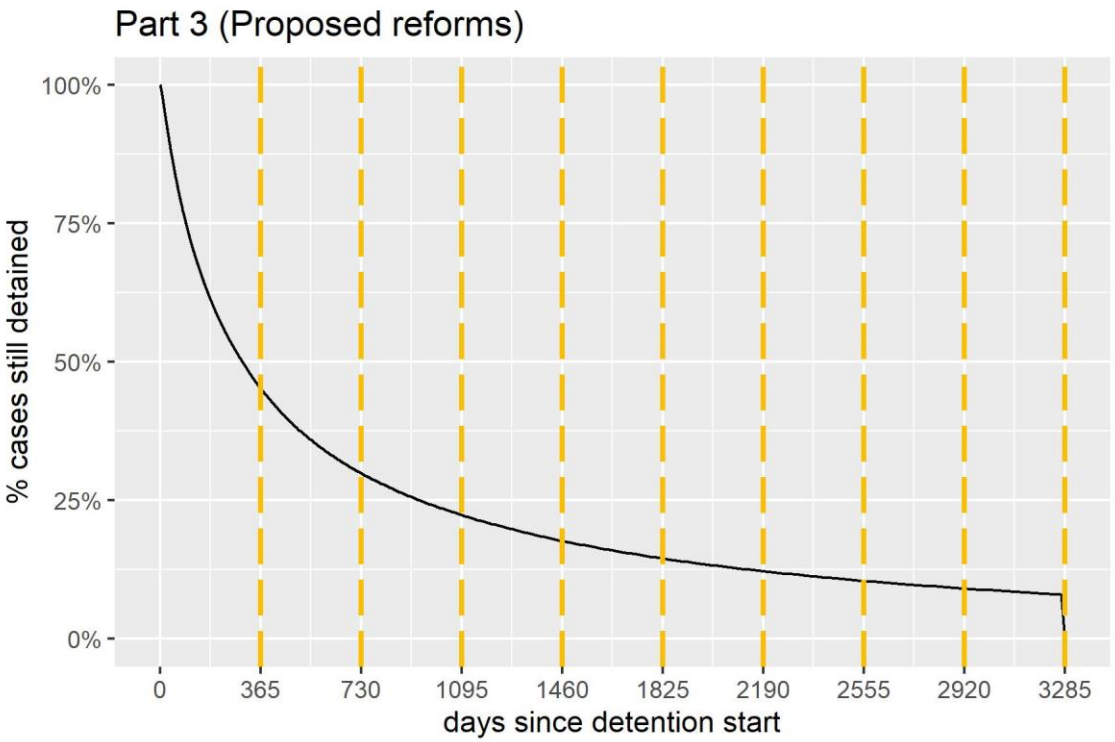




Part 3: Detention durations and intervals between automatic Tribunal referrals

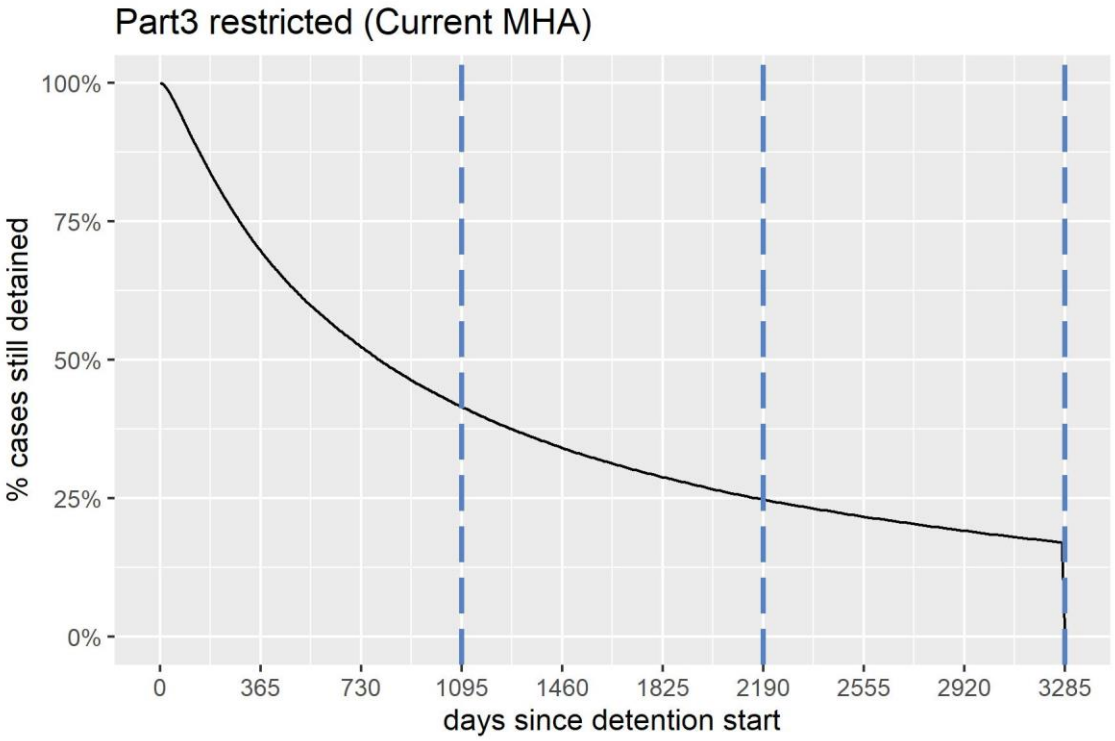
Vertical dotted lines denote points of automatic referral to the Mental Health Tribunal

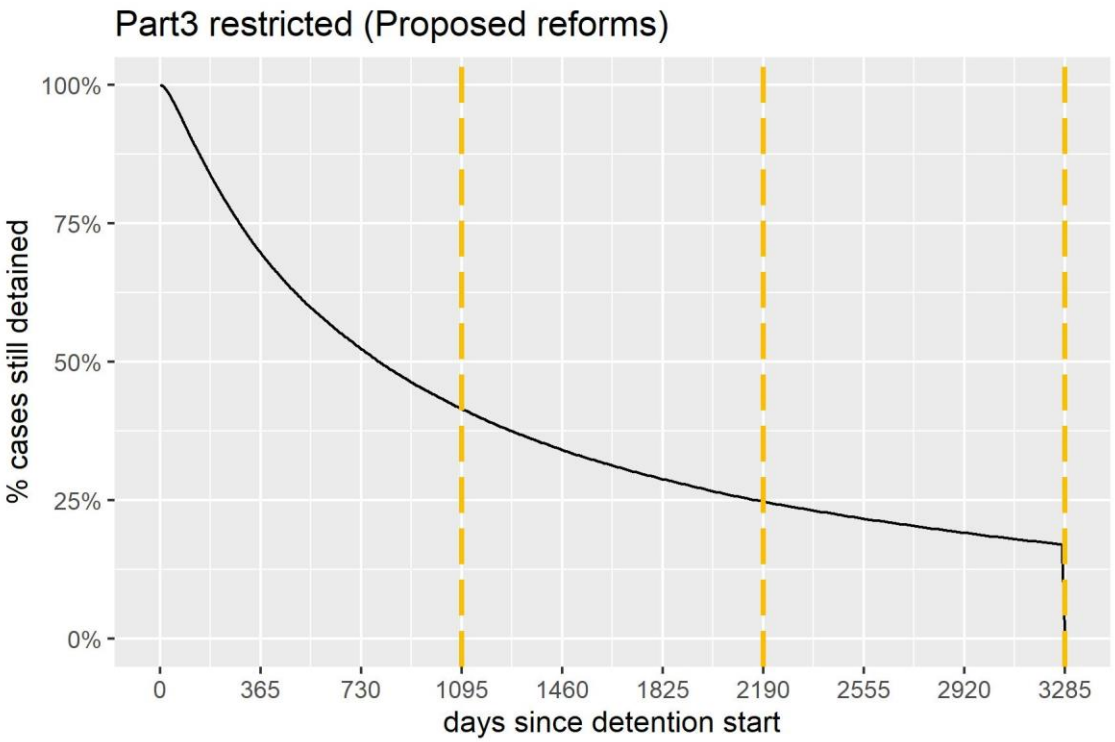




Part 3 Restricted: Detention durations and intervals between automatic Tribunal referrals

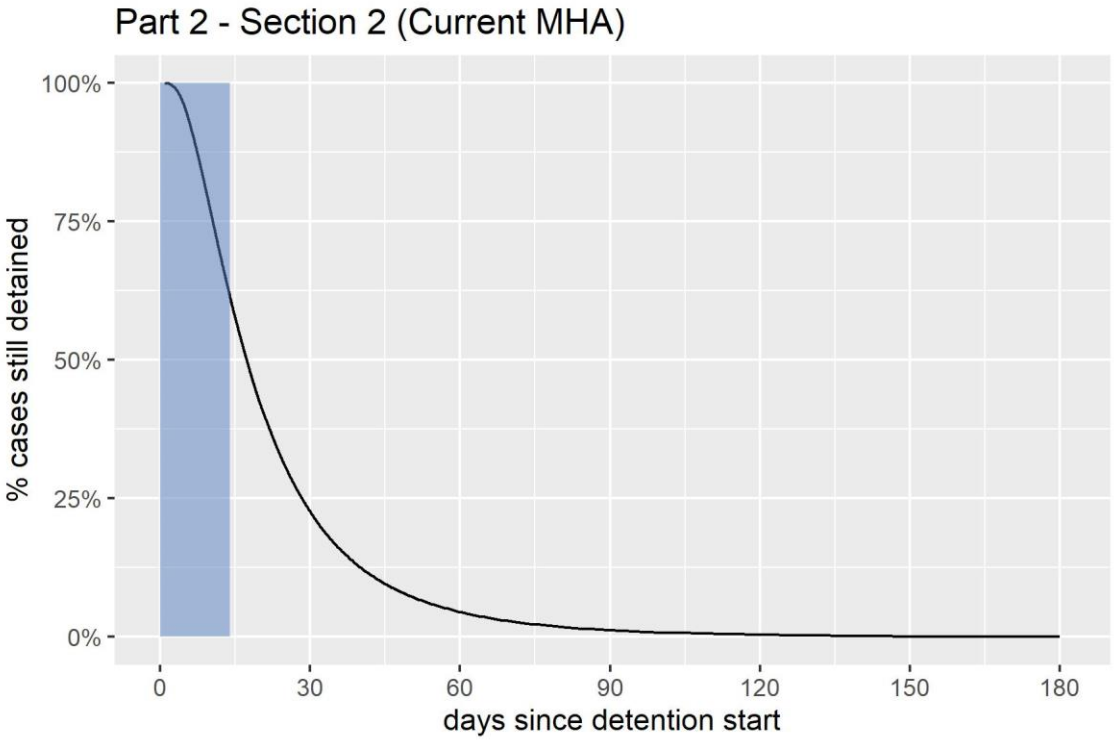
Vertical dotted lines denote points of automatic referral to the Mental Health Tribunal

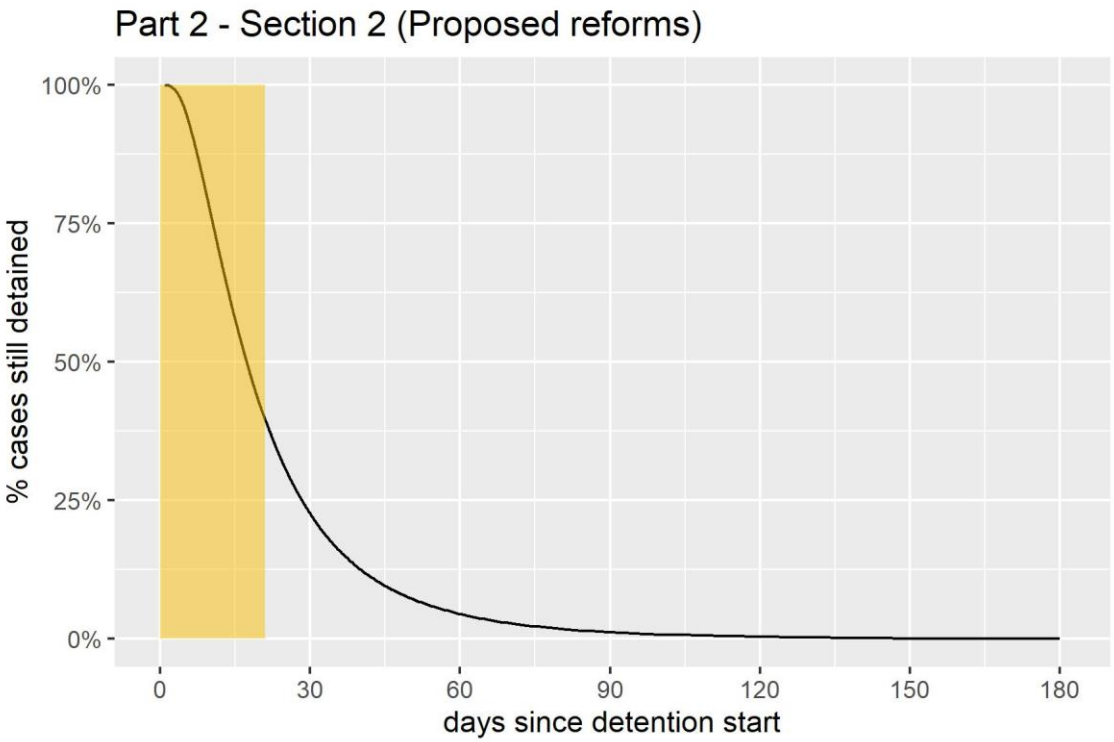




Part 2 Section 2: Detention durations and opportunities for patient-led appeals to Tribunal

Shaded area denotes period when patients can appeal to the Mental Health Tribunal





Appendix D: Sensitivity analysis – additional information

Table 7: Full results of sensitivity analysis

Detention and CTO growth assumption	Expert opinion of extra time per tribunal	Additional WTE career-grade psychiatrists	
		by 2023/24	by 2033/34
Continuation of recent growth	Median of opinions	335	520
DHSC assumed growth	Median of opinions	333	494
No growth	Median of opinions	325	417
Continuation of recent growth	Lower quartile of opinions	264	410
DHSC assumed growth	Lower quartile of opinions	261	389
No growth	Lower quartile of opinions	256	333
Continuation of recent growth	Upper quartile of opinions	460	713
DHSC assumed growth	Upper quartile of opinions	457	678
No growth	Upper quartile of opinions	446	563

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