1.1. As the main professional group implementing and delivering care under the Mental Health Act (MHA), alongside patients and service users', it is vital that the voice of nursing staff is heard throughout the development of these reforms.

1.2. The published consultation questions cover a wide scope of the proposed reforms set out in the department of Health & Social Care's (DHSC) the Reforming Mental Health Act white paper.[1] Feedback from members suggested that the RCN should provide a more concise summary of key areas most pertinent to the nursing workforce. The Royal College of Nursing (RCN) reviewed the 36 consultation questions, consolidating and organising key questions into eight themes[2].

1.3. This response has been developed in collaboration with a wide range of RCN members and staff. We have received contributions from multiple sources including the RCN Mental Health Forum, Learning Disability Nursing Forum, policy-makers, clinical nurses (NHS and independent sector), academic nurses (individuals and groups[3]), as well as people with lived-experience of mental illness.

1.4. This response was formed alongside our submission of written evidence to the Joint Committee of Human rights[4].

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2.1. The RCN welcomes the importance of putting patients at the centre of decisions about their own care, promoting choice, equality and personal-recovery.

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[1] Open consultation: Reforming the Mental Health Act

[2] Reforming the Mental Health Act White Paper: feeding into the RCN response

[3] Mental Health Nurse Academics UK (swan.ac.uk) & University of Central Lancashire Mental Health Nursing Academics

[4] Royal College of Nursing -

2.2. The ‘guiding principles’ should be applied to all healthcare, social care and forensic settings, as well as all codes of practice and government guidance that directly influences NHS and non-NHS services who support people with mental health problems.

2.3. We explicitly recommend that the principles are added to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care[5]. This guidance is widely used in day to day commissioning and care provision, and would benefit from these additions.

2.4. Continuity of care is key to all four of the guiding principles, particularly choice and

automatic referral to a tribunal during a CTO, from every 3 years to every 12

5.6. Prior consent to be admitted as an informal patient is seen as being helpful; providing the person still has recourse to advocacy and other checks and balances. Admission and discharge, crisis management, carer and caring responsibilities, risk to others and the needs of carers must be considered.

5.7. If a person under 16 is deemed to have capacity, then they are seen as having the same rights as an adult and thus should be granted the right to request a nominated person. It is vital that the young person fully understands the implications of choosing a nominated person. This should include discussing the statutory rights of parents and carers so the young person is fully aware of their rights.

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6.1. We are concerned that the definition of therapeutic benefit: "ensuring patients are supported to get better, so they can be discharged from the act" is open to interpretation. The concept of "therapeutic benefit" is further complicated by conditions such as learning disabilities and autism where the approach is not to 'treat' these conditions, but to support people through an episode of crisis.

6.2. The historic and contemporary issues surrounding the concept of 'recovery' in mental health care, underpinned by power imbalances between patients and clinicians, must not be ignored. We recommend that the definition of 'therapeutic benefit' must be co-created with people that have experience of mental illness and those who use services, and have been detained under the MHA.

6.3. The biomedical model often persists as the primary treatment option under the MHA. The MHA should explicitly encourage practitioners to also consider other treatment approaches to mental health care (i.e. psychosocial interventions), offering greater choice to patients.

6.4. Therapeutic treatment is not always formal treatment, being therapeutic is a much broader concept.[11] Articulating the outcomes of care should be co-produced between professionals and patients. This needs to be genuine co-production, rather than treating patient-involvement with a tokenistic respect.

6.5. There remains a need to explore what is meant by "least restrictive" to ensure meaning and application is clear. The concept of "least restrictive" is a personal one. Some may prefer to be physically held rather than

Designing education around the use of the MHA, to ensure it is used in the least restrictive way, must involve a range of people with lived-experience.

6.7. The phrase “substantial likelihood and significant harm” holds a large amount of subjectivity and is

8.4. Mental health and learning disability services are already struggling to cope with chronic staffing shortages and a high turnover of staff as a result of pressurised working environments.[18] In quarter 3 of 2020/21 in England, the vacancy rate stood at 13.1%, the highest rate for any NHS nursing sector.[19]

8.5. With growing pressures and increasing number of people needing mental health care and support. The government must urgently take steps to remedy the supply, recruitment and retention of the nursing workforce in order to ensure that services can continue to provide safe and effective care.

8.6. Low levels of staff, unstable teams, and poor working conditions can lead to compassion fatigue and poor practice. Low staffing levels have been shown to increase the occurrence of restrictive practices, while negatively affecting patient outcomes[20]. Addressing these underlying issues will create the conditions for good care and allow advocacy to thrive.

8.7. We continue to call for the expansion of accountability for workforce planning and funding in law and investment into nursing higher education in England. A

accessible to all communities. Many black men find their first interaction with services via the police during a crisis.[22]

9.4. Culturally sensitive care is necessary when caring for individuals from diverse backgrounds with a range of traditions, languages faiths and cultural norms around mental wellness and ill health. It is important to avoid the 'one size fits all' approach. New and evolving approaches to transcultural care must be adopted in the code of practice to meet the varying needs of individuals from culturally diverse backgrounds.

9.5. Central to developing transcultural and culturally-sensitive or competent care is the need to consider the impact of intersecting identities on outcomes and experiences. There should be an explicit reference to intersectionality as it is core to shaping lived experience and outcomes. The proposed reforms would be significantly strengthened if they were more explicit and defined in how they intended to identify mechanisms to tackle this. It is vital that mental health services build their ability to design care pathways that recognise and effectively mitigate the impact that the range of protected characteristics, as defined by the Equality Act 2010, have on patient outcomes and experiences.

9.6. In addressing the disproportionate use of the MHA on certain BAME populations, specifically black men, the legislation must set out the need for mandatory training for all staff working under the MHA. It is imperative that staff receive high-quality, evidence-based training on human rights and equalities issues in the context of the MHA. Training must include the impact of systemic, institutional and interpersonal forms of racism and discrimination. Training must also incorporate how to demonstrably identify and tackle all forms of bias that impact on the delivery of services, as well as the outcomes and experiences of patients and carers. Monitoring of this training should be included in CQC inspection guidance under regulations 18(2)(a)[23] and 10(2)(c)[24].

9.7. People from BAME backgrounds are significantly overrepresented in terms of the number of people detained under the MHA, and yet underrepresented within the statutory MHA roles (i.e. AMHP and AC/RC). More must be done to develop a clear and flexible career pathway/programme for nurse AC/RC. It is imperative that the workforce is representative at every level and layer of the people we care for, which will help to turn the tide in terms of organisational culture. This representation must also be extended to the new mental health advocacy roles.

9.8. The RCN welcomes The Patient and Carer Race Equality Framework (PCREF) to support NHS mental healthcare providers and local authorities to improve access and engagement with the communities they serve. There should be a statutory

[22] Centre for Mental Health (2020), Racial disparity in mental he

requirement for all mental health services to report on their duties as set out in the Public Sector Equality Duty,[25] linked to objectives reflecting the P