Mental Health Act 2025

A detailed look at the detail, scope, implications and required planning of the most significant change to mental health law in more than 40 years.

Thalamos

Contents

Find the analysis you need for your role.

Contents

Navigating this guide

Find the right subject matter that relates to your role and responsibilities.

Executive summary

This resource pack brings together everything leaders and frontline staff need to understand about the Mental Health Act 2025 and what it will mean for practice over the coming decade. The Act is the most significant update to mental health law in a generation and the changes it introduces reach across detention criteria, patient autonomy, tribunal oversight, aftercare duties and crisis pathways. Because the reforms are substantial and will commence in phases, the pack is designed to guide readers through both the legislation and the practical steps required to prepare.

It is structured in three main parts. Each has a distinct purpose and can be read on its own or as part of the wider whole. Senior leaders may want the full document for assurance and planning. AMHPs, clinicians and police colleagues may prefer to focus on the sections that apply most directly to their practice.

Part A: The Mental Health Act 2025 at a glance

This opening section provides a clear overview of why the Bill exists, what it changes and why these reforms matter. It explains the headline shifts in detention criteria, patient rights, tribunal oversight and interagency responsibilities. It also summarises the expected phasing of commencement and the likely long term trajectory of reform. Readers new to the Bill should begin here. It sets the direction of travel and frames the underlying purpose of the legislative changes. Leaders who need a concise briefing to share with colleagues or boards can also use this section as a standalone summary.

Part B: The Mental Health Act 2025 explained

Part B is the core of the pack. It gives a full and detailed walkthrough of the Act's provisions, organised into ten chapters that mirror the structure of the reforms. It is designed as a reference guide that can be dipped into as needed.

- Chapters 1 to 4 examine who can be detained, on what test and under what conditions. These chapters are essential for AMHPs, responsible clinicians and tribunal teams
- Chapters 5 to 7 focus on autonomy reforms, including the nominated person, Advance Choice Documents and statutory care and treatment plans. These chapters will be of particular interest to ward teams, care coordinators, safeguarding leads and system partners responsible for care planning
- Chapters 8 to 10 explain wider reforms across police powers, Section 117 aftercare and documentation duties. These chapters are important for commissioners, local authorities, crisis teams and police liaison units

Each chapter follows a consistent pattern. It explains the current law, the new position under the Act, what will change in day to day practice and the specific issues that legal experts we have spoken to highlight as areas to watch. This structure allows readers to understand both the letter of the

law and its real world implications.

Readers looking for depth should spend most of their time in Part B. It contains the technical explanation of each reform and is designed to support policy updates, training design, legal briefings and operational planning.

Part C: From legislation to system reality

Part C shifts from what the Act says to what the system will need to do. It examines implementation challenges, phasing, risks and opportunities. While Part B focuses on legal detail, Part C focuses on system change.

This section is particularly useful for:

- Boards and executive teams planning multi year readiness programmes
- ICBs preparing for new duties around ACDs and aftercare
- Local authorities considering resource implications for Section 117 and LD or autism pathways
- Police forces adjusting crisis operating models
- Clinical leaders reviewing staffing, training and documentation expectations

Part C also identifies common misinterpretations that could create risk if not addressed early and provides guidance on early, medium term and long term priorities for organisations.

How to navigate the pack

Readers who need an overall understanding should read Parts A, B1 and C1 first.

Readers who want a technical breakdown should move straight into Part B.

Readers planning operational implementation should focus on Part C.

Readers who want role specific impact may choose to read:

- Chapters 1 to 4 for clinical teams and AMHPs
- Chapters 5 to 7 for care coordinators, inpatient teams and safeguarding leads
- Chapters 8 and 10 for NHS and local authority commissioners
- Chapter 8 for police colleagues

The pack is intentionally modular. It can be read front to back or used as a reference guide. Each section builds on the previous one but is designed to stand alone.

Purpose of the pack

The Mental Health Bill presents both challenge and opportunity. The legislation raises expectations on decision making, documentation, interagency coordination and the use of least restrictive practice. It also offers a chance to modernise pathways, strengthen rights and improve consistency across the system. This pack provides the clarity, structure and practical guidance needed to navigate that transition.

PART A: The Mental Health Act 2025 at a glance

You heard it here first.

A1: An overview

The Mental Health Act 2025 represents the first substantial update to the Mental Health Act since 1983. It does not replace the law in full, but it reshapes the conditions under which people can be detained, strengthens patient autonomy, introduces new duties for providers and commissioners, and raises the standard for justifying the use of compulsory powers.

The purpose of the refomred Act is threefold. First, to ensure that detention is used only where it is necessary and genuinely therapeutic.

Second, to give people a stronger say in their care, both before and during detention.

Third, to tackle long recognised inequalities, including racial disparities in the use of compulsory powers, inconsistent application of the nearest relative rules, and prolonged stays for people with learning disabilities or autism in settings that do not meet their needs.

Five reforms have the greatest impact across the system:

1. A redefinition of the criteria for detention under Section 3, introducing a higher threshold centred on serious harm, therapeutic benefit, and necessity

2. A clearer distinction between learning disability or autism and a psychiatric

disorder that requires treatment under the Act

3. A shift from the nearest relative scheme to a modern nominated person model that gives individuals greater choice in who advocates for them

4. New duties around Advance Choice Documents to ensure a person's preferences are considered in a future crisis

5. Increased frequency of reviews and tribunal oversight, with new expectations around documentation, reasoning and transparency in decision making

The Act is best understood as a recalibration of the existing Act. It raises expectations, sharpens accountability and introduces new duties that will touch almost every part of the mental health system. Some changes are modest in text but significant in practice, particularly those related to documentation, information sharing and the visibility of decision making. Others, such as the exclusion of learning disability and autism from Section 3, depend on wider system capacity before they can safely take effect.

The journey from legislation to operational reality will be gradual. This period offers a major opportunity for Mental Health Trusts, Local Authorities, police forces, ICBs and community partners to prepare, strengthen pathways and address the gaps that the Bill brings into sharper focus. The next stages will depend heavily on the Code of Practice, forthcoming regulations and the extent to which national funding supports the system changes expected of providers.

A2. Reform timeline and phasing

The reform will commence in stages. Some reforms require only adjustments to guidance, forms or wording. Others rely on community capacity, tribunal infrastructure and workforce availability. The timeline below draws on the impact assessment and parliamentary debate to set realistic expectations. It should only be used as a very basic guide that will likely adapt and change.

Early commencement upon Royal Assent

These changes require minimal system build.

- Updated legal wording, including the refined detention criteria
- Nominated person provisions where the operational steps are straightforward
- Documentation and information giving duties, including the use of checklists to evidence reasoning
- Early tribunal powers that do not require major expansion of the tribunal system

- Duties to have regard to Advance Choice Documents

Medium term commencement

These changes require planning, guidance and local implementation work.

- The majority of tribunal and renewal reforms, including increased review frequency
- The more detailed elements of the nominated person framework for children and young people
- New duties on ICBs and LHBs relating to ACD arrangements
- Section 117 ordinary residence rules, which require updated processes between local authorities and ICBs
- Strengthened care and treatment plan requirements once secondary legislation is introduced

Long term or resource dependent commencement

These rely on significant national investment, community capacity and workforce.

- Exclusion of learning disability and autism from Section 3 treatment powers
- Any changes that increase reliance on community alternatives to admission, including crisis support and specialist accommodation
- Tribunal and aftercare functions that require sustained workforce expansion
- Replacement or redesign of digital and data collection processes that support reporting and oversight.

Realistically, some elements may not take effect until the end of the decade. This does not reduce their importance. Instead, it gives leaders and frontline staff the opportunity to prepare for changes that will influence practice, risk and partnership working for years to come.

A3. Who this matters for and why

The Act affects every part of the mental health system. Its impact is not limited to people already detained or at risk of detention. The reforms will influence how services assess risk, use the Mental Health Act, coordinate care and evidence their decisions.

Frontline clinicians and ward teams

The new criteria for detention introduce a sharper focus on serious harm, therapeutic benefit and necessity. Clinicians will need to provide more explicit reasoning about why detention is required, why treatment cannot be provided in a less restrictive setting and how interventions are expected to help. Care and treatment plans will become statutory, and

their content will be closely examined by tribunals and managers' hearings. Ward teams will also need to understand nominated person rights, support patients who wish to create Advance Choice Documents and prepare more frequent tribunal reports.

Approved Mental Health Professionals

AMHPs will experience some of the most direct change. The new detention criteria alter the threshold for applications, and documentation will need to reflect a clearer link between risk, therapeutic benefit and the chosen setting. AMHPs will also have responsibilities relating to the appointment of a nominated person where individuals lack capacity. Increased scrutiny from tribunals will influence the level of detail required in reports and recommendations.

Trust boards and senior leadership teams

Boards will need to assure themselves that their organisation can track, document and justify decisions under the new Act. This includes preparing for a greater volume of hearings, ensuring that reasoning is transparent, strengthening governance around the use of compulsory powers and working with ICBs to deliver the new aftercare responsibilities. Leaders will need to balance the shift in legal thresholds with continued expectations to maintain safety, manage risk and reduce inequalities.

ICBs and local authorities

The Act places new responsibility on ICBs for ACD arrangements and clarifies who holds long term responsibility for Section 117 aftercare. Local authorities will need to ensure joint processes are workable and that community provision, particularly for learning disability and autism, can support the new legal framework. Disputes that previously turned on ordinary residence rules should reduce once the new provisions take effect.

Police forces and acute partners

The removal of police stations as places of safety, combined with unchanged police powers under sections 135 and 136, will increase the need for clear, robust pathways between police, ambulance services and acute and mental health trusts. Police forces will continue to manage complex situations where a person deteriorates in custody. The higher civil detention threshold may lead to more crises in the community if individuals fall short of meeting the new criteria yet still require urgent support.

Independent and voluntary sector providers

Providers that support people with learning disabilities, autism or complex mental health needs will play an increasingly important role in community alternatives to admission. Many may come within the scope of the Human Rights Act going forward. They will need to prepare for closer scrutiny of risk management, accommodation suitability and the role they

play in aftercare planning.

A4. Three key risks and opportunities

The Act provides an important opportunity to modernise mental health care, but its success depends on how well the system prepares for the practical challenges that sit behind the legal text.

1. Community capacity and the LD and autism reforms

The exclusion of learning disability and autism from Section 3 detention is significant in principle. In practice, it will only deliver its intended benefits if housing, social care and specialist support are available in the community. Without these services, the risk is that individuals cycle through crisis pathways, experience longer stays under Section 2, move into forensic routes or rely on Mental Capacity Act frameworks that offer fewer safeguards. The phased commencement offers time to design stronger community alternatives, but that time must be used wisely.

2. Greater legal scrutiny and rising tribunal demand

Shorter review periods and new tribunal powers will increase the volume of hearings, paperwork and preparation required from clinical teams. This shift raises the standard for documenting decision making and will require new systems, training and consistent governance. The opportunity is a framework that supports more consistent and transparent decisions. The risk is unintended pressure on already stretched services if preparation and capacity planning do not begin early.

3. Digital readiness and the need for reliable data

Almost every reform pushes the system towards better documentation, clearer reasoning and more accessible information. Detention criteria checklists, ACDs, nominated person decisions and tribunal recommendations all require up to date, accurate and shareable data. The Bill therefore aligns with, and strengthens the case for, digital Mental Health Act systems. Trusts and partners that invest early in digital pathways will be better placed to meet the documentation and assurance expectations that the new Act introduces.

PART B — CLUSTER 1: The Mental Health Act 2025 explained

The catalyst for the shift.

B1. Context and headline changes

The Mental Health Act 2025 is the most significant set of changes to mental health law in England and Wales in more than four decades. Although it is an amendment to the existing Mental Health Act rather than a full rewrite, its combined effect reshapes the conditions under which individuals can be detained, increases the standard of justification for compulsory powers and strengthens the rights and voice of people who come into contact with mental health services.

This reform has been a long time in development. Much of the current Mental Health Act dates back to 1959 and 1983, with the 2007 amendments adding new powers but not addressing deeper issues. Over the past twenty years, a growing body of evidence has highlighted areas where the Act is out of step with modern rights based practice, including concerns about the volume of detentions, striking racial disparities, the quality of inpatient environments and the length of stay for people with learning disabilities and autism. These concerns reached a critical point in the mid 2010s, prompting a renewed push for legislative change.

In 2017, Prime Minister Theresa May commissioned the Independent Review of the Mental Health Act. Led by Professor Sir Simon Wessely, with significant contributions from legal experts including Alex Ruck Keene and lived experience leaders such as Steve Gilbert, the Review set out to examine how the Act could be modernised to reflect contemporary principles of autonomy, dignity and therapeutic care. The Review identified substantial gaps in patient voice, inconsistencies in the use of the nearest relative scheme, a need to clarify the purpose of detention and an urgent need to reduce inappropriate hospitalisation for people with learning disabilities or autism.

The Review's recommendations informed the White Paper and ultimately shaped the structure of the Mental Health Bill. However, the political context significantly influenced the path of reform. As the Review reached its final stages in 2018, Brexit was generating considerable turbulence across government departments. This accelerated the drafting timetable and meant that some areas of reform were less fully developed than originally intended. The government also chose to move forward with amendments to the existing Act rather than creating a new, cleaner piece of legislation. This decision makes the new Act complex to read but more politically deliverable.

Alongside domestic drivers, international legal developments have shaped the reforms. The United Kingdom is a signatory to the UN Convention on the Rights of Persons with Disabilities, which emphasises autonomy, equality and the right to live in the community. European Court of Human Rights judgments in cases such as Rooman v Belgium, V I v Moldova and Fernandes de Oliveira v Portugal have also prompted a shift towards requiring a clear therapeutic purpose for detention, greater scrutiny of hospital environments and closer alignment with the principle of proportionality. These judgments have influenced

the legal tests included in the Bill, particularly the requirement that treatment must deliver therapeutic benefit.

Taken together, the reformed Act focuses on three core areas of change.

1. **Detention criteria and thresholds.** The criteria for detention under Section 3 will now require a serious risk of harm, a clear therapeutic benefit from treatment and evidence that detention is necessary. Learning disability or autism alone will no longer meet the threshold for detention for treatment.

2. **Patient voice and autonomy.** The Act replaces the nearest relative mechanism with a nominated person model, strengthens expectations around patient participation and places Advance Choice Documents on a statutory footing.

3. **Oversight, reviews and documentation.** Renewal periods for detention are shortened, tribunal oversight is strengthened, and care and treatment plans become statutory. The Act also increases the duties on services to document and explain decisions in a clear and structured manner.

Each of these reforms is significant in its own right, but it is their combined effect that will reshape practice. The new detention criteria require more visible reasoning. The autonomy reforms necessitate new systems for involving and responding to patient preferences. The oversight reforms increase the demand for tribunal preparation, documentation and cross agency cooperation. The changes to Section 117 ordinary residence rules improve clarity but require new working relationships between ICBs and local authorities.

What the Act does not do is replace the Mental Health Act with a capacity based model similar to that introduced in Northern Ireland. Instead, the Act adapts the current structure to meet modern ethical and legal expectations. This approach reflects a political compromise between those who advocated for more radical change and those who favoured continuity with reform.

The commencement of the new Act will be phased, with some provisions coming into force quickly and others taking many years. The impact assessment suggests that the full implementation may stretch across a decade, with the most resource intensive reforms, such as the exclusion of learning disability and autism from Section 3, introduced later once community capacity has strengthened.

The following chapters explore each reform area in detail, combining legal explanation with practical implications for frontline staff, leaders, commissioners and police partners.

Cluster 1: Who can be detained, where and on what test

B2. Detention criteria reforms

The most fundamental change introduced by the Act concerns the criteria for detention under Section 3 of the Mental Health Act. This is the test that governs whether a

person can be detained for treatment. The current test is broad and grants significant discretion to clinicians and AMHPs. The new test is more structured, more rights focused and more closely aligned with international expectations about when it is appropriate to deprive someone of their liberty.

The current criteria

Under the existing Act, a person may be detained for treatment if:

- They have a mental disorder of a nature or degree that warrants detention
- Detention is necessary for their health or safety or the protection of others
- Appropriate medical treatment is available

This test does not require the decision maker to establish a specific level of harm. Nor does it require a detailed explanation of how treatment will provide benefit, beyond the general requirement that treatment must be available. This flexibility has allowed the Act to be applied to a broad group of patients, but it has also created variation in practice. Decisions often rely on local custom, individual professional judgement and the prevailing risk culture of a service.

The new criteria

The Act introduces a clearer and more demanding test. A person may only be detained for treatment if:

1. They have a psychiatric disorder
2. They present a risk of serious harm to themselves or others
3. Detention is necessary because treatment cannot be provided without it
4. The treatment is available and expected to deliver therapeutic benefit
5. Learning disability or autism alone cannot justify detention

This test is narrower than the existing one. It introduces a specific harm threshold, strengthens the requirement for treatment to be meaningfully therapeutic and elevates the concept of necessity from a broad justification to a structured requirement.

Why this change matters

The new test raises the evidential bar for detention. Clinicians and AMHPs must now show not only that a person is at risk, but that the risk meets the serious harm threshold, that there is a clear therapeutic goal and that detention is the least restrictive option. This will require more structured reasoning and more detailed documentation than many existing reports contain.

Tribunals will expect decision makers to address each limb of the test explicitly. The absence of a clear rationale for therapeutic benefit or necessity may result in a detention being challenged successfully.

Legal analysis

As part of producing this resource, Thalamos spoke with a number of legal experts to understand the legislation in more detail. They

highlighted the importance of the revised language around likelihood. Earlier drafts of the Bill had raised concerns that clinicians and AMHPs would be expected to predict risk with high precision. The final version introduces a more balanced test that avoids moving into the realm of precise forecasting. The question is whether the decision maker can show a credible basis for believing that detention is necessary to reduce a significant risk of serious harm.

Legal expertise also noted that although the test is more structured, it still allows for professional judgement. The Act requires visible reasoning, not mathematical certainty. This aligns with case law from the European Court of Human Rights which emphasises proportionality and rationale over predictive accuracy.

Implications for clinical teams

- Assessments will require more detailed exploration of risk dynamics
- Ethical and clinical questions about necessity will play a more central role
- Ward rounds and multidisciplinary meetings will need to reference therapeutic benefit in a more explicit way
- Care and treatment plans must demonstrate progress against articulated therapeutic aims

Implications for AMHPs

AMHPs will carry a significant part of the reasoning burden. Their applications will need to include:

- A clear explanation of the harm the person poses to themselves or others
- Evidence that detention is the only viable route to treatment
- Details of how community alternatives were considered and ruled out
- Analysis of how the proposed treatment will reduce the identified risk

Given the complexity of the criteria, many AMHPs will likely require additional training and support during the transition phase.

Implications for leaders

Boards and senior clinicians will need to ensure the organisation has processes to support these changes. This includes:

- Structured assessment tools
- Updated forms and templates
- Digital systems that help teams document reasoning
- Governance oversight for detentions that may border the threshold.

The new criteria represent a shift in the culture of detention decision making. They are not a change in wording alone.

B3. Learning disability, autism and detention

The treatment of learning disability and autism under the Mental Health Act has been one of the most contentious areas of modern mental health law. Families, advocacy groups and parliamentary

committees have raised concerns about the prolonged use of hospital detention for people whose needs may be better met in the community. The Mental Health Act 2025 seeks to address this issue through a targeted and symbolic reform.

Current position

Today, learning disability and autism can in some cases meet the definition of mental disorder for the purposes of detention under Section 3. This has been used to justify hospital admissions where treatment for the underlying condition is limited or unavailable. Many such detentions occur not because treatment is required but because community support has broken down.

The Wessely Review criticised this practice and recommended removing learning disability and autism from the definition of mental disorder except where a coexisting psychiatric condition is present.

What the Act changes

The Act excludes learning disability or autism alone as a basis for detention for treatment. People with LD or autism may still be detained under Section 2 for assessment if they present acute risk or deterioration. They may also be detained under Part III if involved in criminal justice pathways.

The Act introduces new requirements for regular reviews and maintains duties on authorities to track how people with LD or autism move through the system.

How significant will this be

The exclusion is ethically and symbolically important. It signals that detention for treatment must be justified by a psychiatric disorder and therapeutic purpose.

Relatively few individuals are currently detained solely under Section 3 on the basis of LD or autism. Many have coexisting psychiatric conditions that remain detainable. The change therefore affects a narrow group, but it highlights wider system issues that require attention.

Three displacement routes to plan for

When LD or autism no longer meet Section 3 criteria, the system will rely on three alternative pathways.

1. Mental Capacity Act and Deprivation of Liberty
2. Overlapping diagnoses
3. Criminal justice routes

If a person lacks capacity, community deprivation of liberty frameworks may be used. These frameworks offer fewer safeguards than the Mental Health Act and require close oversight.

Many people with LD or autism also experience psychiatric conditions. These remain detainable under the new criteria.

Behaviour arising from unmet needs may escalate and lead to criminal charges, increasing the risk of forensic detention.

Implications for community services

Community provision will

determine whether this reform delivers positive change or unintended consequences. Local authorities, ICBs and community providers will need to ensure:

- Stable accommodation pathways
- Suitable autism specific services
- Availability of intensive support teams
- Close joint working with Mental Health Trusts

Without this, individuals may be held on Section 2 for longer periods or move through crisis pathways more frequently.

Implications for clinical teams

Clinicians will need to:

- Distinguish more clearly between LD or autism and psychiatric diagnoses
- Document the presence of any coexisting conditions carefully
- Plan for the transition from hospital care to community alternatives

Implications for leaders and commissioners

Commissioners will need to:

- Invest in specialist community provision
- Reconsider long-term placement strategies
- Ensure cross area funding arrangements reflect the new ordinary residence rules
- Participate in system planning for people who may be directly affected by commencement

Why commencement will be slow

The impact assessment and parliamentary debate suggest that this provision will not commence until adequate community alternatives are available. This places responsibility on system leaders to build capacity early and prepare for a phased transition.

B4. Section 117 aftercare and ordinary residence

Section 117 aftercare is a foundational part of mental health law. It ensures that people discharged from certain detention routes receive the support needed to prevent deterioration and readmission. However, the rules governing responsibility for funding and providing aftercare have been a frequent source of dispute.

Current ordinary residence rules

Today, responsibility for Section 117 aftercare often depends on ordinary residence. Disputes arise when:

- A person has been placed out of area
- The placing authority and resident authority differ
- Accommodation is managed by one local authority but funded by another
- Individuals move between regions during the course of their care

These disputes can lead to significant delays in care planning, fragmented provision and tension between local authorities and NHS bodies.

What the Act changes

The Mental Health Act 2025 clarifies that responsibility for Section 117 remains with the original authority when a person is placed out of area. This change aims to:

- Prevent the exporting of responsibility
- Reduce financial disputes
- Support more consistent commissioning

One of the most important changes

Legal experts describe this provision as a significant but under recognised reform. It removes a major source of friction between agencies and provides clarity for long term planning. The change means that the authority that places someone remains responsible for their aftercare needs, even if the individual moves across boundaries. This should produce more predictable financial and operational arrangements.

Implications for discharge planning

- **Improved continuity.** Teams can plan confidently without the risk that responsibilities will shift unexpectedly
- **Fewer disputes.** Clarified rules reduce the scope for disagreement between authorities
- **Clearer funding lines.** ICBs and local authorities can build long term budgets with greater certainty
- **Better experience for individuals.** People discharged from hospital should face fewer administrative barriers to receiving support

Implications for commissioners

Commissioners will need to:

- Update internal processes and guidance
- Revise dispute resolution arrangements
- Map the cohort of individuals placed out of area
- Develop joint planning systems for long term aftercare

This provision aligns with broader system priorities to reduce out of area placements and improve local pathways.

PART B — CLUSTER 2: The Mental Mental Health Act 2025 explained

Autonomy tools and relational changes

B5. The nominated person model

The move from the nearest relative model to a nominated person system is one of the most meaningful cultural changes introduced by the Mental Health Act 2025. It addresses long standing concerns about fairness, modern family structures, safeguarding and personal autonomy. While the change looks relatively modest in legislative terms, its implications for practice are substantial. It affects how clinical teams involve families, how AMHPs assess suitability, how disputes are resolved and how patients experience decision making during periods of detention.

Why the nearest relative model needed reform

The nearest relative mechanism has been widely criticised for its rigidity and lack of alignment with contemporary family life. The hierarchy set out in the 1983 Act determines who holds key rights in relation to a person who is detained, such as objecting to admission, receiving information about changes to detention and participating in discharge discussions. The hierarchy cannot easily accommodate complex or estranged family relationships, nor does it reflect situations where the individual places trust in someone outside the statutory list.

The displacement process is also slow. Where the nearest relative is unsuitable or their involvement creates safeguarding concerns, AMHPs must apply to the county court for displacement. This can be time consuming, expensive and distressing for the individual and their family.

The Wessely Review highlighted these issues and recommended an approach that gives the individual greater control over who should represent and support them.

What the nominated person model introduces

The nominated person (NP) model allows individuals to choose who should act for them if they are detained under the Mental Health Act. The NP has the right to be consulted about detention, treatment and discharge decisions. They receive information about renewals, transfers and care plans, and they can object to certain applications. Their voice carries significant weight in shaping the individual's care.

Where a person has capacity, they may nominate anyone they choose. This could be a family member, a partner, a friend, a carer or someone else they trust. If the person lacks capacity and has not previously nominated someone, an AMHP may appoint the most appropriate individual.

The reform also updates the process for challenging NP appointments. A court can displace an NP if they are unsuitable or if involvement would not be in the person's best interests. Importantly, the Act allows for temporary overrides where immediate action is necessary, although full displacement remains a judicial function.

Children and young people

The nominated person changes raise specific considerations for children and young people. A child may express a preference for who should act as their NP, but the final

decision must take account of suitability and safeguarding considerations. This ensures that the person chosen to act has the maturity, relationship and ability to engage in decisions that affect the child's welfare.

Professional judgement plays a significant role here. The Act does not prescribe a rigid test, and the Code of Practice will be important in shaping how services interpret suitability for younger patients.

Legal analysis

1. **Autonomy is strengthened but not absolute.** The model respects the person's choice but recognises that nomination may not always be safe or appropriate

2. **Suitability is intentionally broad.** The Act avoids prescriptive criteria, which creates flexibility but also places responsibility on AMHPs and clinical teams to assess risk, relational dynamics and potential conflicts of interest

Legal experts also emphasise that the NP model carries new documentation requirements. Decisions about nomination, appointment and displacement must be clearly recorded. The rationale for temporary overrides must also be documented to meet legal scrutiny.

Implications for practice: For clinicians

Clinicians must identify the NP early in the detention process and ensure they understand the role the NP plays in consultation and decision making. This includes checking for:

- Advance nominations recorded in medical records
- Nominations created during previous admissions
- Nominations held digitally or in an Advance Choice Document
- Situations where the NP might need to be reassessed or confirmed

Clinicians will also need to involve the NP in care planning, risk discussions and discharge arrangements unless there is a compelling reason not to.

For AMHPs

AMHPs will carry much of the responsibility for appointment decisions where capacity is lacking. They must:

- Assess relational dynamics
- Determine suitability
- Consider safeguarding concerns
- Avoid decisions that create conflict or risk for the individual

Clear documentation will be critical, particularly where families hold differing views about who should act.

For governance and legal teams

Organisations will require policies covering:

- How to verify nomination and capacity
- How to handle disputes within families

- How to make temporary override decisions safely
- How to manage cross boundary arrangements where individuals move between regions

For patients

The NP model offers greater control and supports more relational care. It allows individuals to choose someone who understands their values, history and preferences. When combined with ACDs, it provides a stronger foundation for personalised treatment planning.

B6. Advance Choice Documents

Advance Choice Documents (ACDs) represent a significant step towards embedding autonomy, shared decision making and anticipatory care planning within mental health services. They respond to consistent feedback from people with lived experience who report feeling sidelined during crisis care or unable to communicate their preferences effectively during periods of distress.

ACDs build on the concept of advance statements in the Mental Capacity Act but go further. They are intended to be co produced, respected wherever possible and used actively in treatment planning.

What an ACD is

An ACD is a written document in which a person records their treatment preferences, care preferences and relational preferences in advance of a mental health crisis. It may include:

- Preferred medications
- Medications the person has previously reacted poorly to
- Preferences for communication and de escalation
- Preferences for ward environment or supportive measures
- People the person wishes to involve or exclude from decisions
- Practical matters such as caring responsibilities

The aim is not to bind clinicians to specific actions, but to ensure decisions align with the person's values and past experiences.

What the Act introduces

The Mental Health Act 2025 places a statutory duty on ICBs and Local Health Boards to make appropriate arrangements for supporting the creation, storage and accessibility of ACDs. This includes ensuring that:

- People are offered opportunities to create an ACD
- ACDs can be stored and accessed across settings
- Staff are trained to understand and use ACDs
- Processes exist to review and update ACDs where needed

Clinicians must have regard to an ACD when making treatment decisions. Where they depart from it, they must record and justify the reasons.

Behavioural insight and regulatory design

The Act reflects an interesting use of behavioural insight. Instead of prescribing ACD content or tightly regulating format, the government has opted for a flexible approach that encourages local co production. This is similar to the nudging techniques recommended by the Cabinet Office Behavioural Insights Team, which suggest that placing friction on undesirable behaviours and reducing friction for desirable ones can shift practice. In this case:

- It is easier for clinicians to follow an ACD
- It is more administratively demanding to override one

This encourages services to align with patient preferences wherever possible without creating rigid legal duties that limit clinical judgement.

SLaM example and early practice

South London and Maudsley NHS Foundation Trust piloted an ACD approach before the Act was introduced. Evaluations showed:

- Improved rapport between clinicians and service users
- Fewer conflicts during crisis admissions
- Better medication choices based on past tolerances
- Improved confidence among staff that they understood patient preferences

However, the pilot also highlighted challenges. These included:

- Staff time to support ACD creation
- Variability in the quality of ACDs
- Difficulty ensuring documents were accessible across ward and community teams
- Limited digital infrastructure

These challenges are instructive for system leaders preparing to meet the new statutory duties.

Legal analysis

The phrase appropriate arrangements is intentionally broad. It does not prescribe staffing levels, funding models or document formats. Instead, it places responsibility on system partners to determine what arrangements will secure safe and consistent practice. The Code of Practice will likely provide further detail, but flexibility will remain.

Legal expertise also emphasises that the duty aligns with the broader shift in mental health law from a provider centred model to a rights centred one. It creates a legal expectation that services will embed ACDs in routine care.

Practical implications: For clinical teams

Clinicians will need to:

- Familiarise themselves with ACD content
- Incorporate ACDs into assessments, ward rounds and care planning
- Justify departures from ACDs in clear and structured terms

- Work sensitively with individuals who may be anxious about how their preferences will be interpreted

For ICBs and system leaders

ICBs must:

- Build infrastructure for ACD creation
- Ensure digital platforms can store and share ACDs across providers
- Support training for staff across inpatient, community and crisis teams
- Collaborate with local authorities, voluntary sector partners and community groups

For AMHPs

AMHPs will need to consider ACDs during applications, including:

- Whether the ACD provides information about risk
- Whether the proposed care plan aligns with ACD contents
- How to manage scenarios where the ACD appears to reject essential interventions

For legal and governance teams

ACDs introduce new legal scrutiny. Decisions that override ACDs without clear rationale may be challenged. Governance teams will need to update:

- Treatment decision templates
- Clinical reasoning guidance
- Incident review processes

What ACDs cannot do

ACDs cannot override mental health legislation. They cannot prevent detention where criteria are met or require clinicians to administer treatments that are unsafe or contraindicated. They do not alter the legal tests for capacity or best interests under the Mental Capacity Act.

What ACDs can do

They can:

- Make crises less chaotic
- Preserve personal identity and agency
- Improve therapeutic alliance
- Reduce the use of coercive practices
- Contribute to more consistent and humane care

Even in systems with resource constraints, ACDs can anchor decision making in the individual's voice.

B7. Care and treatment plans and SOAD changes

Care planning is central to safe and effective inpatient treatment. Under the current Mental Health Act, care plans are expected, but their content and structure are not strictly defined in statute. The Mental Health Act 2025 strengthens the legal basis for care and treatment plans, making them a statutory requirement for all detained patients.

At the same time, the Act updates the process for seeking second opinions from a Second Opinion

Appointed Doctor (SOAD), particularly in situations where a person with capacity refuses treatment or where a proposed treatment conflicts with an ACD or advance decision.

Taken together, these changes raise expectations for documentation, planning and clinical reasoning.

Care and treatment plans under the new Act

The Act introduces a duty for responsible clinicians to develop care and treatment plans that meet standards set out in secondary legislation. The exact requirements will be defined later but are expected to include:

- Personalised objectives
- Clinical and therapeutic rationales
- Consideration of ACDs and NP involvement
- Regular review and updating
- Clear links between treatment and the serious harm and therapeutic benefit criteria

This aligns with the approach already used in Wales, where statutory care and treatment plans have helped reduce variation in practice.

Why this matters

A statutory plan increases accountability. It provides a document that tribunals, hospital managers and families can review to ensure treatment is appropriate, proportionate and aligned with the person's preferences. It reduces the scope for care to drift or become custodial, particularly during long admissions.

SOAD changes

The Act introduces several adjustments to the SOAD process.

- In some cases, the time before SOAD approval is required will be shortened
- If a patient with capacity refuses treatment, SOAD authorisation will be needed more quickly
- If a proposed treatment conflicts with an ACD, advance decision or Court of Protection order, clinicians must provide a compelling reason to proceed before obtaining a SOAD opinion

These changes are designed to ensure that the individual's expressed wishes remain central, even during compulsory admission.

Implications for clinical teams

- More structured treatment decisions. Clinicians must show that proposed interventions align with the care plan and the patient's known preferences
- Closer liaison with SOAD services. Timely referrals will be essential to avoid delays in urgent treatment
- Increased documentation. Treatment decisions must record any conflict with ACDs or NP views and include rationale.

Implications for governance

Organisations will need:

- Updated SOAD policies
- Consistent processes for reviewing care plans

- Digital systems that link ACDs, NPs, care plans and tribunal documentation.

Implications for AMHPs and system partners

AMHPs, commissioners and partners will need to ensure care plans are realistic and supported by appropriate community pathways. For example, plans that rely on intensive community support will require assurance that provision exists at discharge.

Why these changes matter culturally

Care and treatment plans and SOAD adjustments reinforce the direction of travel in mental health law. They reflect a system that expects clinicians to explain decisions, involve individuals meaningfully and justify departures from their stated preferences. These expectations will influence not only legal compliance but also the therapeutic culture of inpatient services.

PART B — CLUSTER 3: Rights, oversight and system accountability

Autonomy tools and relational changes

B8. Police powers and place of safety

Police officers play a significant role in the early stages of many mental health crises. They are often first on the scene when someone is at risk in a public place or when concerned relatives contact emergency services. The 1983 Mental Health Act gives police powers under sections 135 and 136 to remove a person to a place of safety for assessment. Over the past decade, police forces have raised concerns about the pressures created by this responsibility and the limited availability of health based places of safety. Likewise, health services have raised concerns about police taking individuals to emergency departments that are not equipped to offer mental health assessments.

The Mental Health Act 2025 responds to some of these concerns. It reflects the direction of travel towards reducing police involvement in health crises while maintaining the need for police powers where immediate risks must be managed.

Background to reform

In the early 2010s, a significant proportion of people detained under section 136 were taken to police stations. This practice was widely viewed as inappropriate and potentially harmful. Policy interventions and investment gradually reduced reliance on police custody, and by the time the Bill was drafted, police stations were already becoming a last resort.

The Wessely Review recommended that police stations should no longer be used as places of safety for adults, except in rare and tightly defined circumstances. It also proposed stronger integration between police forces, ambulance services and mental health providers, supported by clear national standards and investment in crisis infrastructure.

What the Act changes

The Act removes police stations from the statutory list of places of safety for adults. Children are already protected from being taken to a police station under the existing Act, and this reform aligns adult practice with that principle.

The Act also clarifies police powers in the context of custody. If an individual detained for a non-mental health reason begins to show signs of severe mental illness or acute distress, police can request urgent assessment or transport the person to a health based place of safety, depending on risk and clinical advice.

Notably, some of the more ambitious reforms originally discussed during the White Paper process did not appear in the Bill. These included proposals to create a new category of authorised persons with limited detention powers and proposals to widen the range of secure non police locations that could be designated as places of safety. Ministers have indicated these proposals may be subject to future consultation, reflecting the need for further policy development and interagency planning.

Legal analysis

The reform is important but practical barriers remain. Many regions still face significant shortages in health based places of safety and specialist Section 136

suites. Without addressing these capacity issues, the system risks continued reliance on emergency departments. Police stations may no longer be legally recognised, but if alternative capacity is inadequate, operational pressures may persist.

Legal experts also note that the Act takes a cautious approach to expanding police powers. The government has avoided creating new detention powers for non police professionals until there is clarity on workforce, training and safeguarding implications.

Implications for police forces

Police forces will need to:

- Work closely with mental health partners and ambulance services
- Ensure all officers understand the removal of police stations from the legislation
- Update internal guidance, training and escalation pathways
- Strengthen liaison with crisis services
- Develop clearer call handling and triage arrangements

Police forces will also need to prepare for potential increases in 136 activity if community crisis services remain stretched. Although the Act seeks to tighten when detention is used, operational demand often reflects capacity elsewhere in the system.

Implications for mental health and acute trusts

Providers must ensure:

- Sufficient health based places of safety
- Efficient handover processes between police and clinical teams
- Rapid assessment pathways
- Robust staffing models for Section 136 suites
- Effective diversion from emergency departments where possible.

Some trusts have already invested in joint crisis teams, co-located liaison services and front door triage models. These will be important in managing any shifts in demand under the reformed Act.

Implications for ambulance services and ICBs

Ambulance services may face increased demand for transport to places of safety. ICBs will need to support multi agency crisis planning and ensure capacity is in place across local urgent and emergency care pathways.

Wider system considerations

The removal of police stations is an ethical and rights based reform, but it also places responsibility on the NHS and local authorities to provide safe and timely alternatives. In some areas, investment in crisis facilities, mental health emergency departments or specialist hubs will be essential to deliver this reform safely.

B9. Tribunals and rights of challenge

Tribunal oversight was a central feature of the Mental Health Act 1983. Tribunals protect individuals from prolonged or inappropriate detention and ensure decisions are lawful, justified and proportionate. The Mental Health Act 2025 strengthens this oversight by increasing the frequency of hearings and clarifying certain tribunal powers.

These changes are intended to support more patient centred practice, but they will also create operational pressures for services. Preparation for tribunal hearings requires clinician time, administrative coordination and accurate documentation. Tribunals may also issue recommendations that require actions from services and commissioners.

Current framework

Under the 1983 Act:

- Patients detained under Section 2 may apply once for tribunal review
- Patients detained under Section 3 may apply initially, and then after each renewal
- Renewal periods are six months, then six months, then yearly
- Tribunals can discharge, defer discharge, or make recommendations

Tribunal hearings often focus on whether detention criteria are met, whether the treatment plan is appropriate and whether the least restrictive principle has been followed.

What the 2025 Act changes

1. Shorter renewal periods

Initial renewal of Section 3 detention will be reduced from six months to three months. This means more frequent opportunities for tribunal review and greater scrutiny of how the treatment plan is progressing.

2. Increased tribunal activity

More frequent renewal periods will naturally increase the number of tribunal hearings. Patients may also exercise their right to apply for discharge at any renewal point. This will require more clinician reports, more administrative preparation and more panel time.

3. Expanded tribunal recommendations

The Act strengthens tribunal powers to make recommendations about treatment, care planning and aftercare. Tribunals may also make recommendations about:

- Community Treatment Order conditions
- Section 117 aftercare arrangements
- Transitions between inpatient and community care

While recommendations are not binding, services must give them serious consideration and document their responses.

4. Procedural clarity

The Act also tidies up certain procedural matters, including timing of applications and alignment with decisions by

hospital managers.

Legal analysis

Tribunals are an essential safeguard in the new system. The increased frequency of review ensures that detentions are continually justified. However, there are warnings that the resource implications will be substantial. Legal aid, tribunal staffing and clinical time will all be affected.

The impact assessment acknowledges these pressures and anticipates a phased approach to commencement. Early reforms may focus on procedural clarity, with more resource intensive elements commencing later.

Implications for clinicians

Clinicians will need to:

- Prepare more reports
- Justify decisions using the new detention criteria
- Demonstrate how care plans address therapeutic benefit
- Clarify how risks are being managed
- show how ACDs and NP involvement have shaped decisions.

Tribunal preparation may require protected time or additional administrative support.

Implications for AMHPs

AMHPs may be asked to provide evidence about the original decision making, availability of alternatives and the rationale for necessity. Their records will need to be thorough and well structured.

Implications for governance teams

Governance teams must ensure:

- Systems for tracking tribunal deadlines
- Templates that align with new statutory criteria
- Processes for responding to tribunal recommendations
- training for staff involved in tribunal preparation

Implications for ICBs and local authorities

Tribunals may issue recommendations that affect Section 117 responsibilities. ICBs and LAs must coordinate responses and ensure that aftercare arrangements are workable and timely.

Benefits and risks

Benefits

- Stronger protection for patient rights
- More responsive care planning
- Improved consistency in applying the new legal tests

Risks

- Increased administrative burden
- Potential delays if tribunal capacity is not expanded
- Pressure on clinical time, particularly in services already under strain

B10. Documentation, information and record keeping duties

Documentation has always played a central role in mental health law, but the Mental Health Act gnificantly strengthens expectations in this area. Almost every major reform relies on accurate, accessible and transparent records. The new detention criteria demand structured reasoning. The nominated person and ACD reforms require systems for storing and sharing essential information. Tribunal oversight increases the need for clear records of treatment progress and risk management.

While these may appear to be administrative matters, they are in fact central to the legal and ethical purpose of the Act.

Key documentation reforms

1. Detention criteria checklists

One of the clearest examples of the Act's shift towards structured reasoning is the introduction of checklists for treatment decisions. These checklists require clinicians to record:

- How the serious harm threshold is met
- Why detention is necessary
- What therapeutic benefit is expected from treatment
- How alternative options were considered
- How the proposed treatment aligns with ACDs and NP involvement

Legal analysis reflects that these checklists reflect a broader regulatory trend across health and social care. They provide visible evidence of a reasoned decision, reducing the risk of error and supporting tribunal oversight.

2. Documentation of NP decisions

Records must show:

- How nomination was verified
- How suitability was assessed
- When temporary overrides were used
- Why displacement was sought
- Any disputes or safeguarding concerns

This requires a level of clarity and consistency that will necessitate updated templates and training.

3. ACD documentation

ACDs must be:

- Recorded in a durable and accessible format
- Available to all staff involved in the person’s care
- Linked to digital systems where possible
- Referenced during assessments and ward rounds

Where decisions depart from an ACD, the rationale must be recorded.

4. Care and treatment plans

These plans must reflect:

- The individual's preferences and goals
- The therapeutic rationale for each intervention
- Review schedules
- Progress against outcomes
- Input from NPs and professionals across agencies

They must be updated regularly and available to tribunals.

5. Section 117 aftercare documentation

Clarified ordinary residence rules require:

- Updated records of responsible authorities
- Clear handover processes when individuals move
- Documentation of agreed community support

This is essential for avoiding disputes and ensuring timely discharge planning.

Implications for digital systems

The Act's documentation requirements highlight the need for modern, connected digital systems. Paper based processes make it difficult to:

- Locate ACDs during crises
- Verify NP appointments
- Track tribunal deadlines
- Update care plans across teams
- Provide evidence of structured reasoning

Digital Mental Health Act systems and integrations with EPRs and shared care records will become increasingly important in meeting the new legal expectations.

Implications for governance and audit

Governance teams will need to:

- Revise local policies
- Update record keeping standards
- Introduce audits focused on documentation quality
- Ensure compliance with new statutory duties
- Prepare for increased external scrutiny

Documentation failures may carry greater legal and reputational risk under the reformed Act.

Implications for staff training

Training must cover:

- The new detention criteria
- Documentation of NP and ACD decisions
- Care plan standards
- Tribunal preparation
- Interprofessional communication

This training will need to be delivered across inpatient, community, crisis and police liaison teams.

Ethical and cultural implications

More than a technical requirement, the emphasis on documentation supports a cultural shift towards clarity, accountability and patient involvement. It encourages teams to articulate their reasoning, consider individual preferences and reflect on the impact of decisions. This supports safer care and strengthens trust between individuals and services.

The link between documentation and rights

Documentation is the mechanism through which rights are made real. Without clear records, individuals cannot challenge decisions, tribunals cannot conduct effective reviews and organisations cannot demonstrate compliance. The Act recognises this by embedding documentation requirements in multiple reforms. It reflects a system that expects decisions to be not only lawful, but also transparent, explainable and grounded in the principles of least restriction.

PART C: From legislation to system reality

TBD

The Mental Health Act 2025 sets the direction for the next decade of mental health care, but its success will depend entirely on how the system responds to the operational, financial and cultural challenges it introduces. The law will only achieve its aims if services are able to interpret complex reforms, apply new legal tests accurately, embed new rights in practice and resolve longstanding gaps in crisis and community care. Part C focuses on this transition from legislative design to day to day reality. It examines where risk lies, where opportunity sits and what leaders across health, social care and policing can do to prepare.

The Act does not land on a blank canvas. It arrives during a period of sustained pressure on mental health services, with inpatient demand high, workforce capacity stretched, community alternatives uneven and crisis care often dependent on informal arrangements between agencies. This means the reforms will interact with existing weaknesses as much as with strengths. Implementation will therefore need to be deliberate, collaborative and sensitive to local conditions.

Part C is structured around five questions that matter most to the system.

1. What mindset and interpretive approach does the reformed Act require

2. What changes can realistically begin early, and which require longer preparation

3. Which misinterpretations could cause operational risk if left unaddressed

4. What do leaders across NHS, local authorities and policing need to do now

5. What does a responsible and sustainable transition look like over the coming decade

C1. A new interpretive mindset for modern mental health law

The Act introduces not only new legal requirements but also a new interpretive culture. It expects decision makers to balance autonomy, risk and therapeutic purpose carefully. It demands visibility of reasoning. It calls on services to justify the least restrictive option and to demonstrate how decisions align with individual preferences.

Certainty and discretion in tension

One of the challenges in interpreting the Act lies in understanding how much certainty the Act provides and how much discretion it expects decision makers to exercise. Legal experts have been clear that the Act is a mixture of precise statutory tests and areas where judgement must be applied. Detention criteria contain structured elements, such as serious harm and therapeutic benefit, but they rely on professional assessment to determine how those elements are met. ACDs create clear duties to have regard to preferences, but discretion remains in how those preferences are interpreted during crisis. The NP model offers choice but requires suitability assessments that cannot be purely mechanical.

Understanding this blend is critical. The system will need to avoid two missteps.

- Over confidence that the Act provides complete clarity. The Act refines many areas but does not eliminate interpretive complexity

- Over caution that stifles decision making. The Act requires good reasoning, not immobility

The Code of Practice and case law will gradually shape these interpretive spaces, but the early years will depend on thoughtful and well documented professional judgement.

Where the law bites hardest

Three areas create the highest interpretive demands.

1. Serious harm tests under Section 3

2. Necessity and least restriction

3. Departure from ACDs

Decision makers will need to draw on clinical evidence, risk history and the current presentation to show why the harm threshold is met. Services will need to demonstrate how alternatives were considered, which places pressure on community capacity. Any departure requires clear recorded justification that will be scrutinised during tribunals or complaints.

A more relational Act

The reformed Act is more relational. It assumes that decisions should be co produced, or at least informed by the person's values and relationships, even during periods of compulsory treatment. This changes how ward teams, AMHPs and community services must think about involvement. It makes the NP an active partner in decision making. It requires clinicians to read and understand an ACD before making treatment decisions. It expects partnerships between agencies to be well coordinated.

These relational expectations cannot be delivered solely through training. They require supportive systems, adequate time, digital infrastructure and a shared understanding of what meaningful involvement looks like.

C2. Early commencement, phased commencement and what this means for planning

Not all reforms will begin at once. The impact assessment and parliamentary commentary are clear that commencement will be phased. Some reforms require minimal resource, others depend heavily on additional capacity. Planning must therefore distinguish between short term adjustments and long term strategic shifts.

Early commencement: reforms that can begin quickly

The following changes are likely to commence soon after Royal Assent.

Updated detention criteria

The wording change to serious harm and therapeutic benefit requires updated training and documentation but not new infrastructure. This is why it can commence early, although doing so without adequate preparation carries risk.

Nominated person model

Where nomination is straightforward, services can adopt the NP process quickly. More complex cases will still need clear guidance.

Information giving and documentation duties

Checklists, reasoning templates and updated internal guidance can be implemented at pace.

Tribunal procedural updates

Where reforms do not require increased tribunal panel numbers, they can commence early.

Duties to have regard to ACDs

Clinicians can begin aligning decisions with existing ACDs without major system redesign.

Medium term commencement: reforms that require structured preparation

ACD infrastructure duties on ICBs and Local Health Boards

This duty requires systems, training and pathways. It is not a switch on activity.

Section 117 revised financial responsibility rules

Although conceptually simple, implementation requires updated agreements between local authorities and ICBs and clear operational processes.

Full incorporation of NP decision making in children's services

Suitability assessments and dispute handling require training and clear governance.

Expanded tribunal review workloads

Tribunal capacity and trust reporting capacity must be in place before commencement.

Long term or resource dependent commencement

Exclusion of LD and autism from Section 3

This requires sustainable accommodation, social care support, intensive community teams and stable specialist provision. Premature commencement could increase risk.

Expansion of SOAD capacity

New SOAD requirements will require additional workforce and updated national arrangements.

Any reforms that shift demand from inpatient to community services

The harm threshold, necessity test and emphasis on least restriction

will only function safely if there are viable alternatives to admission. Without this, inappropriate pressure may fall on crisis services, emergency departments or police.

Why understanding phasing matters

Misjudging the timeline could lead to:

- Unrealistic expectations of front line staff
- Premature system change
- Missed opportunities to prepare for long term reforms
- Difficulty managing financial and workforce pressures

Providers will need structured implementation plans that span multiple years, aligned with national commencement schedules.

C3. Five high risk misinterpretations the system must avoid

Reform often fails when assumptions take hold that are not supported by the legislation. Several misconceptions are already circulating in early commentary. Addressing them early will prevent operational errors.

1. Misinterpretation: All reforms begin at once

The Act is deliberately phased because simultaneous commencement would overwhelm the system. Leaders must communicate clearly that reform will unfold gradually. Local planning needs to mirror this approach, with staged training, policy updates and workforce development.

2. Misinterpretation: LD and autism changes will rapidly reduce inpatient numbers

The change is important but will not drive immediate reductions. Only a small proportion of detentions rely solely on LD or autism. Without investment in community alternatives, inappropriate detention could shift into other pathways rather than decrease. Leaders must manage expectations and prepare for complex transitional cases.

3. Misinterpretation: ACDs are standardised and fixed documents

The Act does not specify the content or structure of an ACD. This flexibility is intentional. Services must avoid assuming that all ACDs will look the same or that quality improves through standardisation alone. The emphasis is on meaningful involvement, not form completion.

4. Misinterpretation: The NP model removes all family conflict

The NP model increases autonomy, but it does not resolve relational complexity. Disputes between families may still occur. Safeguarding concerns may still arise. Decisions will require professional judgement and careful documentation.

5. Misinterpretation: Care plans and SOAD changes are routine administrative updates

Care and treatment plans will become central legal documents.

SOAD referrals will be required earlier in certain circumstances. These changes will alter workflow, increase clinician time requirements and heighten scrutiny from tribunals. They are operationally significant reforms.

C4. How leaders across the system can prepare now

The transition to the reformed Act will place demand on multiple parts of the system. Leadership will determine whether implementation is safe, coherent and sustainable. Preparation should begin before commencement, not after.

For trust boards and executive teams

1. Establish governance for Mental Health Act readiness

Boards must ensure:

- A clear executive lead for implementation
- Oversight processes for detention decisions
- Integration of new legal tests into governance dashboards
- Alignment between clinical, legal, digital and operational teams

2. Invest in digital foundations

Documentation duties cannot be met safely with paper based systems. Trusts will need:

- Digital MHA pathways
- Integration with EPRs and shared care records
- Structured templates for detention criteria, ACDs, NP decisions and care plans
- Reporting tools for tribunal preparation

Trusts that modernise early will avoid backlogs and reduce risk.

3. Prepare staff for new documentation expectations

Training must go beyond awareness sessions. Staff will need support to write structured reasoning, document risk appropriately and integrate ACDs and NP involvement into their decision making.

4. Review inpatient capacity and flow

The new criteria may influence admission patterns. Trusts must anticipate:

- Complex borderline cases
- Increased scrutiny from families and advocates
- Challenges in step down planning where community support is limited

For Approved Mental Health Professionals

1. Build confidence in applying the new criteria

AMHPs must understand how to:

- Evidence serious harm
- Assess necessity
- Evaluate alternatives
- Balance personal autonomy with risk

- Integrate ACDs and NP positions.

2. Strengthen report quality

Tribunal expectations will rise. Reports must be clearer, more structured and better linked to the statutory tests.

3. Work closely with local authorities and trusts on discharge planning

Section 117 changes require AMHPs to ensure early engagement between agencies.

For ICBs and local authorities

1. Prepare for Section 117 responsibility changes

ICBs and LAs must update:

- Funding agreements
- Dispute resolution processes
- Joint commissioning arrangements

2. Build infrastructure for ACD creation and storage

ACDs will require:

- Clinical time
- Digital systems
- Cross boundary accessibility

3. Strengthen community capacity for LD and autism

Commencement of this reform depends on:

- Housing availability
- Supported living
- Specialist teams
- Intensive support and crisis pathways

For police forces and policing partners

1. Update operational guidance

Removal of police stations as places of safety requires:

- New pathways with mental health trusts
- Clearer relationships with ambulance services
- Revised custody procedures

2. Review training in mental health crises

Officers must understand:

- How to recognise acute mental disorder
- How to interpret risk behaviours
- When to involve healthcare partners

3. Engage directly with NHS partners on capacity planning

Police cannot compensate for gaps in crisis provision. Joint planning will be essential.

For independent and voluntary sector providers

1. Prepare for greater involvement in aftercare and crisis alternatives

Providers may receive more referrals as community options expand.

2. Ensure documentation and

safeguarding meet new standards

Providers must be ready for increased scrutiny from tribunals and commissioners.

C5. A sustainable implementation journey for the next decade

The reforms in the Mental Health Act 2025 are ambitious, but their impact depends entirely on implementation. A sustainable transition will require cautious commencement, consistent leadership and realistic expectations. The following is a suggested steer on phasing.

Short term priorities: the first two years

1. Training on detention criteria and NP decisions
2. Digital readiness for documentation duties
3. Updated care plan templates and SOAD pathways
4. Revised local authority and ICB processes for Section 117
5. Crisis pathway strengthening for police and acute partners

These tasks are achievable before the more resource intensive reforms commence.

Medium term priorities: two to six years after commencement

1. ACD infrastructure roll out across ICBs
2. Tribunal capacity expansion
3. Community alternatives for LD and autism
4. Joined up workforce planning across agencies
5. Embedding a relational culture in inpatient and crisis care

These measures will determine whether the legal reforms translate into better experiences and outcomes.

Long term priorities: up to a decade after Royal Assent

1. Full commencement of LD and autism exclusions
2. Wider crisis infrastructure reform, including mental health emergency departments
3. National digital maturity for MHA pathways
4. Consistent application of autonomy and least restriction across regions
5. Ongoing refinement through case law, research and service evaluation

The long term agenda recognises that legislative reform must be accompanied by cultural, financial and operational reform.

C6. The opportunity ahead

The Mental Health Act 2025 does not solve every problem in the system. It will not transform community capacity alone. It will not eliminate risk or remove the need for difficult decisions. It will not reduce inequalities without wider systemic change. But it does recalibrate mental health law in ways that match modern

expectations of rights, accountability and personalised care.

If implemented well, the Act can help the system:

- Reduce unnecessary detention
- Improve patient experience
- Support shared decision making
- Increase transparency and fairness
- Strengthen interagency cooperation
- Modernise digital and documentation infrastructure
- Embed therapeutic purpose at the heart of the Act

Successful implementation will require commitment, coordination and clear communication. It will require leaders to recognise that law alone cannot change practice. It is through policy, staffing, culture, digital tools and partnership that the intentions of the Act become real.

The next decade offers a rare opportunity to build a mental health system that reflects what people value most: care that is safe, respectful, personalised and grounded in their own voice. The Mental Health Act 2025 provides the framework. The system must provide the substance.

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