

# The Mental Health Act 2025: What social care providers need to know

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“Definitely my go to law firm,  
would highly recommend.”

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# Mental Health Act 1983

- The Mental Health Act 1983 (MHA) is the primary legislation governing the assessment, detention and treatment of people with mental disorder.
- How might you come across mental health in your day-to-day?
  - Supporting people:
    - In the community following discharge from hospital
    - On Community Treatment Orders (CTOs)
    - Entitled to section 117 aftercare
    - With conditions linked to mental disorder, risk or relapse
  - Working alongside NHS clinicians, Approved Mental Health Professionals (AMHPs) and community mental health teams.

# Terminology, Roles and Responsibilities

Key sections of the MHA 1983

- Formal/detained/sectioned
- Informal/voluntary
- Common sections:
  - S2 – up to 28 days, cannot be renewed
  - S3 – initially up to 6 months, renewable
  - If a section is in the 30s e.g. s37 = diversion from criminal proceedings part of MHA
  - S136 – power of the police to take someone in public to a place of safety (hospital)
  - S17 – leave of absence
  - S117 – arranging/funding aftercare
- CTO – community treatment order (does not actually allow compulsory community treatment)

# Terminology, Roles and Responsibilities

Within the MHA 1983

- Responsible Clinician (RC) – the Approved clinician in overall charge of the treatment
  - Community RC – if there is a CTO
- Approved Clinician (AC) – most often a psychiatrist
- S12 doctor – approved under s12 MHA. Doctor ACs are automatically s12 approved
- Approved Mental Health Professional (AMHP) – most often a social worker
- SOAD – Second Opinion Approved Doctor
- Hospital Managers
- Tribunal (Judge; Doctor; Lay)

# Who does what in the community

Within the MHA 1983

- CAMHS – Children and Adolescent Mental Health Service
- Liaison Psychiatry – work in acute hospitals
- IHBTT – Intensive Home Based Treatment Team
- CMHT – Community Mental Health Team
- SPA – Single Point of Access
- There may be other specialist teams e.g. learning disability or autism

# The Mental Health Act 2025

## Key changes

- Choice and autonomy
  - Advance choice documents
  - Nominated person
  - Independent mental health advocates – opt out, rather than opt in & greater availability
  - Statutory care and treatment plans
- Least restriction & therapeutic benefit
  - Criteria for detention amended
    - Therapeutic benefit
    - Risk of causing serious harm to self or others
  - Long term aim - stopping Ps with a learning disability and autism without co-occurring MH condition being subject to long term detention
  - More opportunities for care plan review – greater CQC, SOAD scrutiny
  - Greater access to MH Tribunal
- Changes within the criminal justice system for Ps with mental health problems

# The Mental Health Act 2025

What is the DHSC's intention by these reforms

## The new Act will improve care across the pathway



Reforms take forward **the vast majority of the 2018 Independent Review's recommendations** and include a wide range of changes to shift the balance of power from the system to the patient.

These changes have been **informed by the four principles** developed by the Independent Review and in partnership with people with lived experience. They are:

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

The wording of the guiding principles are on the face of the Act, within the Act's requirements for the statutory Code of Practice.

# The Mental Health Act 2025

## Next steps & implementation

### Next Steps

#### February 2026: First reforms commence

- This includes supervised discharge.

#### By December 2027 (2 years from Royal Assent)

- Commencement of reforms to timeline for prison transfers



#### 2028/2029: First Major Reforms "Phase 1"

- Reforms that come at little to no additional cost or burden on the workforce. Such as:
  - Principles
  - Detention criteria changes (not including s3 for people with a learning disability and autistic people)
  - Nominated Person
  - Other reforms that change processes and decision making, but do not require significant workforce expansion, such as some of the treatment reforms that do not place additional burden on the SOAD system.



#### Post 2029: Later Reforms

- Reforms that require additional funding; workforce expansion and/or development of infrastructure to commence safely. Such as:
  - Section 3 detention criteria changes for people with a learning disability and autistic people
  - Increased frequency of Mental Health Tribunals
  - ICB / NHSE Duties on Advanced Choice Document
  - Statutory care and treatment plans
  - Removal of police stations as place of safety

- Consultation on s 135/136 promised – scope of powers available to police and other professionals

## Impact on social care providers

- Impact is likely to be uneven – where do you fit?
  - Do you provide care to anyone:
    - Subject to a CTO?
    - Entitled to s.117 aftercare?
    - On conditional discharge with DoL/CD Dep/supervised discharge?
    - Admitted to, or discharged from, inpatient mental health care?
    - Who displays behaviours linked to mental disorder?
    - In receipt of care funded or arranged by the NHS?
  - Misconceptions to avoid:
    - *"We don't detain people under the MHA ourselves, so this doesn't affect us"*
    - *"That's the NHS's responsibility"*
- Duty to act in accordance with human rights law – s 51 MHA 2025

# Impact on social care providers

## Wider themes:

- (1) Greater complexity of need in the community
  - Changes to detention criteria intended to lead to less detentions in hospital.
  - Greater expectation for staff caring for people with mental health need to recognise risk in the community.
  - Greater community provision needed for people with complex mental health need and people with learning disability or autism.
  
- (2) Greater strength and depth of relationship with local NHS community care and mental health bodies required
  - More complex need in the community = more involvement from CMHT with your service users.
  - More responsibility for CMHT in terms of oversight of care (statutory care and treatment plans (SCTPs) etc)
  - Increased responsibility to recognise deterioration and escalate mental health concerns appropriately.

## Impact on social care providers

- (3) Increased focus on patient empowerment
  - Advance choice documents – intended to capture patient's wishes in respect of future detention, but expressed wishes will need to be considered in care planning in the community too.
  
- (4) Increased CQC scrutiny
  - Likely to need to be able to evidence knowledge of and cohesion with MHA provisions where applicable.
  - Greater focus on alignment between statutory care and treatment plans (where in place) and local care planning.

## What can you do to prepare?

- What kind of provider are you?
  - Will you be one of the most affected by this?
- If so, how can you prepare for these changes?
  - Work out which of the services you offer might be most affected & how
  - Do you have a working relationship with local community mental health services? If not, what can you do to start building that
  - Do your staff need training, or qualifications, incorporated into their training over the next few years?
  - How good are your records? Updating of care plans & changes being carried over?

## What can you do to prepare?

- Ensure you know certain specifics about your service users
  - Who, within your service, received s 117 services?
  - What does their s 117 care plan say? Is that carried over/reflected in your local care plans?
  - Advance decisions / advance choice documents
- Fits with the approach of the CQC
  - Current framework asks for 'planning for the future' and 'person centred care'
  - Under the draft framework for adult social care, this is emphasised:
    - Safe systems, pathways and transitions
    - Assessing needs
    - Person-centered care
    - Care provision, integration and continuity

# Checklist



Consider the impact of the MHA 2025 at senior leadership level to demonstrate organisational ownership



Know which service users are on CTOs/receiving s.117 aftercare/on conditional discharge +/- DoL



Review how information relating to a service user's mental health is recorded



Build and refresh links with local CMHTs



Plan staff training where needed

## And one last thing...

The overlap between the Mental Capacity Act 2005 and the MHA as amended

- MHA does not cover care and treatment in the community
- Can be conditions but response to refusal to comply is consider re-admission not compulsion
- So care and treatment is either with consent or under MCA
- Liaison with any ongoing mental health team involved is vital

# And one last thing...

## Deprivation of Liberty

- Deprivation of Liberty is a key area of overlap
- Arises when P lacks capacity to decide where to live to receive care and treatment
- Generally, MHA cannot impose a DOL in the community
  - CTO; Guardianship – No
  - May also need Standard Authorisation/Court of Protection
- Exceptions:
  - Section 17(3): leave of absence in custody
    - Non-hospital staff must be authorised in writing
  - Conditional discharge + DoL

# And one last thing...

## (3) Liberty Protection Safeguards

- LPS are intended to replace the Deprivation of Liberty Safeguards (DoLS) under the Mental Capacity Act 2005.
- Their purpose is to provide a lawful framework for authorising arrangements that deprive a person of their liberty where:
  - The person lacks capacity to consent, and
  - The Mental Health Act does not apply
- LPS are designed to be:
  - More proportionate
  - More person-centred
  - Better aligned with Article 5 (right to liberty) requirements
- Implementation of LPS has been delayed
- Further consultation promised and updated guidance are awaited
- In the meantime:
  - Providers must continue to operate in line with MCA principles
  - DoLS remain in force
  - Clear understanding of the MHA / MCA boundary remains essential

# Questions/ discussion



# Contact

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