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Joint Committee on the Draft Mental Health Bill

Draft Mental Health Bill

Session 2004-05

Volume I
The Joint Committee on the Draft Mental Health Bill

The Joint Committee on the Draft Mental Health Bill was appointed by the House of Commons and the House of Lords on 22 July 2004 to examine the draft Mental Health Bill and report to both Houses by 31 March 2005. It has now completed its work.

Membership

Lord Carlile of Berriew (Lib Dem) (Chairman)

Liz Blackman (Labour) Erewash
Mrs Angela Browning (Conservative) Tiverton and Honiton
Mr David Hinchliffe (Labour) Wakefield
Mr George Howarth (Labour)Knowsley North and Sefton East
Tim Loughton (Conservative) East Worthing and Shoreham
Mr Paul Marsden (Lib Dem) Shrewsbury and Atcham
Laura Moffatt (Labour) Crawley
Ms Meg Munn (Labour) Sheffield Heeley
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Baroness Finlay of Llandaff (Cross Bench)
Baroness Flather (Conservative) (Discharged 29 November 2004)
Baroness Fookes (Conservative) (Discharged 14 September 2004)
Lord Mayhew of Twysden (Conservative) (Appointed 14 September 2004)
Baroness McIntosh of Hudnall (Labour)
Baroness Murphy (Cross Bench) (Appointed 29 November 2004)
Baroness Pitkeathley (Labour)
Lord Rix (Cross Bench)
Lord Turnberg (Labour)

Powers

The Committee had the power to require the submission of written evidence and documents, to examine witnesses, to meet away from Westminster, to meet at any time (except when Parliament is prorogued or dissolved), to appoint specialist advisers, and to make Reports to the two Houses.

Publication

The Report and evidence of the Joint Committee are published by The Stationery Office by Order of the two Houses. All publications of the Joint Committee (including press notices) are on the Internet at:

www.parliament.uk/parliamentary_committees/jcdmhb.cfm
Committee staff
The staff of the Joint Committee were drawn from both Houses and comprised Glenn McKee (Commons Clerk), Chloe Mawson (Lords Clerk), Annette Toft (Inquiry Manager), Manjit Gheera (Legal Adviser), Alison Mara (Committee Assistant), Richard Dawson (Committee Assistant), Lisette Pelletier (Team Manager), Jonathan Coe (Senior Office Clerk), Tes Stranger (Senior Office Clerk), and George Fleck (Office Support Assistant). This inquiry was run from the Scrutiny Unit in the Committee Office, House of Commons.

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# Contents

<table>
<thead>
<tr>
<th>Report</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>1 Background</strong></td>
<td>7</td>
</tr>
<tr>
<td>The Committee’s inquiry</td>
<td>7</td>
</tr>
<tr>
<td>Overview</td>
<td>8</td>
</tr>
<tr>
<td>Origins</td>
<td>8</td>
</tr>
<tr>
<td>The post-1983 policy environment</td>
<td>10</td>
</tr>
<tr>
<td>Reducing stigma</td>
<td>10</td>
</tr>
<tr>
<td>Public protection and risk management</td>
<td>11</td>
</tr>
<tr>
<td>Human Rights Act 1998</td>
<td>12</td>
</tr>
<tr>
<td>Towards a new Mental Health Act</td>
<td>14</td>
</tr>
<tr>
<td>The draft Mental Health Bill 2004</td>
<td>15</td>
</tr>
<tr>
<td><strong>2 Principles and codes of practice</strong></td>
<td>20</td>
</tr>
<tr>
<td>Introduction</td>
<td>20</td>
</tr>
<tr>
<td>Principles</td>
<td>20</td>
</tr>
<tr>
<td>The significance of general principles</td>
<td>21</td>
</tr>
<tr>
<td>The nature of the principles</td>
<td>24</td>
</tr>
<tr>
<td>The disapplication of general principles</td>
<td>27</td>
</tr>
<tr>
<td>Codes of practice</td>
<td>28</td>
</tr>
<tr>
<td><strong>3 Definitions and conditions</strong></td>
<td>30</td>
</tr>
<tr>
<td>Introduction</td>
<td>30</td>
</tr>
<tr>
<td>The current framework</td>
<td>30</td>
</tr>
<tr>
<td>The framework proposed in the 2004 draft Mental Health Bill</td>
<td>31</td>
</tr>
<tr>
<td>The interrelationship between definition and conditions</td>
<td>32</td>
</tr>
<tr>
<td>The definition of mental disorder</td>
<td>32</td>
</tr>
<tr>
<td>Review of the definition</td>
<td>32</td>
</tr>
<tr>
<td>Proposed changes and additions to the definition</td>
<td>38</td>
</tr>
<tr>
<td>Specific exclusions</td>
<td>38</td>
</tr>
<tr>
<td>Conditions for the use of compulsory powers</td>
<td>43</td>
</tr>
<tr>
<td>The single gateway to assessment and treatment</td>
<td>43</td>
</tr>
<tr>
<td>The combined effect of the proposed definition and conditions</td>
<td>56</td>
</tr>
<tr>
<td><strong>4 Interface with the Mental Capacity Bill</strong></td>
<td>57</td>
</tr>
<tr>
<td>Advance Statements</td>
<td>60</td>
</tr>
<tr>
<td>The &quot;Bournewood Gap&quot;</td>
<td>61</td>
</tr>
<tr>
<td><strong>5 Compulsory treatment in the community</strong></td>
<td>65</td>
</tr>
<tr>
<td>Introduction</td>
<td>65</td>
</tr>
<tr>
<td>The principle and efficacy of non-residential compulsory powers</td>
<td>67</td>
</tr>
<tr>
<td>The principle</td>
<td>67</td>
</tr>
<tr>
<td>Efficacy</td>
<td>68</td>
</tr>
<tr>
<td>The framework proposed in the draft Bill</td>
<td>69</td>
</tr>
<tr>
<td>Availability of treatment</td>
<td>114</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Treatment</td>
<td>115</td>
</tr>
<tr>
<td>Type A treatments - psychosurgery</td>
<td>115</td>
</tr>
<tr>
<td>Type B treatments</td>
<td>116</td>
</tr>
<tr>
<td>Electroconvulsive therapy (ECT)</td>
<td>117</td>
</tr>
<tr>
<td>Other treatments</td>
<td>118</td>
</tr>
<tr>
<td>Emergency drug treatment</td>
<td>120</td>
</tr>
<tr>
<td>The mental health advocacy service</td>
<td>120</td>
</tr>
<tr>
<td>Funding for the mental health advocacy service</td>
<td>121</td>
</tr>
<tr>
<td>Quality and independence of the mental health advocacy service</td>
<td>121</td>
</tr>
<tr>
<td>The role and responsibilities of the mental health advocacy service</td>
<td>126</td>
</tr>
<tr>
<td>Carers and nominated persons</td>
<td>127</td>
</tr>
<tr>
<td>Nominated persons</td>
<td>127</td>
</tr>
<tr>
<td>Carers – role and rights</td>
<td>131</td>
</tr>
</tbody>
</table>

10 Resources and professional roles 133

- Trends in mental health 133
- How much will it cost? 135
- Consequences of getting it wrong 138
- Conclusions 141

Professional Roles 141

- The Approved Mental Health Professional (AMHP) 141
- The role of the clinical supervisor 143

11 The application of the Bill in Wales and devolved issues 145

- Application of the Bill in Wales 145
- MPs and Members of devolved legislatures who become mentally-ill 147

Conclusions and recommendations 148

Annex 1: Extract from Press Notice No. 1 issued 16 September 2004: JOINT COMMITTEE SEEKS EVIDENCE ON DRAFT MENTAL HEALTH BILL 161

Annex 2: Programme of visits undertaken by the Joint Committee on the draft Mental Health Bill during the course of its inquiry 162

Annex 3: Glossary 163

Annex 4: Schedule of detailed comments on the draft Mental Health Bill with responses from the Government 166

Formal minutes 258

Witnesses 279

List of written evidence 284

List of unprinted written evidence 293
Summary

The Joint Committee on the draft Mental Health Bill was appointed to examine the draft Mental Health Bill which was published on 8 September 2004. The purpose of pre-legislative scrutiny is to examine draft legislation and, on the basis of consultation, to recommend improvements before a Bill proper is introduced into Parliament. In 1998 the Government announced their intention to undertake the first comprehensive review of mental health law since the 1950s, taking into account developments such as the adoption of the European Convention of Human Rights. This draft Bill is part of that process and follows the publication in 2002 of a previous draft Bill which was widely criticised.

We received more than 450 written submissions and heard oral evidence from 124 witnesses, including professionals, carers and service users. We were particularly anxious to hear from those who have been subject to compulsion under the Mental Health Act 1983. Having considered all the evidence we reached the view that the Government should proceed with the Bill, but only with significant amendments, as proposed in our report.

The primary purpose of mental health legislation must be to improve services and safeguards for patients and to reduce the stigma of mental disorder. To this end, the fundamental principles underpinning the legislation must be set out on the face of the Bill. This will provide clear guidance for professionals and tribunals and provide assurances to users of mental health services. We believe that the principles in the new Scottish Act serve as an excellent model. In addition, the principles should reflect the need to protect the public from the small minority of mentally disordered people who pose a risk of harm.

We accept the merits of having a broad definition of mental disorder, but the Bill needs to have clear exclusions ensuring that the legislation cannot be inappropriately used as a means of social control. A broad definition of mental disorder also necessitates that the conditions on the use of compulsion are tightly drawn. We have recommended a range of changes that would tighten the conditions and ensure that this legislation cannot be used inappropriately. In particular, we have proposed that the threshold for risk of harm to others should be raised and that compulsion should only be used where a treatment is available which would be of therapeutic benefit to the patient.

The legislation should take greater account of a person’s ability to make decisions about his treatment. We recommend that a new condition be met before compulsory powers can be used which is that a person’s ability to make a decision about accepting treatment is significantly impaired as a result of mental disorder. Where a person’s decision making is unimpaired, he should be able to reject treatment.

As a consequence of the inclusion of criteria of therapeutic benefit and impaired decision-making, a small group of people with dangerous and severe personality disorder (DSPD) may not meet the conditions for the use of compulsory powers. We do not believe that this group should be dealt with by mental health legislation. Separate legislation should be introduced to manage individuals with DSPD.

The introduction of non-residential orders will regularise the current use of leave and guardianship provisions. However, we believe that the use of these orders is appropriate only in a relatively small number of cases. The Bill should delineate clearly the clinically
identifiable group of persons to whom such orders can be applied and it should limit and control the length of time patients can be subjected to such orders. In addition, there should be a duty on health and local authorities to provide adequate care for non-resident patients without placing undue burdens on families and carers.

We welcome the inclusion in the draft Bill of a section dedicated to children and adolescents and we welcome most of its provisions. We would, however, like to see the Bill limit and control the use of adult wards for the treatment of under 18s subject to compulsion, and to require the involvement of specialists in child and adolescent mental health in both the assessment of and the tribunal hearings for under 18s.

We are pleased to see the enhanced safeguards in the draft bill. We welcome, in particular the new Mental Health Tribunals, the right to an Independent Mental Health Advocate and the placing of care plans on a statutory footing. We have recommended the retention of the Mental Health Act Commission as the best vehicle for visiting and inspection.

We have major concerns about the resources needed to implement the Bill. We lack confidence in the Government’s models and underlying assumptions used to predict the funding and staff required to make the new provisions work. Without adequate staffing and funding, the new tribunal, for example, will fail to improve patient safeguards, and mental health could remain the “Cinderella service” of the NHS.

The draft Bill proposes several changes in professional roles. We broadly favour these changes, and believe that they are in line with modern interdisciplinary and team-based working practices. We recommend that the Bill should be amended so as to provide for the creation of national training standards and monitoring.
Background

The Committee’s inquiry

1. We were appointed on 22 July 2004 “to consider and report on any draft Mental Health Bill presented to both Houses by a Minister of the Crown” and to do so by 31 March 2005. The draft Bill was published on 8 September 2004, and the Committee first met on 15 September.

2. From the outset, we recognised that it was vital to ensure that all those with an interest in the draft Bill had an opportunity to contribute to the inquiry. We therefore issued a call for written evidence from all interested parties.

3. We received over 450 written submissions, and held 15 oral evidence sessions starting on 20 October 2004. We took oral evidence from a very broad range of witnesses, ranging from mental health user groups and national professional bodies to the Welsh Language Board. In all, we took oral evidence from 124 witnesses, and we made a particular effort to include among these as many individuals who have used mental health services and who have been subject to compulsion under the Mental Health Act 1983 as possible. There was also an international dimension to these proceedings, with some witnesses providing us with insight into the experiences of the legal and mental healthcare frameworks operating in Australia and Canada. We also took evidence from the Scottish Executive which is about to complete the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, which constitutes a major change in Scottish mental health law.

4. We are publishing, in additional volumes of this Report, most of the memoranda received, as well as the transcripts of the oral evidence (which were produced by Gurney’s shorthand writers and the text corrected as appropriate by witnesses). The full list of memoranda and witnesses appears on pages 279 to 294.

5. We took evidence from three Ministers – Ms Jane Hutt AM, at the time Minister for Health and Social Services, Welsh Assembly Government, Ms Rosie Winterton MP, Minister of State at the Department of Health and Mr Paul Goggins MP, Parliamentary Under-Secretary at the Home Office.

6. We are very grateful to all those who submitted oral or written evidence. We would also like to express our thanks to our two Specialist Advisers: Professor Thomas Burns, Professor of Social Psychiatry, University of Oxford, and Visiting Professor of Social Psychiatry, St. George’s Hospital Medical School, London, and Professor Philip Fennell, Professor of Medical Law and Human Rights at Cardiff Law School, University of Wales.

7. At an early stage of the inquiry, the Committee decided to take the opportunity to visit a representative range of mental health facilities in England and Wales to discuss the potential impact of the draft Bill with a wider range of potential interlocutors than would be possible in Westminster, and to learn more about the existing facilities and the operation of current legislation. We therefore visited the South London and Maudsley

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1 Draft Mental Health Bill, Cm 6305, September 2004
2 An extract from the Press Notice which the Joint Committee issued on 16 September 2004 is at annex 1.
NHS Trust on 24 November 2004, Whitchurch Hospital, Cardiff, on 15 December 2004 and Broadmoor Hospital on 9 February 2005. We would like to thank all service users, patients and staff who facilitated the visits and took the time to talk to us.

Overview

8. Mental health legislation has at least three centuries of history behind it. Many of the issues which the current Government and this Joint Committee have had to address would be familiar to our predecessors since at least the beginning of the 19th century. At the heart of these is the question of how we as a society balance the care and the control of people suffering mental distress or disorder. It is an issue which raises fundamental questions about personal autonomy and liberty, the role of the state and the extent of its powers and responsibilities, public attitudes towards people who are mentally-ill, developments in medical and behavioural sciences, the clinical judgment of medical practitioners and other professionals and complex questions of medical science, ethics and belief.

Origins

9. The history of legislation in the United Kingdom authorising detention of people with mental disorders reaches back to the Vagrancy Act 1744, which allowed unregulated confinement of the “furiously and dangerously mad”. Legislation in the 18th and early 19th centuries progressed from pure confinement to an emerging concern about the abuse of the mentally disordered in asylums. By the beginning of the 19th century people with mental illness were beginning to be seen as a separate group, whose needs were not met in workhouses or Houses of Correction. The County Asylums Act of 1808 provided for asylums to be built in “airy and healthy” locations, to which patients who were too “dangerous to be at large” were admitted. The emerging emphasis on the protection of “lunatics” against abuse led to a requirement in the 1828 Madhouses Act for all asylums and private hospitals to have a medical officer. Patients who recovered were to be discharged by the visiting justices. In 1845, the Lunatics Act marked another significant shift with the creation of a national system of inspection of standards in the form of the Lunacy Commission.

10. By the middle of the century parliamentary committees were grappling with problems with which we as a Committee have also become familiar. These included:

- shortage of resources and spaces; mentally-ill people were overflowing into workhouses and prisons, which were unsuitable to their needs;
- controversy around certain forms of treatment, particularly the use of restraint;
- inadequate mechanisms to ensure the release of patients who had recovered;
- tensions between lawyers, doctors and lay people, in particular the lay reformers;
- inadequacy of inspection;

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3 We also held an oral evidence session in Wales at the National Assembly for Wales on 15 December 2004; see also annex 2.

4 In 1576 an Act enabled Houses of Correction or “Bridewells”, administered by local justices of the peace, to be built where able-bodied “idlers” and the unemployed were sent and put to work.
• the quality and training of staff in asylums - the Earl of Shaftsbury, who was a key figure in the reform of lunacy laws, urged the importance of a “school for students of lunacy”; and

• negative public perceptions of mentally-ill people.

Nonetheless, mental health services built around former asylums predominated in England until the 1990s and, as we found, they still predominate in Wales, although the National Assembly for Wales is moving forward to replace them.5

11. Scandals, and concerns about wrongful detention, facilitated the next key legislative development in the form of the 1890 Lunacy Act. It introduced judicial and medical certification of patients.

12. The traumatic effects of trench warfare on soldiers during the First World War gave a huge impetus to the development of the specialism of psychiatry, which was reflected in the Mental Treatment Act 1930 which also built on, and encouraged, an emerging willingness to integrate rather than segregate people with mental disorders by bringing mental health care closer to general health services. The abandonment of the terms “lunatic” and “asylum” in favour of “person of unsound mind” and “mental hospital” illustrated the emerging awareness of the stigma attached to mental disorders. But even as late at 1948, it was a matter of debate as to whether mental health services should form part of the new NHS.

13. The domination of the medical profession in the treatment of mental illness was strengthened by the 1950s “psychotropic revolution”, with the arrival of the first effective anti-psychotics and antidepressants. The “medical” model saw mental illness as a disease which could be treated.

14. The Percy Commission, set up to review mental health legislation, in its 1957 report recommended a move towards a more flexible system allowing treatment without the stigma of certification, and a move away from the dominance of mental hospitals towards care in the community. The Mental Health Act 1959 provided the legislative framework for the treatment of mentally-ill people which, with some adjustments in the Mental Health Act 1983, remains in place today. Certification was replaced by an application to the receiving hospital by the patient’s nearest relative or social worker, and supported by two medical recommendations. There were three types of compulsory admission (known colloquially as “sectioning”): for observation, emergency observation, and treatment.

15. The 1959 Act was a major shift in the way society looked at mental illness. This reflected not only developments in psychiatry, but broader changes in values, beliefs and structures. Those changes, which had provided an impetus for the Percy Commission and the 1959 Act, were also key in prompting the move towards de-institutionalisation which brought mental health care into the community.

16. The Mental Health Act 1983 Act did not mark the creation of a fundamentally different treatment model, but rather updated aspects of the 1959 Act. The main changes were the introduction of new and improved safeguards, driven in part by rulings of the European
Court of Human Rights\(^6\) and in part by a series of statutory inquiries which had uncovered abuses in psychiatric hospitals.\(^7\) Improvements included wider access to review by tribunals and the re-establishment of a national inspection and visiting authority in the form of the Mental Health Act Commission, which the 1959 Act had abolished. Health and social services authorities were placed under a duty to provide after-care for patients who were detained other than for assessment under the 1983 Act.\(^8\)

### The post-1983 policy environment

17. Through the 20th century, mental disorder became more medicalised with an emphasis on treatment and de-institutionalised, through the move from segregated asylums to community services via mainstream hospitals. But the medical model has not held the monopoly. A social model of mental illness emerged in the 1960s which at its most extreme saw mental illness as a product of social attitudes and conventions and mental health legislation as social control of deviants. Although divisions of opinion between the two models have at times been sharp – particularly in the 1970s and 1980s – these models have helped to develop the public understanding of mental illness, to provide a shift towards individual autonomy and to extend the full panoply of human rights to a group which previously had been actively excluded. Since the 1983 Act, the attention given to the human rights of people with mental illness has continued to develop and gather momentum. At the same time, a number of well-publicised homicides have produced demands for greater protection of the public from those who are mentally-ill and dangerous. This is an issue which has challenged us acutely.

### Reducing stigma

18. Despite the legislative changes since the 1950s, there remains to this day a considerable degree of stigma attached to mental disorder. The Government has recognised this and has stated, as reflected in the National Service Frameworks\(^9\) and the Report of the Deputy Prime Minister’s Social Exclusion Unit, a determination to combat social exclusion suffered by mentally disordered people,\(^10\) recognising: “the need for determined action to end the stigma of mental health – a challenge not just for Government, but for all of us”.\(^11\) We strongly endorse that objective.

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\(^{6}\) For example, X v. United Kingdom (1981) 4 EHRR (European Human Rights Reports) 188

\(^{7}\) The first major case concerned ill-treatment at the Ely Hospital in Cardiff; the Government’s response to the inquiry was announced in March 1969 (The Times, 28 March 1969)

\(^{8}\) R v Manchester City Council ex parte Stennett [2002] UKHL 34

\(^{9}\) National service frameworks are long term strategies for improving specific areas of care which set national standards and identify key interventions for a defined service or care group; put in place strategies to support implementation; establish ways to ensure progress within an agreed time-scale; form one of a range of measures to raise quality and decrease variations in service; introduced in The New NHS and A First Class Service. The NHS Plan re-emphasised the role of NSFs as drivers in delivering the Modernisation Agenda. (http://www.publications.doh.gov.uk/nsf/)


\(^{11}\) Office of the Deputy Prime Minister: report of the Social Exclusion Unit, Mental Health and Social Exclusion, 9 June 2004, foreword by the Prime Minister
Public protection and risk management

19. Mental health legislation over the past two centuries has been subject to much media interest and public comment, combining concerns over the potential abuse of psychiatric patients in hospital, with concern about the risk posed to the public by mentally disordered people in the community. Two homicides, in particular, committed by persons with severe mental disorders, fuelled this debate. First, in 1992, Jonathan Zito was killed by a complete stranger, Christopher Clunis, who was suffering from schizophrenia. The inquiry into the case identified a catalogue of failures to provide adequate care for Mr Clunis, including the absence of an after-care plan, and failure by the authorities to manage or oversee the provision of health and social services for him. Second, Michael Stone was convicted of the homicides of a mother and her daughter in 1996. It emerged that Stone had previously been detained under the Mental Health Act, but had been released because it was deemed that his psychopathic disorder could not be alleviated by compulsory treatment. The 1983 Act only permits detention if there is a likelihood that medical treatment will alleviate or prevent deterioration in the patient’s condition. The existence of this “treatability” clause in the 1983 Act has been repeatedly criticised as a barrier to the availability of treatment to patients with a personality disorder. Concerns about the protection of the public, provoked partly by the two cases described above, led to changes in practice and policy, and became a powerful driver for reform of mental health legislation.

20. The key changes introduced in the course of the 1990s were as follows.

a) **The Care Programme Approach** was comprehensively established across secondary services in England. All seriously ill patients were to have an assessment of needs and risks, and a plan for their management was to be recorded in a “care plan” with a named person responsible for its delivery and systematic review.

b) **Supervised Discharge** was introduced, providing the power to require the patient to live at a specific address, to allow access for monitoring and the power to take and convey the patient to hospital if he did not attend for medical treatment as required.

c) **Mandatory external enquiries** were required for all homicides committed by individuals who had been in contact with the mental health services in the year preceding the fatal incident.

21. This period also saw the emergence of the concept of Dangerous People with Severe Personality Disorders (DSPD). DSPD is not a single diagnostic category, and whilst it includes diagnoses of psychopathy (now called antisocial personality disorder), it goes beyond these. The Government had been considering for some time the problems posed by people with this category of disorder, which had been identified primarily in prisons and special hospitals. The Stone case provided a focus for public debate about DSPD, and led to a Home Office discussion paper in 1999, “Managing Dangerous People with a Severe Personality Disorder: Proposals for Policy Development,” July 1999.
Personality Disorder”. The Home Office has subsequently researched risk management strategies for this group of people, and pilot schemes have been set up in an attempt to provide some forms of treatment for serious offenders with DSPD.

**Human Rights Act 1998**

22. The Human Rights Act 1998 incorporated the European Convention on Human Rights into UK law, and gave direct access to the Convention rights in the domestic courts as well as Strasbourg. Since October 2000, there has been a considerable body of case law in the English courts testing the provisions of the 1983 Act against the duty in the Human Rights Act 1998 for public authorities (including courts and tribunals) to give effect to Convention rights. The Mental Health Act Commission explained to us that:

> “Aspects of the 1983 Act require urgent amendment. In particular, the 1983 Act’s provision regarding ‘Nearest Relatives’ have been deemed incompatible with ECHR Article 8, and it may be that the current Tribunal arrangements will not withstand challenges based upon the requirements of Article 5 of the ECHR. It would be possible to deal with such matters through an amendment Bill, if perhaps no less complicated than redrafting the law as a new Bill”.

23. The main focus of the case law, and of the evidence we received, has been on Articles 3, 5, 8 and 14 of the Convention.

**Article 5 and the right to liberty and security of the person**

24. The only Convention Article which expressly mentions mentally disordered people is Article 5 which provides as follows:

> “1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: […]

> (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;”

> “4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful”.

25. The European Court of Human Rights has built up a considerable body of legal safeguards around the power to detain on the ground that a person is of unsound mind.

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14 Home Office, *Managing Dangerous People With Severe Personality Disorder :Proposals for Policy Development, July 1999*

15 The DSPD programme is aimed at people who have committed a violent and/or sexual crime and have been detained under the criminal justice system or current mental health legislation. The programme is currently setting up pilot projects in prison and high security hospital settings to identify, assess and treat people who meet the DSPD criteria. There are now four pilot units open at Broadmoor and Rampton Hospitals, Frankland and Whitemoor prisons, assessing and treating offenders who meet the DSPD criteria. In total there are now over 250 places, and the assessment and treatment programmes are under active development. See [http://www.dspdprogramme.gov.uk/home/upgrade_flash.php](http://www.dspdprogramme.gov.uk/home/upgrade flash.php)

16 Ev 13 (Mental Health Act Commission), para 4.2
The following criteria are necessary for a deprivation of liberty, on grounds of unsoundness of mind, to be lawful.

(1) Objective medical evidence of a true mental disorder must have been presented to a competent authority.

(2) The mental disorder must be of a kind or degree warranting confinement.

(3) There must be a periodic review of the continued need to detain a patient to verify that the conditions of detention continue to apply.\(^\text{17}\)

(4) Detention must be a proportionate response in all the circumstances.\(^\text{18}\)

**Article 3 and the prohibition of torture or inhuman or degrading treatment**

26. Article 3 prohibits torture or inhuman or degrading treatment. English courts have accepted that treatment without consent can breach Article 3 if it is not a therapeutic necessity and reaches a minimum level of severity causing physical or recognised psychiatric injury.\(^\text{19}\)

**Article 8 and the right to respect for private and family life**

27. Article 8 of the ECHR provides:

“1. Everyone has the right to respect for his private and family life, his home and his correspondence.

“2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”.

The right to respect for private life includes the right to self determination in relation to decisions about medical treatment.\(^\text{20}\) Article 8 requires compulsory treatment to be carried out “in accordance with law”. This means that the law must be sufficiently clear to be predictable in its effects, so that patients will know the circumstances in which they may be treated without consent, and the grounds on which such treatment must be based (i.e. protection of own health or the protection of others). The patient must be able to tell which of the Article 8(2) grounds is relied upon.

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17 (1) – (3) are the “Winterwerp criteria” laid down by the European Court of Human Rights in Winterwerp v the Netherlands (1979) 2 EHRR 387

18 In Litwa v Poland (2000) ECHR 240 the European Court held that detention of an individual is such a serious measure that it is only justified where other, less severe, measures have been considered and found to be insufficient to safeguard the individual or public interest which might require the person concerned to be detained. The deprivation must be shown to be necessary in the circumstances.


20 Glass v United Kingdom [2004] 39 EHRR 15
**Article 14 and the prohibition of discrimination**

28. Article 14 of the ECHR provides:

“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status”.

**Towards a new Mental Health Act**

29. In 1998 the Government appointed an Expert Committee, chaired by Professor Genevra Richardson to review mental health legislation. The objective of the Committee was to produce proposals for reform which would comply with the newly-incorporated Convention rights, and which would, in the words of the then Parliamentary Under-Secretary of State for Health, ensure that “non-compliance can no longer be an option when appropriate care in appropriate settings is in place”.21 The Expert Committee recommended a system which would provide a “single pathway” to compulsory treatment, whether in hospital or in the community. It also recommended that, as far as possible, a new Act should be based on notions of autonomy and non-discrimination, an approach which was endorsed by the Health Committee of the House of Commons in its report, “Provision of NHS Mental Health Services”, in 2000.22

30. The Government subsequently published a Green Paper23 a White Paper,24 and, in 2002, a draft Bill.25 Each reflected the Government’s rejection of some recommendations of the Expert Committee, although it also adopted others such as the broad definition of mental disorder and a single gateway to treatment. Critics were concerned about the prominence given by the Government to considerations of risk and protection of the public.26 The 2002 draft Bill went for consultation, to re-emerge in September 2004 as the current draft Bill. The Government is clear that reform of the Mental Health Act 1983 is needed, and it states the objectives of the proposed new legislation as providing:

“a comprehensive new legal framework in line with modern practice and developments in human rights law. It ensures that there is no compulsion without the provision of appropriate treatment and it strengthens support and safeguards for patients”.27

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22 Health Committee, Fourth Report of Session 2000-01, Provision of NHS Mental Health Services, HC 373, para 117
23 Department of Health, Reform of the Mental Health Act 1983: Proposals for Consultation, Cm 4480, November 1999
24 Department of Health, Reform of the Mental Health Act, Cm 5016, December 2000
25 Draft Mental Health Bill, Cm 5538, June 2002
27 Department of Health, Improving Mental Health Law: Towards a new Mental Health Act, September 2004, Ministerial Foreword
31. Many witnesses to the inquiry agreed that the current Mental Health Act has reached the end of its useful life. The Royal College of Psychiatrists explained that:

“the practice of psychiatry (new treatments, more multi-disciplinary working, much greater patient and carer involvement) and the expectations and aspirations of patients, their families and staff have changed substantially. Medicine as a whole, of which psychiatry is an integral part, has recognised the central importance of both patient choice and the patient/doctor partnership in decision making. Discrimination and stigma are unacceptable and their elimination must be our goal”.28

However, we also received evidence from those who do not believe that there is any need for a wholesale reform of mental health legislation at this stage. Mr David Hewitt, a partner in Hempsons, solicitors, suggested that:

“The Government need not introduce a new Act; it could make all the truly necessary changes by amending MHA 1983. It did so before, when it introduced Supervised Discharge and reversed the burden of proof in MHRT proceedings”.29

32. We consider that the case for reform of the Mental Health Act is cogent but is by no means overwhelming. On balance, we accept that it is desirable for thorough legislative reform to be implemented and we believe it is appropriate that Parliament take the opportunity offered by the draft Bill to set important aspects of mental health policy on a new course for the next 20 years or so.

33. We also accept that the public (including people with mental disorders) needs to be protected from the extremely small minority of mentally disordered people who pose a serious risk of harming others. We fully accept the need to incorporate effective risk management and public protection into mental health policy and a new Mental Health Act. However, this objective must never be allowed to predominate as the primary objective of reform.

The draft Mental Health Bill 2004

34. The draft Mental Health Bill applies to England and Wales and would replace most of the Mental Health Act 1983, which made provision for the compulsory detention and treatment in hospital of some people with mental disorder. The draft Bill would not replace the provisions for the management of property and affairs of patients. These are subsumed by provisions in the Mental Capacity Bill,30 which was before Parliament when we were considering the draft Bill.

35. We have to record that we found the draft Mental Health Bill difficult to read and to follow. We hope that any Bill the Government presents to Parliament will be clearer and easier to read and follow than the current draft Bill.

28 Ev 50 (Royal College of Psychiatrists), Introduction
29 Ev 279, (Mr Hewitt), para 1.3
30 Mental Capacity Bill [Lords] [Bill 1 (2004-05)]
36. The draft Mental Health Bill has thirteen parts. Part 1 requires the appropriate authority - either the Secretary of State for Health or, in relation to Wales, the National Assembly for Wales - to issue codes of practice. The codes will set out the guiding principles for all decisions concerning the use of formal powers, and provide guidance as to the discharge of functions under the Bill. This Part also introduces definitions for some terms used throughout the draft Bill, including mental disorder and medical treatment. Part 1 provides for the creation of the Mental Health Tribunal (“the tribunal”) (one in England and one in Wales), an Expert Panel to advise the tribunal, and the Mental Health Appeal Tribunal (MHAT).

37. Part 2 sets out the procedures for the use of formal powers for patients who come through the civil route into compulsion (patients who come through the criminal justice system are covered by Part 3). It consists of three main stages: examination, initial assessment and assessment and treatment, under the order of the tribunal. Part 2 covers the following.

- The relevant conditions which must be satisfied before any of the formal powers can be used (clause 9).
- The arrangements for the examination of a patient, who should examine the patient and the decisions to be made. Where the examiners decide that the relevant conditions are met, the patient will be liable to formal assessment.
- The arrangements for a period of assessment and treatment under the supervision of a clinical supervisor. It details, too, the determinations to be made on assessment, such as whether treatment should be provided under the Bill and, if so, what treatment. Subject to Part 5, the patient may be treated without the patient’s consent during the assessment period on the basis of an individual care plan.
- The procedure available to a patient to apply for discharge from initial liability to assessment via an application to the tribunal.
- The procedure for authorisation of treatment and assessment under formal powers after the initial assessment period - either by application to the tribunal for orders authorising the medical treatment of the patient or an extended period of assessment.
- The discharge of orders ending assessment or treatment under formal powers.
- Deferred discharge of orders while post-discharge services are being organised.
- Tribunal proceedings generally.
- Powers to permit the transfer of patients between hospitals, the enforcement of a requirement on a non-resident patient to attend hospital, and the return of patients who are absent without leave.

38. Part 3 provides for the management and treatment of patients concerned in criminal proceedings. It retains the sentencing options and mental health disposals which are available to the courts under the 1983 Act. However, these disposals are set in the context of a new framework for dealing with mentally disordered people who are before the courts
or sentenced to prison. Such people will, as far as possible, be treated in the same way as patients who are not concerned in criminal proceedings. Chapter 1 sets out a new system of remand to hospital for mental health reports, and for remand and committal to hospital for medical treatment, thereby ensuring that the court can have access to a full report on the defendant's mental health before deciding on the disposal which it will make in respect of that person. It also sets out the courts' powers in respect of absconders. Chapter 2 sets out the conditions under which the courts can make mental health disposals (mental health orders) or penal disposals with a mental health component (hospital directions), and the effects of these disposals on the patient. It provides for the courts to make a restriction order in respect of the patient, thereby giving the Home Secretary powers over the management of the patient. It sets out the patient's right of appeal against a disposal made by the magistrates' courts where the person has not been convicted of an offence. Chapter 3 provides for persons detained in prison to be transferred to hospital for report or treatment, and sets out the restrictions on their discharge as well as the provisions for termination of transfer directions. Chapter 4 deals with applications to the tribunals and the tribunals' powers in dealing with applications and references concerning restricted patients. Chapter 5 provides supplementary information on interpretation and also provides for various miscellaneous court powers.

39. Part 4 deals with the transfer of patients who are subject to formal powers in England and Wales to and from "relevant territories", i.e. Scotland, Northern Ireland, any of the Channel Islands and the Isle of Man.

40. Part 5 provides for the delivery of treatment. It sets out the circumstances in which treatment under formal powers may be given. Provision is made for the authorisation and delivery of treatments such as electroconvulsive therapy (ECT) and psychosurgery, to which special safeguards apply.

41. Part 6 provides for the treatment of people aged under 18. The effect of clause 202 is that the decisions of patients aged 16 and 17 relating to the giving or withholding of consent will be treated as if they were adults. A person under 16 who meets the conditions set out in clause 207 will be treated as a "qualifying child patient" - with the safeguards under Chapter 2 of this Part. The consent of at least one parent or other person in a position of parental responsibility is required.

42. Part 7 provides for powers to enter property and to transport and detain people which may be required in relation to patients who may need care and treatment. It provides the police with powers to enter and remove a person so as to enable them to deal with a mentally disordered person who is in need of care and treatment but not receiving it. Such a person can be removed to a place of safety and detained there for up to 72 hours pending an examination.

43. Part 8 sets out the arrangements for patients to have access to support and representation. Chapter 1 is concerned with nominated persons appointed to act on behalf of patients subject to formal powers (apart from restricted patients) or who qualify to act as safeguards for children under 16. Chapter 2 makes provision for the availability of independent mental health advocates to patients and to their nominated persons.
44. Part 9 sets out the arrangements for appeal on points of law against decisions of the tribunal and the Mental Health Appeal Tribunal.

45. Part 10 deals with the abolition of the Mental Health Act Commission (MHAC) set up under the 1983 Act and makes provision as to the functions of the Commission for Healthcare Audit and Inspection (CHAI). CHAI is the healthcare inspectorate established under the Health and Social Care (Community Health and Standards) Act 2003 to promote improvement in the quality of both the NHS and private and voluntary healthcare across England and Wales. The draft Bill would require CHAI to exercise certain functions – for example, the gathering of information and the carrying out of investigations – in relation to mental health.

46. Part 11 creates offences under the draft Bill. Clause 278 deals with the offence of obstruction. Clauses 279 to 281 deal with forgery and false statements, ill-treatment and wilful neglect of patients and assisting patients to absent themselves without leave.

47. Part 12 deals with supplementary issues.

- Chapter 1 makes provision for the rectification of documents which are found to be incorrect or defective.
- Chapter 2 imposes various duties to provide patients and their nominated persons with information and explanation so that they may understand how the provisions in the draft Bill may affect patients; and the sharing of information about patients.
- Chapter 3 provides for the control of patients’ correspondence in the interests of the safety of the patient or for the protection of other people. It also covers the payment of occasional personal expenses to resident patients who would otherwise be without resources.
- Chapter 4 sets out the arrangements in relation to Members of Parliament and members of the devolved legislatures who are subject to formal powers under the Bill or to corresponding provisions in the other countries.
- Chapter 5 provides that in any civil proceedings against a member of staff who purports to act under or in pursuance of the draft Bill, the individual may have a defence of good faith and reasonable care. It also sets out provisions in relation to inquiries held in connection with any matters arising under the Bill.

48. Part 13 sets out general provisions.

49. The Schedules set out further details for the exercise of powers and duties under the draft Bill.

**Territorial application: Wales**

50. To ensure that the administration of an independent review process remains responsive to local needs, clause 4 provides for the creation of two separate tribunals, one being the tribunal for England, the other the tribunal for Wales.
51. In relation to the functions of CHAI in investigations, clause 263 requires that copies of reports produced by CHAI regarding functions exercised in relation to Wales (under clause 260) or investigations into deaths in relation to a patient in a Welsh hospital (under clause 262) should be sent to the National Assembly for Wales.
2 Principles and codes of practice

Introduction

52. Clause 1 of the draft Bill provides for the publication of codes of practice by the relevant authorities, which in respect of England means the Secretary of State, and in respect of Wales the National Assembly for Wales. The clause provides that the codes of practice must:

“[…] set out general principles to which a person must have regard whenever coming to a decision under or in pursuance of this Act in respect of a patient”.

The draft Bill sets out three overarching principles which are to be safeguarded by the principles in the codes of practices. These are that:

a) patients are involved in the making of decisions,

b) decisions are made fairly and openly, and

c) the interference to patients in providing medical treatment to them and the restrictions imposed in respect of them during that treatment are kept to the minimum necessary to protect their health or safety or other persons.

Principles

53. The approach in the draft Bill differs fundamentally from the recommendations of the Expert Committee\(^\text{31}\) as well as the approach adopted in the new Scottish mental health legislation,\(^\text{32}\) where a full set of fundamental principles to which practitioners must have regard are set out on the face of the new Act. Table 1 below provides a comparative overview of the principles in the Scottish Act, the proposals made by the Expert Committee and the Mental Health Alliance, and the broad principles set out on the face of the draft Bill.

### Table 1: Principles on the face of mental health legislation - proposals and practice

<table>
<thead>
<tr>
<th>Draft Mental Health Bill 2004</th>
<th>Expert (Richardson) Committee 1999</th>
<th>Scottish Mental Health (Care and Treatment) (Scotland) Act 2003</th>
<th>Mental Health Alliance proposed principles(^\text{33})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General principles to be set out in code of practice must secure:</strong></td>
<td><strong>Principles to be contained on the face of the Bill:</strong></td>
<td><strong>Principles on the face of the Act. Practitioners must have regard to:</strong></td>
<td><strong>Principles to be contained on the face of the Bill:</strong></td>
</tr>
<tr>
<td>Patient involvement in decision-making</td>
<td>Patient autonomy</td>
<td>Past and present wishes of patient</td>
<td>Respect for autonomy</td>
</tr>
<tr>
<td>Participation by service users</td>
<td>Importance of full patient participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interference with, and restrictions of, patient</td>
<td>Least restrictive alternative</td>
<td>Minimum restriction of the freedom of the</td>
<td>Least restrictive and least invasive</td>
</tr>
</tbody>
</table>

\(^{31}\) Department of Health: Report of the Expert Committee: Review of the Mental Health Act 1983, December 1999, Chapter 2; See also Q 1 (Professor Richardson)

\(^{32}\) Mental Health (Care and Treatment) (Scotland) Act 2003

\(^{33}\) Ev 119, para 2.3
### General principles to be set out in code of practice must secure:

<table>
<thead>
<tr>
<th>Principles to be contained on the face of the Bill:</th>
<th>Principles on the face of the Act. Practitioners must have regard to:</th>
<th>Principles to be contained on the face of the Bill:</th>
</tr>
</thead>
<tbody>
<tr>
<td>must be kept to minimum necessary to protect their health or safety or other persons.</td>
<td>patient necessary in the circumstances</td>
<td>alternative</td>
</tr>
<tr>
<td>Informal care wherever possible</td>
<td>Compulsion as a last resort</td>
<td></td>
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<tr>
<td>Consensual care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reciprocity</td>
<td>Importance of providing maximum benefit to patient</td>
<td>Reciprocity</td>
</tr>
<tr>
<td></td>
<td>Importance of providing appropriate services to patient</td>
<td></td>
</tr>
<tr>
<td>Fair and open decision-making</td>
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<tr>
<td>Non-discrimination</td>
<td>Non-discrimination</td>
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<tr>
<td>Respect for Diversity</td>
<td>Respect for Diversity</td>
<td></td>
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<tr>
<td>Encouragement of equal opportunities</td>
<td>Equality</td>
<td></td>
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<tr>
<td>A holistic approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Views of patient’s named person, carer, guardian, welfare attorney</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs and circumstances of patient’s carer</td>
<td>Rights for carers</td>
<td></td>
</tr>
<tr>
<td>If patient is a child, the best way to secure their welfare</td>
<td></td>
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<td></td>
<td></td>
<td>A right to information</td>
</tr>
</tbody>
</table>

**The significance of general principles**

54. The Minister of State at the Department of Health, Ms Rosie Winterton MP, acknowledged the importance of basic principles. She explained to the Committee why the Government opted to have only three very broad statements of principle on the face of the Bill, leaving the fully articulated set of principles to be set out in the codes of practice:

“I am not opposed in principle to having the principles on the face of the Bill but we felt that it was better to have them in the code of practice because it may well be that, as practice develops over time, we might want to look at whether it was necessary to alter the emphasis of some of the principles and it is easier to do that with the code of practice. […] If we were to have the principles on the face of the Bill, I would want them to reflect the balance between the need for patient autonomy and the principles of least restriction and so on, but balancing that with the right of society as well in terms of public [safety] […] If they were to be on the face of the Bill, I just would
want to be clear that it would be about reflecting that balance that runs throughout the Bill between those two very sensitive issues”.  

55. A broad range of witnesses disagreed with the Government on this point, and we received many representations emphasising the vital need for basic key principles to be set out on the face of the Bill, rather than being placed in the codes of practice. Some witnesses pointed to precedents for guiding principles to be set out on the face of Acts. In England and Wales, both the Children Act 1989 and the Mental Capacity Bill, currently before Parliament, set out principles within the legislation itself, as does the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003. The Law Society believed that it would be extraordinary if the draft Bill were to become law without a clear statement of principles on the face of the Bill.

56. When considering the background to this Bill in chapter 1, we acknowledged the need to balance a number of different objectives, in particular the autonomy of the patient and the protection of the public from the small minority of mentally-ill people who pose a danger to others. The Government believes that this balance can be best maintained by not having guiding principles on the face of the Bill.

57. Some of those giving evidence to the Committee also acknowledged the need to balance the various objectives, but did not see this as a hindrance to setting out the fundamental guiding principles on the face of the Bill. Ms Lucy Scott-Moncrieff, Joint Chair of the Mental Health and Disability Committee of the Law Society, commented:

“Of course, there are rights on both sides and it is a matter of balance but to underline the fact that there are rights on both sides and not just on one side does not seem to me to be a bad thing to do. The ECHR could be said to have conflicting principles: rights of freedom of speech, the right to publish what you like or whatever and the right to privacy, but it is a balancing act. Both rights are on the face of the document so they are both things that have to be taken into account”.

58. The Minister suggested that the principles were better placed in the codes of practice because it might become necessary to alter them with the passing of time, and it would be easier to do so if they were not on the face of the Bill. We are concerned by the suggestion that fundamental guiding principles for a major piece of legislation might be changed.

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34 Q 818
35 See for example: Ev 594 (British Psychological Society), section 1; Ev 50 (Royal College of Psychiatrists), summary para 20; Ev 210 (No Force), para 1.1; Ev 259 (Sainsbury Centre for Mental Health), para 1.1; Ev 817, (IRRHC), section 2; Ev 895 (Depression Alliance Cymru); Ev 189 (Mind); Ev 299 (Mencap), question 4; Ev 427 (Council of Tribunals), para 7; Ev 659 (Professor Thornicroft), section 3; and Q 143 (Dr Daw, Mental Health Alliance)
36 Q 181 (Mr Spencer-Lane, Law Society)
37 Mental Capacity Bill [Lords], [Bill 1 (2004-05)]
38 Q 34 (Professor Patel, Mental Health Act Commission)
39 Q 181 (Ms Scott-Moncrieff and Mr Spencer-Lane)
40 Q 147 (Dr Shooter, Mental Health Alliance)
41 Ms Scott-Moncrieff gave evidence to the Joint Committee on two occasions: the first on 3 November 2004 in her capacity as Joint Chair of the Mental Health and Disability Committee of the Law Society and, secondly, on 17 November 2004 as a solicitor in private practice.
42 Q 183
without the full scrutiny and consideration of an Act of Parliament. The Royal College of Psychiatrists put it thus:

“They are very fundamental principles and we cannot see that they will lose either their authority or their appropriateness, but if times were to change, then we would feel very strongly that such matters should be discussed by Parliament, and it would be for Parliament to decide that they had now become inappropriate rather than for them either to be ignored or set aside in some lesser fashion”.

Our evidence pointed to a number of key reasons for setting out fundamental principles on the face of the Bill. First, mental health legislation and services are surrounded by fear, stigma and prejudice, and witnesses emphasised the very powerful and important signal value of having clear and explicit guiding principles on the face of the Bill which set out the ethical standards that apply when a person is deprived of his liberty and autonomy under the Act. The values signalled would be transmitted not only to service users and practitioners, but also to the public at large. Dr Rowena Daw, Chair of the Mental Health Alliance’s Policy Group, also explained that “it will help give service users much more confidence in the law”.

59. There are also human rights concerns about the relegation of principles to the Codes of Practice. When the Government introduced the 2002 draft Mental Health Bill it adopted an almost identical approach of reserving the principles to the codes of practice. That approach led the Joint Committee on Human Rights (JCHR) to express reservations about:

“The capacity of the proposed Code of Practice to give sufficient protection to the human rights of patients in the decision-making processes envisaged by the draft Bill. We recommend that these matters be clarified on the face of the legislation when a Bill is introduced to Parliament”.

60. Bevan Brittan Solicitors believed that, given that the key effect of the draft Bill was the deprivation of liberty under Article 5(1) of the ECHR, leaving fundamental decisions to codes of practice would make the legislation susceptible to legal challenges.

61. We cannot see that the Government has sought to address directly either the JCHR’s concerns or those submitted in the memoranda we received, other than to state that it believes that the provisions in the Bill meet the requirements of the Convention.

62. Practitioners from both the legal and the clinical professions argued that one of the key functions of principles, as set out on the face of legislation, is to guide practitioners when

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43 Q 73 (Dr Zigmond); see also Q 74 (Dr Zigmond)
44 Q 73 (Dr Zigmond, Royal College of Psychiatrists); Q 145 (Mr Farmer, Mental Health Alliance)
45 Q 145 (Mr Farmer, Mental Health Alliance)
46 Q 143 (Dr Daw, Mental Health Alliance)
47 Draft Mental Health Bill, Cm 5538, June 2002
48 Twenty-fifth report of the Joint Committee on Human Rights, Session 2001-02: Draft Mental Health Bill, 11 November 2002 HL 181, HC 1294, para 22
49 Ev 1047, question 7
50 Department of Health, Improving Mental Health Law: Towards a new Mental Health Act, September 2004, para 1.1
working with the legislation on a daily basis. The Royal College of Psychiatrists emphasised the benefit of:

“real transparency for everybody as to the principles which would enable us, or indeed require us, to use compulsion as opposed to those where we would quite properly say, "No, not appropriate here".\(^{52}\)

Clinicians and practising lawyers are not the only groups to see advantages in having principles set out in the Bill. The Council on Tribunals submitted that “since the Code of Practice will not bind the Mental Health Tribunal, it would greatly assist the tribunal in carrying out its judicial functions under the Act if a clear statement of the guiding principles were specified in the legislation itself”.\(^{53}\) The Mental Health Act Commission indicated that the very existence of different and potentially conflicting objectives in the Bill might in fact provide all the more reason for principles to be set out on the face of the Bill:

“We recognise that there is a public safety concern but, primarily, what is the Bill concerned with? Primarily, the Bill must be concerned with maximising the autonomy of people who have suffered from mental disorder or suffer mental disorder, and we feel that putting those principles on the face of the Bill provides that direction, that tone. It will then assist everybody to understand what was the primary purpose of the Bill, notwithstanding there are secondary purposes”.\(^{54}\)

We have considered carefully the submissions on the need to have fundamental principles on the face of the Bill. The Children Act 1989 and the Mental Capacity Bill have shown that putting principles on the face of a major piece of complex legislation serves a clear purpose, in that it helps to make clear to everyone implementing the Act, what the legislation is trying to achieve and what considerations should guide their actions. This now well-established approach to framing legislation should only be jettisoned if there are sound and compelling reasons for taking a different approach. We believe that it is essential that fundamental principles be set out on the face of the Bill. It is not appropriate to leave fundamental guiding principles to the codes of practice.

The nature of the principles

On the question of which principles should be on the face of the Bill, many witnesses pointed to those proposed by the Expert (Richardson) Committee, those included on the face of the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003, or some adaptation of these models.\(^{55}\) (See table 1.) The memorandum from Professor Graham Thornicroft, Professor of Community Psychiatry at the Institute of Psychiatry, King’s College London, and Director of Research and Development of the South London and Maudsley NHS Trust, provided a more elaborate tabular comparison between the draft Bill

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51 Q 181 (Mr Bowen, Bar Council); Q 183 (Ms Weereratne, Bar Council)
52 Q 73 (Dr Zigmond)
53 Ev 427 (Council on Tribunals), para 7
54 Q 35 (Mr Heginbotham); see also Q 34 (Professor Patel, Mental Health Act Commission)
55 See for example: Ev 13 (Mental Health Act Commission), para 1.6; Ev 210 (No Force), para 1.1; Ev 189 (Mind); Ev 682 (British Medical Association), question 1; Ev 282 (Ms Scott-Moncrieff), para 7
and internationally accepted principles such as those set out by the UN and the World Health Organization. Professor Thornicroft argued that “most of the principles seen as fundamental to good practice in mental health (in the relevant national and international policies) are neither explicit nor implicit within the current draft Bill”.56

66. It has not been possible for us to consider the merits of all the proposed principles in detail, but on the whole, we conclude that the Mental Health (Care and Treatment) (Scotland) Act 2003 serves as an excellent model for the range and specificity of principles that must be set out on the face of a new Mental Health Act for England and Wales. We recommend that the Government use this model as a starting point for creating a set of explicit guiding principles to be set out in clause 1 of the Bill when re-drafted. It follows that the provisions of the Bill proper must reflect and support the principles included.

67. Given the need to balance the rights and safeguards for patients with the protection of patients themselves and others from harm, we believe that this principle must be included in the list of principles to which practitioners must have regard. We propose that for the principle listed in the Scottish Act of “minimum restriction of the freedom of the patient necessary in the circumstances” there be substituted in the Bill proper a principle based on the wording of the draft Bill, namely interference with, and restrictions imposed on, patients must be kept to the minimum necessary to protect their health or safety or the health or safety of other persons.

Capacity, personal autonomy and non-discrimination

68. Like most previous mental health legislation, certainly the 1983 Act, the fundamental test for the use of compulsion in treatment is necessity: in other words, the question that those involved are required to ask is whether it is necessary, for the safety of the patient or others, to force patients to undergo treatment, including detention within a mental health institution. The draft Bill, like the 1983 Act, does not require consideration to be given to whether the patient is capable of choosing to refuse treatment. As a result, neither the definition of mental disorder nor the conditions for the use of compulsion make any distinction between people with capacity and those without. Notwithstanding that a patient refusing treatment has capacity, if all the relevant conditions for compulsion are met, compulsory treatment can be applied. This distinguishes the draft Bill from legislation concerning the treatment of physical illness.

69. The Expert Committee recommended an approach based at least in part on capacity. Their commitment to non-discrimination on grounds of mental health was driven by the need to produce a framework which can help to reduce stigma. Professor Richardson, who chaired the Expert Committee to review mental health legislation and is now Professor of Law, Queen Mary, University of London, explained to us that “if you have discriminatory law, it feeds on the stigma and the stigma feeds on the discriminatory law”.57 Patients with capacity who have physical illnesses have autonomy to decide whether they accept or reject the treatment on offer, whatever the consequences for their health. The principle of non-discrimination against mental health patients therefore, in the view of the Expert

56 Ev 659 (Professor Thornicroft), table 1 & para 3.1
57 Q 1 (Professor Richardson)
Committee, entails the same respect for the patient’s autonomy to choose whether to accept or reject the treatment:

“Respect for patient autonomy implies respect for the treatment choices of those who have capacity necessary to make them. Patient autonomy therefore brings with it an inevitable emphasis on capacity”.  

The Expert Committee concluded that:

“Whatever the initial difficulties in refining the concept the Committee is convinced that the notion of capacity has an independent value and meaning the core of which is accepted by all those involved in the operation of mental health legislation. The introduction of capacity in place of the current test of ‘appropriateness’ should lead to a more precise and objectively justifiable use of compulsory powers”.

70. The Mental Health (Care and Treatment) (Scotland) Act 2003 makes it an explicit principle that practitioners must have regard to the past and present wishes of the patient. It is also partly based on capacity, and a patient cannot be brought under the Act unless his ability to make decisions about his treatment is deemed to be significantly impaired as a result of his mental disorder. A large proportion of the evidence received by our Committee favoured a capacity-based approach as the starting point for a new Act, although some proposals were more radical than others. Many witnesses pointed to the Scottish concept of “impaired decision-making” as a desirable precedent, and the Mental Health Alliance explained how the criterion would work:

“This is seen as a softer option to mental capacity in that it permits a more relative approach - it does not ask whether a person is unable to understand and make a decision in relation to a particular issue but whether their ability to make decisions is ‘impaired’. The more serious the decision, the less evidence of impairment may be required”.

71. We conclude that the Bill should follow the Scottish example in incorporating the concept of impaired decision-making. This would be most directly expressed as one of the conditions for the use of compulsion, but needs too to be reflected in the principles and other provisions of the Bill and codes of practice. We recommend that the Bill include a concept of capacity as one of its principles in the form of “significantly impaired decision-making”. The concept would be most directly expressed as one of the conditions for the use of compulsion. However, this will also need to be reflected in the principles and other provisions of the Bill. It should also be an explicit principle that practitioners must have regard to the past and present wishes of the patient.


60 See for example: Ev 594 (British Psychological Society), question 2; Ev 50 (Royal College of Psychiatrists) question 2(B), rec 1; Ev 210 (No Force), para 2.3; Ev 779 (King’s College London), para 2.4; Ev 119 (Mental Health Alliance), paras 4.12 – 4.16; Ev 165 (Law Society) question 1; Ev 882 (Committee of Leeds Consultant Psychiatrists); Ev 189 (Mind), para 2.12; Ev 282 (Ms Scott-Moncrieff), para 22; Ev 1083 (General Medical Council) question 1

61 Ev 119, para 4.14
The weight to be attached to the principles

72. The draft Bill sets out three overarching objectives which should be reflected in the principles set out in the codes of practice. We have concluded that this is unsatisfactory, and recommended that a full set of principles should be included on the face of the Bill. But what force should these principles have? The Mental Capacity Bill\(^{62}\) provides that key principles must be applied, whilst the Scottish Act provides that, when discharging functions under the Act, *regard must be given to the general principles*.\(^{63}\) Some witnesses, such as Mind, suggested that the weight given to the principles should be phrased in terms stronger than “have regard to”.\(^{64}\) However, an inflexible set of principles which purports to represent absolutes could become unworkable because there are balances to be struck, and decisions cannot be made without a degree of clinical discretion. **We conclude that a provision on the face of the Bill that anyone operating the legislation “must have regard to” a range of principles would provide a reasonable balance between flexibility, on the one hand, and transparency and confidence on the other.**

The disapplication of general principles

73. Clause 1(4) provides that the codes of practice can allow principles to be disapplied either in relation to specified persons or decisions, or where it is deemed inappropriate or impractical to adhere to them. The Minister of State at the Department of Health explained:

> “When we talk about disapplication, let me give you an example that I think would be helpful to the Committee. If you had a situation whereby the general principle would say the patient should have the maximum amount of information available to them [and if a care worker felt that they were given information but to pass that information on to a patient might put the care worker at risk, then that would be a situation where you might say, ‘the general principle of giving the patient maximum information would be disapplied at that time’”.\(^{65}\)

This provision was a cause of considerable alarm among witnesses.\(^{66}\) The Mental Health Act Commission saw the idea of allowing disapplication as wholly unacceptable,\(^{67}\) whilst the Law Society summed up the concerns thus:

> “the effectiveness of the proposed principles is rendered meaningless by the provision allowing the Secretary of State to disapply any of the principles in the Code of Practice. The circumstances in which the principles could be disapplied are left undefined and are potentially wide ranging. Therefore they cannot be relied upon as effective principles and merely resemble a set of ‘nice ideas’”.\(^{68}\)

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62 Mental Capacity Bill [Lords], clause 1 [Bill 1 (2004-05)]
63 For the principles on the face of the Mental Health (Care and Treatment) (Scotland) Act 2003 see Table 1
64 Ev 189 (Mind), para 7.8
65 Q 821 Minister of State at the Department of Health, Ms Rosie Winterton MP
66 See for example: Ev 210 (No Force), para 1.3; Ev 119 (Mental Health Alliance), para 2.1; Q 34 (Professor Patel, Mental Health Act Commission)
67 Q 34 (Professor Patel)
68 Ev 165 (Law Society), question 1
74. We have further concerns that the provisions for disapplication of principles may breach the European Convention on Human Rights. One of the principles proposed by clause 1(3) to be included in the codes of practice is that the interference to patients in providing medical treatment to them, and the restrictions imposed in respect of them are kept to the minimum necessary to protect their health or safety or those of other persons. This is the equivalent of the European Convention on Human Rights principle of proportionality, which cannot be disapplied. We cannot see the need to disapply the principle of proportionality. If a person genuinely needs care in high security to protect others, this will be a proportionate response, and the restrictions will be the minimum necessary.

75. Principles which are not considered important enough to be on the face of the Bill, which are easy to change, and which can be disapplied whenever the relevant authorities see fit, cannot be described as fundamental. We see no need for a provision to disapply principles. As Professor Richardson pointed out, “principles do not have to be absolute to be effective”, and the legal principle of proportionality will ensure a degree of flexibility when fundamental principles are in conflict. We do not believe that it should be possible to disapply general principles. **We recommend the removal from the Bill of the provision for the possible disapplication of any principles when the Bill proper is brought forward.**

**Codes of practice**

76. Setting aside the question of whether the fundamental principles should be on the face of the Bill or not, the arrangements which the Government proposed mean that a number of very important and fundamental provisions will appear in the codes of practice rather than in the Bill itself. The Mental Health Act Commission pointed to four key areas which have a clear human rights dimension, namely:

a) the principles upon which the law is to be interpreted;

b) seclusion and restraint;

c) other control and discipline issues, such as searching of patients or control and confiscation of patient’s property;

d) consent to treatment issues, including the regard to be given to questions of mental capacity, refusal of consent and advance directives; the framework for consent to psychiatric medication for people subject to compulsion; and the emergency administration of psychiatric medication (for which the Bill proposes no powers, so that the common-law will be relied upon).

77. No draft codes of practice have yet been produced, but the aim is for the English draft code to be published before the Bill proper is placed before Parliament, whilst the then

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69 Q 5 (Professor Richardson)

70 In this report we generally use “advance decision” to apply to a refusal of treatment and “advance statement” to relate to wishes regarding the continuation of treatment.

71 Ev 13, para 7.3

72 Q 816 (Minister of State at the Department of Health, Ms Rosie Winterton MP)
Welsh Minister, Jane Hutt AM, thought the Welsh code might emerge in 2007.\textsuperscript{73} The Department of Health has supplied us with a draft table of contents for the English code, and it has also kept us informed with regard to the consultation process. The Minister explained to us that as the codes of practice are produced on the basis of consultation, and consultation cannot commence before the draft Bill has been published,\textsuperscript{74} in order for the Committee to have had sight of the draft codes in our inquiry, \textit{either} a first draft of the codes would have to have been produced without consultation, \textit{or} pre-legislative scrutiny would have to have been delayed by a significant amount of time.

78. We recognise the dilemma, but in the absence of draft codes of practice there are clearly key areas we have been unable to scrutinise adequately and effectively. We found accuracy in the forecast that Professor Richardson made at the beginning of this inquiry:

“you are going to be in a very difficult position if you do not have the Codes of Practice or some clear idea of what will be contained in the Codes of Practice, particularly in relation to the relationship between the Mental Capacity Bill and the Mental Health Bill, where a Code of Practice will be available”.\textsuperscript{75}

79. Had the Government included a full set of guiding principles in the draft Bill, rather than, as it proposes, placing them in the codes of practice, it would have allowed us to review a central element of the new framework. It would not, however, have obviated our need to scrutinise the codes of practice as they underpin the whole of the new arrangements. \textbf{We consider that in cases where draft Bills leave significant provisions to be contained only in secondary legislation or codes of practice, it is not feasible to conduct completely effective pre-legislative scrutiny of the draft Bill without access to draft codes as well.} We believe that in cases such as the draft Mental Health Bill, the best option is to publish skeleton codes and, if necessary, regulations, at the same time as the draft Bill, and undertake a full consultation on the codes and regulations in tandem with pre-legislative scrutiny of the draft Bill. We urge the Government to consider this option for future pre-legislative scrutiny wherever possible. We note, in the present instance, that several years have passed since the draft legislation was first mooted. We are disappointed that some of that time was not used to produce draft codes of practice.

\textsuperscript{73} Q 540 (Jane Hutt AM, then Minister for Health and Social Services, National Assembly for Wales)
\textsuperscript{74} Q 817 (Minister of State at the Department of Health, Ms Rosie Winterton MP)
\textsuperscript{75} Q 3 (Professor Richardson)
3 Definitions and conditions

Introduction

80. The definition of mental disorder in conjunction with the conditions for the use of compulsion determines to whom the new Mental Health Act will apply, and in what circumstances. The definition and conditions are at the heart of the Bill. Not only will vital decisions about people’s lives be directly based upon them, but the remainder of the Bill depends on and is shaped by them.

81. On the one hand, there is the aim of providing appropriate mental health care and treatment to people in desperate need. On the other, there is the aim of managing the perceived risk posed by a very small minority of mentally disordered people. Legislation with protection of the public as its touchstone would look very different from legislation giving maximum weight to patient autonomy. By its very nature legislation founded on dangerousness will focus on risk and would have to circumscribe patient autonomy and favour containment over treatability. The Government has attempted to balance the two to create a framework that satisfies both76 (some witnesses argue that it satisfies neither).77 We have already recognised the need to weigh carefully these two objectives against each other, but the question remains as to whether the draft Bill succeeds in achieving an ethically sound, fair, and workable balance. If such a balance is not achieved, the Bill will almost certainly result in serious over- or under-inclusion on one side or the other of the divide. Any legislation designed to deprive individuals who have committed no offence of their personal liberty and autonomy requires Parliament to go to considerable lengths to satisfy itself that the Government has the balance right and is creating a framework in which mental health professionals can more appropriately exercise their judgment.

The current framework

82. Under the 1983 Act, mental disorder is defined in terms of categories: “‘mental disorder’ means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind and ‘mentally disordered’ shall be construed accordingly”.78 The definition of mental disorder as well as the conditions for the use of compulsory powers is “stepped” so that the net is relatively wide for the purposes of assessment for up to 28 days, but significantly narrower for treatment beyond the first 28 days. Thus the test for assessment is that the patient “is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment”;79 while the test for treatment is that the patient “is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital”.80 The definition of mental disorder is supplemented by explicit and specific

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76 Q 818 (Minister of State at the Department of Health, Ms Rosie Winterton MP)
77 See Ev 721 (Dr Cavadino), para 6; Ev 882 (Committee of Leeds Consultant Psychiatrists); Ev 988 (Barnet Voice for Mental Health)
78 1983 Act, s 1(2)
79 1983 Act, s 2(2)(a)
80 1983 Act, s 3(2)(a)
exclusions, which prevent the Act from being applied to “a person […] suffering from mental disorder […] by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs”.81

83. In determining where the use of compulsion might be appropriate, the definition of mental disorder in the current Act is combined with conditions which stipulate that the Act can be applied only in cases where treatment in hospital is appropriate, where treatment is necessary for the health and safety of the patient or for the protection of other persons, and where the necessary treatment could not be provided without the use of compulsory powers. An extra test of “treatability” is applied to patients who are either mentally impaired or who are diagnosed with a psychopathic disorder. Patients from these two groups can only be treated under the Act if treatment “is likely to alleviate or prevent deterioration in the patient’s condition”.82 Table 2 below sets out the definition of mental disorder, exclusions from it, and the conditions for the use of compulsion contained in the 1983 Act, the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003, as well as the provisions in the 2002 and 2004 draft Mental Health Bills for England and Wales.

The framework proposed in the 2004 draft Mental Health Bill

84. The framework proposed under the draft Mental Health Bill 2004 differs radically from the approach in the 1983 Act, and from that adopted in the Scottish Act. The proposed definition of mental disorder is very broad and general, and is based upon behaviour rather than diagnosis, or the effect rather than the cause (as the Government puts it).83 A second key difference is that the draft Bill constructs a “single” gateway into assessment and treatment, and hence there is no difference between the definitions and conditions applicable for the initial 28 day assessment and subsequent treatment. The third key difference is that, unlike the 1983 Act, the draft Bill contains no specific exclusions from its scope, and the conditions do not differentiate between different types of patients. The draft Bill thus proposes a much simpler framework than the current Act for determining who is liable to be treated under compulsory powers. (Table 2 below sets out the definitions and conditions in the 1983 Act and the 2004 draft Bill side by side to facilitate comparison.)

85. One other key aspect of the draft Bill which may indirectly impact on the interpretation and application of the definition and conditions in the Bill is that it proposes to de-couple compulsory powers from detention in hospital. Although the current Act, as amended, provides routes through which patients under compulsory powers can be treated in the community (see chapter 5), it is based on a presumption that treatment under compulsion takes place in hospital. As some witnesses have pointed out, this may impact significantly on the number of compulsory patients because it would end the current indirect “rationing” of the use of compulsory powers which results from the need to find a hospital bed in order to section a patient or keep a patient sectioned.84

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81 1983 Act, s 1(3)
82 1983 Act, s 3(2)(a)
83 Department of Health, Improving Mental Health Law: Towards a new Mental Health Act, September 2004, p. 9
84 Q 2 (Professor Richardson)
The interrelationship between definition and conditions

86. The definition of mental disorder and the conditions for the use of compulsory powers are inextricably linked. When clinicians determine whether it is necessary to use compulsory powers in respect of a particular patient, they have to determine, first, whether the person is mentally disordered and, secondly, whether the person fulfils all the conditions for the use of compulsion. Changes in either the definition of mental disorder or the conditions for the use of compulsory powers are likely to alter the nature and size of the population who could be subject to compulsion under the provisions of the draft Bill.

The definition of mental disorder

Review of the definition

87. The draft Bill defines mental disorder as:

“an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain”.  

The Government believes that a single “gateway” into assessment and treatment with a definition based upon “effect” rather than “cause” will ensure that:

“No particular diagnosis or label will limit the way that the powers are used as these may change over time and have, under the current Act, arbitrarily affected how its powers are used by risking exclusion of some people who need treatment on the artificial ground that their initial diagnosis does not seem to match any set category”.  

85 Draft Mental Health Bill 2004, cl. 2(5)
86 Department of Health, Improving Mental Health Law: Towards a new Mental Health Act, September 2004, para 3.12, p 24
Table 2: Definitions and conditions for the use of compulsory powers under different legal frameworks.

<table>
<thead>
<tr>
<th>Definition of ‘Mental Disorder’ for the purpose of assessment (up to 28 days)</th>
<th>Mental Health Act 1983</th>
<th>Scottish Mental Health (Care and Treatment) Act 2003</th>
<th>Draft Mental Health Bill 2002</th>
<th>Draft Mental Health Bill 2004</th>
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</thead>
<tbody>
<tr>
<td>Definition of ‘Mental Disorder’ for the purpose of assessment</td>
<td>mental illness; OR psychopathic disorder; OR arrested or incomplete development of mind associated with abnormally aggressive or seriously irresponsible conduct; OR any other disorder or disability of mind which warrants detention for assessment.</td>
<td>mental illness; OR personality disorder; OR learning disability.</td>
<td>“any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning; and “mentally disordered” is to be read accordingly”.</td>
<td>“an impairment or disturbance of the functioning of the mind or brain which results from a disorder or disability of the mind or brain”.</td>
</tr>
<tr>
<td>Definition of ‘Mental Disorder’ for the purpose of treatment under compulsion</td>
<td>mental illness; OR severe mental impairment associated with abnormally aggressive or seriously irresponsible conduct; Subject to treatability criterion: psychopathic disorder; mental impairment associated with abnormally aggressive or seriously irresponsible conduct</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
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<tr>
<td>Exclusions</td>
<td>Person cannot be treated as mentally disordered only on the basis of: sexual deviancy; addiction to alcohol or drugs.</td>
<td>Person cannot be treated as mentally disordered only on the basis of: sexual orientation or deviancy; dependence on or use of alcohol or drugs; behaviour that causes it is likely to cause harassment, alarm or distress to any other person;</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mental Health Act 1983</td>
<td>Scottish Mental Health (Care and Treatment) Act 2003</td>
<td>Draft Mental Health Bill 2002</td>
<td>Draft Mental Health Bill 2004</td>
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<td>actions that no prudent person would undertake.</td>
<td>Patient must be suffering from mental disorder; Disorder must be of a nature or degree warranting detention in hospital for assessment; and Detention for assessment must be necessary in the interests of the patient's health or safety or with a view to the protection of others.</td>
<td>That the patient has a mental disorder; That, because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired; That it is necessary to detain the patient in hospital for the purpose of— Determining what medical treatment should be given to the patient; or Giving medical treatment to the patient; That if the patient were not detained in hospital there would be a significant risk— To the health, safety or welfare of the patient; or To the safety of any other person; and That the granting of a short-term detention certificate is necessary.</td>
<td>Patient must be suffering from mental disorder; Disorder must be of a nature or degree warranting the provision of medical treatment to him; Medical treatment is necessary for the protection of (1) the patient from (a) suicide or serious self harm or (b) serious neglect by him of his health or safety, or (2) for the protection of other persons; Medical treatment cannot lawfully be provided without applying the Act; Appropriate medical treatment is available; and Point b above is disappplied for patients aged 16+ who are deemed to pose a substantial risk of causing serious harm to other persons.</td>
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<tr>
<td>Conditions for the use of compulsory powers in order to undertake an assessment (max. 28 days):</td>
<td>That the patient is suffering from mental illness OR severe mental impairment OR mental impairment OR a psychopathic</td>
<td>That the patient is suffering from mental disorder. That the mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him. That— In the case of a patient who is at substantial risk of causing serious harm to other persons, that it is necessary for the protection of those persons that medical treatment be provided to him, and In any other case, that— it is necessary for the health or safety of the patient or the protection of other persons that medical treatment be provided to him, and that treatment cannot be provided to him unless he is subject to the provisions of this Act. That appropriate medical treatment is available in the patient’s case.</td>
<td></td>
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</tr>
<tr>
<td>Conditions for the use of compulsory powers for the purposes</td>
<td>Patient must be suffering from mental illness OR severe mental impairment OR mental impairment OR a psychopathic</td>
<td>The patient has a mental disorder; Medical treatment is available for the patient which</td>
<td>As above</td>
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<td>Mental Health Act 1983</td>
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| **of treatment**  
(max. 6 months, and subsequently 12 months): | disorder which makes hospital treatment appropriate;  
Treatment must be necessary in the interests of the patient’s health or safety or for the protection of other persons;  
It must be certified that necessary treatment cannot be provided without detaining patient; and  
For patients with a mental impairment OR a psychopathic disorder:  
treatment must be likely to alleviate or prevent deterioration in patient’s condition. | would either prevent the mental disorder from worsening, or alleviate any of the symptoms or effects of the disorder;  
There would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person if the patient were not provided with such medical treatment;  
The patient’s ability to make decisions about the provision of medical treatment is significantly impaired as a result of that mental disorder; and  
the making of a compulsory treatment order is necessary. |                                                                                           |
88. Many witnesses argued that this attempt to create a definition which does not exclude anyone who might need treatment will only serve to include large numbers of people who should never be considered for compulsory treatment. The definition of mental disorder is simply too broad, it is argued, and some also maintain that the definition is unclear, circular, and tautological. Many experts told the Committee that the proposed definition would result in people suffering from a wide range of physical conditions not covered by the current Act being brought within the ambit of the new Bill. It was suggested that those with epilepsy, people who have suffered traumatic brain damage, and those suffering from neurological disorders such as multiple sclerosis, Parkinson’s disease or metabolic disorders would be covered by the new definition because of the psychological and behavioural symptoms of their conditions. King’s College London believes that this level of potential inclusion of people with essentially physical disorders is both undesirable, and indeed unintentional on the part of the Government.

89. It was also widely predicted that the absence of specific exclusions from the Bill might lead to increasing numbers of people with learning disabilities, autistic spectrum disorders or addictions to alcohol or drugs coming under compulsory powers or being liable to the possibility of the use of compulsory powers. Potential over-inclusion of these groups, which could lead to unjustifiable detentions, is covered in greater detail in our discussion of possible specific exclusions below. The Government, on the other hand, predicts no significant increase in the numbers of people subject to compulsory powers (see chapter 10).

90. The second set of concerns relates to ethical judgments about when, and under what circumstances, it is right for the state to encroach on individual liberty and autonomy. This brings us back to the different and conflicting policy drivers which were discussed in the previous chapter. Should the use of compulsory powers serve the purposes of health care and promotion only, or should it also serve a public protection role? Should it ever be possible to use compulsory powers with regard to a person who retains capacity?

91. It was argued that, with the shift from a definition of mental disorder based on diagnostics to one based on behaviour and the removal of the notion of mental illness, “the test becomes entirely behavioural - and this raises the question of why it should be called a mental health act when it is in effect a public order measure”. The Royal College of Psychiatrists echoed this concern. Dr Anthony Zigmond, Vice President of the Royal College, explained that:

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87 See for example DMH 39, para 3; Ev 92 (Institute of Mental Health Act Practitioners), section 2; Ev 779 (King’s College London), para 2.1; Ev 871 (Mind Manchester), para 4; Ev 949 (Herefordshire Users Group), para 2; Ev 1016 (JUSTICE), para 4; Ev 1026 (Religious Society of Friends), para 7
88 See for example Ev 773 (Professor Pilgrim), para 2.2; Ev 779 (King’s College London), para 2.1; Ev 165 (Law Society), para 2a; Ev 940, Mental Health Foundation, para 2.2
89 Ev 165 (Law Society), para 2a; Ev 279 (Mr Hewitt), para 2.1
90 Ev 279 (Mr Hewitt), para 2.1
91 Ev 1041 (Parkinson’s Disease Society), para 5.1
92 Ev 779 (King’s College London), para 2.1; the latter argument gains some credibility by evidence provided by the Minister to the Committee: see Q 829, Minister of State at the Department of Health, Ms Rosie Winterton MP
93 See for example: Q 36 (Professor Patel, Mental Health Act Commission)
94 Ev 446 (Kent County Council), section 1
“We also need to be very careful that the mental health services do not become solely part of either the criminal justice system or an anti-social order system; that it has to be part of the health service. People who make life-style choices either to behave in a criminal manner, or to drink to excess, or to gamble, or to become addicted to cigarettes should not normally be forced to stop those by a health service. If a government feels that those behaviours are inappropriate, then they should legislate in relation to those behaviours, but they are not part of what is generally understood as people who are ill”.

Referring implicitly to the history of efforts by the Home Office to have people with personality disorders included under mental health legislation, Dr Michael Cavadino, Reader in Law at the Sheffield University Centre for Criminological Research, argued:

“Variations in personality should not be regarded as medical disorders, especially when there is little good evidence or agreement about the nature and aetiology of such ‘disorders’ and over whether there is any appropriate treatment. If legislation is thought to be required to deal with non-mentally-ill dangerous persons, it should be framed in terms of their verifiable dangerousness rather than on what can only ever be a highly contentious diagnosis”.

92. Despite these criticisms, a weighty body of evidence accepted in principle a broad definition of mental disorder. This was, in most cases, accompanied by a desire to have specific exclusions added to the Bill, or to have significant changes to the conditions for the use of compulsion (or both). Professor Richardson told the Committee that,

“I am happy in broad terms with a more broad definition of mental disorder, although I would say that I would like to see some express exclusions, and in our committee report, we were quite clear after our consultation that we did want to see an exclusion on sole grounds of drug and alcohol abuse”.

It was notable too that organisations dealing with offenders, patients who relapse frequently, and victims tended to favour the broad definition of mental disorder. NACRO argued that the broad definition, in conjunction with the removal of exclusions, might make services more accessible for mentally disordered offenders. This point of view was echoed by the Revolving Doors Agency and the Zito Trust, who referred particularly to persons with personality disorders.
Proposed changes and additions to the definition

93. Among stakeholders who had concerns about the proposed definition, two types of solution were proposed - either to change the definition altogether, or to add specific exclusions to the definitions (or both). Among those who favoured a fundamentally different definition, the model used in the Scottish Act was often cited. The Law Society argued that the Scottish model, based on three diagnostic categories, namely mental illness, personality disorder or learning disability, is both more straightforward and tighter, and therefore should be adopted as a model for the draft Bill. A variation on the Scottish model proposed by the British Medical Association was to use more detailed diagnostic categories for the definition of mental disorder. The BMA argued:

“In accordance with the recommendations from the Council of Europe, the BMA believes that the definition of mental disorder should be linked to internationally accepted guidelines such as ICD [International Classification of Diseases] or DSM [Diagnostic and Statistical Manual of Mental Disorders].”

94. We have considered carefully the many representations received with regard to the definition of mental disorder. We share the concerns that, as the Bill currently stands, it is over-inclusive and has the potential to lead to a significant increase in the number of people treated under compulsory powers. On balance, however, we are persuaded that a broad definition is the way forward. We agree with the Government that it is unhelpful to define mental disorder on the basis of diagnostic categories which, first, are liable to change and become out-of-date and, secondly, leave clinicians stranded with patients who are clearly mentally disordered, but who do not fit any specific diagnostic category.

95. Although we conclude that the Government should retain the definition of mental disorder contained in the current draft Bill, we believe the scope should be narrowed by means of specific exemptions and by the conditions for the use of compulsory powers.

Specific exclusions

96. Quite apart from its relatively narrow definition of mental disorder for the purposes of treatment, the 1983 Act contains specific exclusions from the coverage of the Act. Consequently, no person can be treated under the Act solely as a result of substance addiction, or because of his sexual orientation or deviance.

97. The broad definition of mental disorder in the draft Bill could, by itself, include any person behaving in a disordered manner, be it a temporary or more long-term state. As a consequence, addicts of various substances would almost invariably be included under the definition. People with learning disabilities would also clearly be covered by the draft Bill, this apparently being the Government’s intention. The 2004 draft Bill does not restrict the breadth of the definition by specifically excluding any group from the ambit of the Act.

102 Ev 165, para 2a; see also Ev 282 (Ms Scott-Moncrieff), paras 10-13
103 Ev 682, question 2
104 Ev 779 (King’s College), para 2.1
105 Department of Health, Draft Mental Health Bill 2004: Explanatory Notes, Cm 6305, September 2004, para 32
98. The Government maintained that the exclusions in the 1983 Act have often been misunderstood, resulting in some people being excluded from the ambit of the Act, even where they have serious mental health needs which require treatment under the Act. In response to this view, the Mental Health Alliance argued that:

“We believe that this rationale is spurious. Existing law does not prohibit treatment of a mentally disordered person who also has other behavioural issues. If the current law is misunderstood, the problem should be addressed by information and training, and if necessary by a rewording of the 1983 Act”.

99. The absence of specific exclusions, in conjunction with the breadth of the definition of mental disorder, has given rise to concerns, expressed by, for example, the Church of England that there is no defence against mental health legislation being used as a means of social control, and some have argued that this is a potential infringement of human rights. The Law Society maintained that specific exclusions should be retained because they help to:

“ensure that conditions and behaviour, which on their own should not be regarded as a mental disorder, are excluded from mental health legislation. We also believe that exemptions help ensure that practitioners consider carefully the basis for compulsory detention and treatment”.

100. We agree with the position of the Law Society and the Church of England on this issue, and we also accept the view of the Mental Health Alliance that if exemptions are seen to be misused, that is a matter which should be rectified through training and carefully worded codes of practice. **We conclude that a broad definition of mental disorder in the draft Bill must be accompanied by explicit and specific exclusions which safeguard against the legislation being used inappropriately as a means of social control.**

101. There are two exemptions under the 1983 Mental Health Act, namely sexual orientation and deviancy and addiction to alcohol or drugs, whilst the new Scottish Act 2003 contains two further exclusions, to the effect that people cannot be brought under the Act as a result purely of behaviour that causes, or is likely to cause, harassment, alarm or distress to other people or actions that no prudent person would undertake. The extra Scottish exclusions are clearly aimed at preventing the Act from being applied as a means of social or behavioural control where this is not caused by a mental disorder. Below, we consider the merits of the key options for exclusions in the Bill.

**Substance abuse**

102. Substance abuse is strongly correlated with mental health problems of varying degrees of seriousness, and it may be difficult to determine whether such co-morbidity exists in...
a patient, particularly in acute circumstances. Despite this significant overlap, there was concern among many witnesses that the exclusion in the current Act preventing the use of compulsory powers solely on grounds of the symptoms of substance abuse should be reinstated in the draft Bill. Alcohol Concern summed up the concern of many when recommending that:

“it is made explicit that intoxication alone should not be viewed as a mental disorder; it was clearly not the intention that being drunk and being reckless should bring an individual under the scope of the Mental Health Act. [...] In addition, the Bill should make it clear that intoxication, although not a mental disorder in itself, should not be a reason to deny an individual assessment under the Act if there is suspicion of other mental disorder. It is important that individuals who are experiencing mental disorder and are posing an acute risk to themselves or others, do not fall through the net of the Act simply because they are intoxicated”.

103. The Sainsbury Centre for Mental Health also pointed out to us that the absence of a specific exclusion for substance abuse in the Bill might become a disincentive for people to seek help from alcohol and drug services because they would fear the potential use of compulsory powers. Conversely, the treatment of people with addiction problems in mental health services would divert resources away from people with serious mental health problems.

104. We see no convincing reason for changing the current arrangement which excludes a dependency on alcohol or drugs from the definition of mental disorder and, in our view, removal of this exclusion could lead to the problems identified in the evidence we received. **We recommend that a specific exclusion on the grounds of substance misuse alone (including dependence on alcohol or drugs) be inserted into the Bill.**

**Sexual orientation and sexual deviance**

105. The current Act contains an exclusion on the basis of sexual orientation and sexual deviance. The history behind this exclusion is clearly very important given historic attitudes to homosexuality. Today, sexual deviance is associated with phenomena such as paedophilia and seriously predatory and violent sexual behaviour, possibly linked to forms of personality disorder.

106. We received little evidence specifically on this exemption, though most supported retention of an exclusion from the Bill on the basis of sexual orientation. Both the Royal College of Psychiatrists and the Mental Health Act Commission proposed the retention of an exclusion covering both sexual orientation and sexual deviance. We agree on the vital importance of excluding sexual orientation from the scope of the Bill, but we disagree that

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112 Co-morbidity means more than one illness affecting an individual, each of which may impact on the course and management of the others.

113 Ev 729, (Mr Craig)

114 Ev 1055, paras 1.2 and 1.3

115 Ev 259, para 2.2

116 See for example Ev 119 (Mental Health Alliance), summary section 2(f).

117 Ev 50 (Royal College of Psychiatrists), question 2a
sexual deviance should be specifically excluded because we believe that it remains unclear whether some forms of non-violent, violent and predatory sexual behaviour may in fact be symptomatic of mental disorder. We recommend that a specific exclusion on the grounds of sexual orientation be inserted into the Bill. We do not agree that any exclusion should extend to sexual deviance.

**Intellectual disability and other specific conditions**

107. The inclusion of people with learning disabilities and other life-long conditions such as autistic spectrum disorders (ASD), which affect the mind but are not mental illnesses, was a concern to many witnesses. Professor Gregory O’Brien, Chair of the Faculty of Psychiatry of Learning Disability at the Royal College of Psychiatrists, maintained that it is “ludicrous” for people with learning disabilities to be included in the definition of mental disorder,118 whilst the Mental Health Act Commission (MHAC) reasoned that:

> “where somebody has a very stable learning disability which does not have what we might consider to be psychiatric conditions associated with it, then I would have thought an exclusion in that area would be appropriate”.119

Mencap agreed, arguing that “it is fundamentally wrong for someone with a learning disability to come under mental health legislation unless they also have a mental illness”, and suggested that a specific exemption be inserted into the Bill which would preclude application of the Bill purely on the grounds of “impairment of intelligence”120 whether or not accompanied by impairment of social functioning.

108. The National Autistic Society was similarly concerned that disorders on the autistic spectrum, in other words, disorders characterised by impaired communication and social interaction should not be covered by mental health legislation per se, and urged the Committee to consider the non-psychotic nature of such disorders.121 Both Mencap and the National Autistic Society acknowledged that people suffering from learning disabilities and autistic spectrum disorders have higher than average frequencies of mental health problems.122 Both organisations also accepted that specific exemptions on the grounds of learning disabilities or autistic spectrum disorders should exclude patients only in as far as they do not also suffer from a mental disorder of sufficient severity to warrant use of the powers of the Bill.

109. Some witnesses expressed reservations about exempting people with learning disabilities outright from the provisions of the Bill, on the grounds that, if excluded, they would not have access to the safeguards provided by the Bill.123 Also, if caught up in the criminal justice system, there would be no means of redirecting them to services able to cater for their needs. Ms Scott-Moncrieff suggested that the way to resolve this problem would be to retain:

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118 Q 77 (Professor O’Brien)
119 Q 62 (Mr Heginbotham)
120 Ev 299, question 2
121 Ev 561
122 Ev 561 (National Autistic Society), p 1; Ev 299, Mencap, p 1
123 Ev 594 (British Psychological Society), question 8; Q 338 (Mr Hewitt)
“people with learning difficulties within the definition, but to put in all sorts of other restrictions, as with the current Act, where mental impairment has to include abnormally aggressive or seriously irresponsible conduct, and compulsory powers can only be used if somebody needs to be in hospital under the care of a psychiatrist, all these kinds of provisions”.  

110. We are sympathetic to the concerns about over-inclusion of people with both learning disabilities and autistic spectrum disorders under the current definition of mental disorder. However, we also believe that it would be wrong to exclude these groups from the Bill per se. It is crucial that the safeguards of the Bill are available to people from these vulnerable groups, should they come into contact with the criminal justice system.

111. We recommend that the Government include in the Bill proper an extra condition to be met in the case of people with learning disabilities or communicative disorders such as autistic spectrum disorders. The provision in the 1983 Act which limits the range of circumstances in which people with a mental impairment can be detained for the purposes of treatment under the Act should be retained and adapted under the new Bill. A provision should be inserted whereby people with the aforementioned disorders are liable for compulsory treatment under the Bill only if they display seriously aggressive or severely irresponsible behaviour as a result of their condition and if such treatment as is properly and reasonably required can only be provided to such patients under conditions of compulsion. Furthermore, in our view, any reference to learning disability or autistic spectrum disorders on the face of the Bill, in Explanatory Notes or the “Easy Read” version should contain this caveat or a cross-reference to it.

112. We recommend too that the codes provide illustrative examples of the full range of developmental conditions, including Asperger’s Syndrome. The purpose of this recommendation is to emphasise that impaired mental capacity of itself cannot justify the use of compulsory powers.

**Cultural or political beliefs**

113. A number of other specific exclusions were proposed to us. We noted in particular the proposal to include a specific exclusion on the grounds of “cultural, political or religious beliefs” put forward by the Royal College of Psychiatrists among others. The Royal College cited the use of such exclusions in Australia and New Zealand.

114. Although we would wish that specific exclusions of this kind were unnecessary, we note that some cultural minorities are greatly over-represented among patients treated under compulsion. Without making any judgments as to the complex reasons for this, we think an important signal value would be achieved by setting out a specific exclusion of the use of compulsion solely on the basis of behaviour exclusively and directly attributable to cultural or indeed political beliefs. We understand religious beliefs to be part of cultural beliefs, and therefore we do not feel that it is necessary to state religious beliefs separately.

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124 Q 335 (Ms Scott-Moncrieff)
125 Ev 50, question 2a
126 See for example: Ev 1066 (African and Caribbean Mental Health Commission) and Ev 552 (BME Network)
We recommend that the Bill be amended to contain a specific exclusion for the use of compulsory powers on the grounds of cultural or political beliefs or behaviours alone.

Conditions for the use of compulsory powers

The single gateway to assessment and treatment

115. Clause 9 in the draft Bill sets out the proposed conditions for determining when compulsory powers should be used. As set out in table 3 below, there are five conditions, and all five conditions must be fulfilled in order for a patient to be treated under the powers in the draft Bill. The first condition is that the patient suffers from a mental disorder, and we have already dealt extensively with the definition of mental disorder. We will now consider the evidence received on the remaining conditions. In doing so we are mindful of the view expressed that, because it is so broad, the proposed definition of mental disorder is only workable if the conditions for compulsion are restricted.127

Table 3: Conditions for the use of compulsion under the 2004 draft Bill

<table>
<thead>
<tr>
<th>Clause</th>
<th>Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>9(2)</td>
<td>The first condition is that the patient is suffering from mental disorder.</td>
</tr>
<tr>
<td>9(3)</td>
<td>The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.</td>
</tr>
<tr>
<td>9(4)</td>
<td>The third condition is that it is necessary –</td>
</tr>
<tr>
<td></td>
<td>(a) for the protection of the patient from:</td>
</tr>
<tr>
<td></td>
<td>(i) suicide or serious self-harm, or</td>
</tr>
<tr>
<td></td>
<td>(ii) serious neglect by him of his health or safety, or</td>
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<tr>
<td></td>
<td>(b) for the protection of other persons,</td>
</tr>
<tr>
<td></td>
<td>that medical treatment be provided to the patient.</td>
</tr>
<tr>
<td>9(5)</td>
<td>The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.</td>
</tr>
<tr>
<td>9(6)</td>
<td>The fifth condition is that medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.</td>
</tr>
<tr>
<td>9(7)</td>
<td>The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.</td>
</tr>
</tbody>
</table>

The second condition – clause 9(3)

116. The Law Society and the Bar Council both expressed concerns about the second condition, which requires the disorder to be of “a nature or degree as to warrant the provision of medical treatment” to the patient. The Law Society maintained that the provision effectively lowers the threshold in the 1983 Act where “the mental disorder must be of a nature or degree to require compulsory detention in hospital”.128 The change in wording could be construed as assisting the introduction of compulsory treatment in the community (through non-residential orders see chapter 5), and in conjunction with a very broad definition of medical treatment (as discussed under condition five below) it does appear to lower the threshold for compulsion significantly.

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127 Ev 50 (Royal College of Psychiatrists), summary of key issues
128 Ev 165 (Law Society), question 2b; Ev 175 (Bar Council), para 11.4
117. A lowering of the threshold for compulsion is a serious matter in itself, but in conjunction with the formal introduction of non-residential compulsory treatment, it has the potential to cause a significant increase in the number of people treated under compulsion. Professor Richardson indicated that the removal of what is effectively a “physical rationing system” whereby admission depends on a bed being available, in conjunction with a criterion which requires simply that medical treatment is warranted has the potential to cause a very significant rise in the numbers of people treated under compulsion.129

118. The Bar Council proposed that this problem could be resolved simply by adding a qualification to the effect that medical treatment is warranted “under compulsory powers”.130 We agree with the proposal of the Bar Council in that this simple amendment raises the threshold whilst not precluding compulsory treatment in the community. We recommend that the second condition for the use of compulsion at clause 9(3) of the draft Bill be amended so as to read the “mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him under compulsory powers”.

The third condition – clause 9(4)

119. The third condition for the use of compulsory powers is that it is necessary to provide medical treatment to the patient in order to (a) protect the patient from suicide or serious self-harm or self-neglect, or (b) “for the protection of other persons”. This condition caused a great deal of concern. The gravest concerns arise from part (b), and relate, first, to whether public protection should be a criterion at all and, secondly, to whether the wording is appropriate.

120. Criterion (a) raised some concerns and was seen, for example, as problematic by the Royal College of Psychiatrists because some patients can be said to pose a risk to themselves at any time, and therefore they would be liable to be treated under compulsory powers on a permanent basis.131 The Royal College suggests that:

“In the context of the ‘blame culture’ and society’s low tolerance of risk it seems likely that clinicians will err on the side of safety leading to inappropriate detention in hospital […] If the wording were as in the 1983 Act ‘In the interest of’ rather than ‘for the protection of’ it would enable the clinician to weigh up relative risks”.132

Alcohol Concern added that the notion of acute risk should be inserted into the condition in order to preclude the act from being used inappropriately on the basis of chronic risk behaviours such as alcohol dependency.133 Dr Cavadino made a similar point in arguing that the condition should be tightened by adding the notion of a “substantial risk of the serious harm occurring in the absence of compulsion”.134

129 Q 2 (Professor Richardson)
130 Ev 175, para 11.4
131 Ev 50 (Royal College of Psychiatrists), question 2B – issues
132 Ibid
133 Ev 1055, para 1.8
134 Ev 721, para 7
121. We believe there is merit in the arguments outlined above and there is scope for tightening criterion (a) without excluding people who should be subject to compulsory treatment. **We recommend that the Government tighten criterion (a) at clause 9(4) in the draft Bill to prevent compulsory powers from being used on a permanent basis in respect of patients who either have a diagnosis associated with a constant risk of suicide or serious self-harm or who engage in chronic risk behaviours.**

122. As noted, criterion (b) under clause 9(4) caused very significant concerns among those who gave evidence to the Committee. The criterion requires that compulsion is necessary “for the protection of other persons”. But what does protection mean? And protection from what? Dr Cavadino suggested that in its present form, criterion (b) could be taken to mean “small risk of nuisance to others”, whilst King’s College London questioned whether it could refer to “protection from annoyance behaviour, or the anxiety induced by the presence of a mentally-ill person nearby”. Both the Law Society and the Depression Alliance Cymru suggested that this criterion is so broad that in conjunction with compulsory treatment in the community, it could be used as a “mental health ASBO system that is about social control rather than appropriate treatment”.

123. Witnesses also drew attention to the difference between clauses 9(4)(a) and 9(4)(b) - “suicide” and “harm to self” are qualified as having to be “serious” whilst “protection of others” has no limiting qualification attached. The category of people referred to in 9(4)(b) is further subdivided by clause 9(7) which suspends clause 9(5) for people who are deemed to be “at substantial risk of causing serious harm to other persons”. King’s College London told us that:

> “Thus the ‘protection of others’ applies to risk which may be substantial but not serious, or serious but not substantial, or neither serious nor substantial. It is thus very unclear what is meant by the ‘protection of others’ and what others are to be protected from”.

124. Applying the criterion of “protection of other persons” implies that practitioners will have to engage in sophisticated risk assessment of their patients, and that, if the risk threshold is lowered from the current position, the number of cases in which such assessments would have to be made is liable to increase. Many witnesses questioned the existence of techniques which would be sufficiently reliable and accurate for the purpose. King’s College London commented:

> “This is not simply a question of poor predictive tools, but reflects inherent statistical limitations on the prediction of rare events. Applying even the best of our current

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135 See for example: Ev 189 (Mind), para 2.27; Ev 940 (Mental Health Foundation), para 2.6; Ev 1029 (Manic Depression Fellowship), question 2.b; Ev 1083 (General Medical Council), para 16

136 Ev 721, para 7

137 Ev 779, para 2.4.1

138 Ev 165, question 2.b

139 Ev 895

140 Ev 779, para 2.4.1

141 See for example Ev 352, (NACRO); Ev 895 (Depression Alliance Cymru); Ev 189 (Mind), para 3.2
predictive instruments will result in very large numbers of ‘false positives’, people predicted to be violent, for example, who would not have been’.\(^\text{142}\)

125. We found that there is no consensus among psychiatrists as to the efficacy of their current risk assessment techniques. The Royal College of Psychiatrists believes techniques to be highly inaccurate and unreliable. In contrast, Professor Anthony Maden, Professor of Forensic Psychiatry, Imperial College London, Honorary Consultant, West London Mental Health NHS Trust and Lead Clinician of the Dangerous Severe Personality Disorder Service, Broadmoor Hospital, who works with such risk assessment techniques, thought they are improving fast. Dr Zigmond from the Royal College told the Committee that:

“the notion of predicting that somebody is a clear danger either to themselves or, indeed, anybody else, I have to say, is rather a fallacious one. My colleagues and I are not good at it. It raises the question as to how many people we should force to have treatment or lock up in hospital unnecessarily in order to try and pick this one”.\(^\text{143}\)

Professor Maden, on the other hand, explained that techniques have:

“improved tremendously over the last ten or 15 years and within general psychiatric services there has been a transformation of the general approach to risk to the point where one would say that at the moment general psychiatric services probably have too much concern”.\(^\text{144}\)

126. A number of witnesses proposed ways in which clause 9(4)(b) could be amended so as to reduce its breadth and make it more balanced, focusing on a more limited and grave category of risks.\(^\text{145}\) The Mental Health Alliance and the Citizens Advice, for example, felt that the clause should be tightened so as to read “prevent serious harm or violence to others”.\(^\text{146}\) Dr Cavadino touched on one possible motive behind setting the threshold for this condition at such a low level, and suggested a way forward which might satisfy both the Government’s objectives and also the concerns about condition 9(4)(b) being too broad. Dr Cavadino suggested that:

“in conjunction with the broad definition of mental disorder in clause 2(5) and other provisions, the Bill would allow people with diagnoses such as ‘personality disorder’ to be detained indefinitely on the grounds that it is ‘necessary for the protection of others’ even if they have never committed a violent or dangerous act. The 2000 White Paper (Cm 5016, Part II, para. 2.13) claimed that it would be ‘highly unlikely that any individual without a long track record of increasingly serious offending will be affected by these new powers’. If this is the intention, then the Bill could easily be amended to give effect to it. It could for example, state that long-term detention for the protection of others (whether via civil or criminal proceedings)
may only be ordered where the patient has been convicted on two or more occasions of offences of serious violence”. 147

127. Research carried out by NACRO, however, suggested that Dr Cavadino’s proposal of linking the risk criterion to previous criminal convictions might not be the way forward. NACRO stated that: “In respect of public safety, we are concerned that the Government may be making a serious error in equating offending behaviour with a higher risk of future violent or dangerous behaviour. As NACRO [has] showed […] previous behaviour or offending does not, of itself, accurately predict future risk”. 148

128. We are convinced that the threshold for the use of compulsion under clause 9(4)(b) is too low, and we find the current wording unacceptable. We do not, however, have confidence that the detailed alternatives proposed for tightening criterion (b) would prove any better. A criterion based on a diagnosis of personality disorder with two previous convictions may not be accurate enough to identify those people who pose a significant risk to the public. Nor are we persuaded that current techniques of risk assessments are so precise and reliable, or seen as such by professionals and the public, as to be reliably used to determine anything other than the most imminent and serious scenarios. In the circumstances we conclude that the best way to proceed is to bring criterion (b) into line with criterion (a). We recommend that the criterion at clause 9(4)(b) of the draft Bill be changed to read “for the protection of other persons from significant risk of serious harm”.

The fourth condition – clauses 9(5)

129. The fourth condition for the use of compulsory powers is that medical treatment cannot lawfully be provided to the patient unless he is subject to the Bill. In other words, if a patient voluntarily accepts treatment, then he cannot be subjected to compulsion. Few witnesses expressed concerns about this sub-clause in itself, although it is qualified by clause 9(7), which gave rise to considerable concern. We deal with clause 9(7) separately below.

130. Both the Institute of Mental Health Act Practitioners and the user group No Force suggested that the term “lawful” needs clarification. 149 Some witnesses also maintained that this condition raises questions about the applicability to people without capacity and about the interface with the Mental Capacity Bill. 150 The Mental Health Foundation submitted:

“The fourth condition for compulsion […] suggests that where a person, for example an individual with learning disabilities, could receive treatment under ‘common law’ (or perhaps, in the future, a Mental Capacity Act) the powers under the draft Bill cannot be used. However, this should be made clear on the face of the Bill. This raises

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147 Ev 721, para 9
148 Ev 352, part 3
149 Ev 210 (No Force), para 2.5; Ev 92 (Institute of Mental Health Act Practitioners)
150 Mental Capacity Bill [Lords] [Bill 1 (2004-05)]
the lack of clarity on the relationship between the draft Mental Health Bill and the Mental Capacity Bill”.\textsuperscript{151}

131. In our view, it is clear that, in accordance with clause 9(5), a patient who voluntarily accepts treatment cannot be brought under compulsory powers. We think this position is ethically correct. However, we agree that issues need to be clarified regarding the position of people without capacity. In chapter 4 below we discuss the interface between the two Bills in greater detail.

\textbf{The fifth condition – clause 9(6)}

132. The fifth condition for the use of compulsory powers, at clause 9(6), is that “medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances of his case”. We received a very large number of representations about this condition, partly, about its wording and the way key concepts are defined, and, partly, about the nature of the criterion.

133. The first key concern is that the central concepts on which the clause depends are unclear or simply defined in terms that are too broad. The term “medical treatment” is defined at clause 2(7) so as to include:

a) nursing;

b) care;

c) cognitive therapy, behaviour therapy, counselling or other psychological intervention;

d) habilitation (including education, and training in work, social and independent living skills); and

e) rehabilitation, as per (d) above.

Finally, medical treatment has to take place under the supervision of an approved clinician for the purposes of the Bill.

134. King’s College London and the Institute of Mental Health Act Practitioners both made the point that by including care, education and training in the concept of medical treatment the condition is rendered so wide as to have no discernible threshold and therefore that it will fail to limit significantly the numbers of people who can be brought under compulsory powers.\textsuperscript{152} This is compounded by the fact that the Bill fails to define, as Professor Richardson pointed out, “exactly who this approved clinician is going to be”.\textsuperscript{153}

135. Both JUSTICE and King’s College London raised another concern relating to the term “appropriate”. According to JUSTICE, “the idea of appropriateness is a wholly uncertain one and, therefore, not a suitable term to use in provisions governing the use of coercive

\textsuperscript{151} Ev 940, para 2.4; see also Ev 210 (No Force), para 2.5; Ev 442 (Association of Directors of Social Services and Local Government Association), question 2, para 4.2.2

\textsuperscript{152} Ev 779 (King’s College London), para 2.3; Ev 92 (Institute of Mental Health Act Practitioners), section 2

\textsuperscript{153} Q 2 (Professor Richardson)
powers overriding individual autonomy”.\(^\text{154}\) Bevan Brittan Solicitors suggested that the term should be replaced by the term “clinically appropriate” which would limit the scope of treatment to some degree.\(^\text{155}\) The Government, however, responded:

“The concept of ‘appropriateness’ is already in use in mental health legislation, e.g. section 37 and section 72 of the Mental Health Act 1983, both the Courts and Tribunals are experienced in its effect. It is for the decision makers to determine on the basis of their professional judgement whether appropriate treatment is available for an individual patient. Legislation cannot and should not attempt to cater for all permutations of individual circumstances. The legislation gives effect to the ECHR requirement that deprivation of liberty on grounds of unsoundness of mind must rest on objective medical expertise”.\(^\text{156}\)

136. Organisations representing black and minority ethnic groups were keen that the notion of appropriateness should be made to include the idea of “culturally appropriate treatment”,\(^\text{157}\) whilst the Welsh Language Board emphasised the need for appropriateness to encompass the provision of services in Welsh.\(^\text{158}\) (The question of service provision in Welsh is dealt with in chapter 11.)

137. The most frequent criticism of clause 9(6) we heard is that it contains no test of treatability or therapeutic benefit. The 1983 Act contains a so-called treatability criterion for treatment of two specific categories of patients, namely patients with psychopathic disorders or a mental impairment, who can only be treated under the Act if treatment is likely to alleviate or prevent deterioration of the patient’s condition. Other categories of patients, i.e. those who suffer from a mental illness and those who have a severe mental impairment, are not subject to the test of treatability.

138. The Government explained the reasoning behind the removal of the treatability requirement as follows:

“With changing clinical practice, the meaning of this [treatability] requirement has been unclear. This has led to people with a primary diagnosis of personality disorder not being brought under formal powers because of uncertainty about whether their personality disorder can be ‘treated’.

“Rather than distinguish certain categories of patient, the conditions for compulsion will require that appropriate treatment must be available for all patients before formal powers can be used, whatever their diagnosis. There is no intention of requiring general facilities to detain people for whom no treatment is available. As now, clinicians will make decisions based on their professional judgement about whether treatment is available and whether it is appropriate to the patient’s case”.\(^\text{159}\)
139. Many believed that it was unethical to treat people under compulsory powers without there being any health or therapeutic benefit to the patient and that the fifth condition should be amended to reflect this requirement.\textsuperscript{160} Professor Nigel Eastman, Professor of Law and Ethics in Psychiatry, University of London and Head of Forensic and Personal Disorder Psychiatry, St George's Hospital Medical School, London, thought:

“[…] therapeutic benefit to the individual is of crucial importance in terms of protecting the boundary of what is the business of mental health professionals. I am not at all against protecting the public, of course not, but it must be in conjunction with some benefit to the individual that goes beyond simply stopping them offending. If you adopt a definition of treatability, which is simply the reduction of risk or the avoidance of offending, that means that locking somebody up is treating them”.\textsuperscript{161}

140. The Scottish Mental Health (Care and Treatment) (Scotland) Act 2003 includes a therapeutic benefit criterion in that compulsory powers can only be used where medical treatment is available “which would be likely to (i) prevent the mental disorder worsening; or (ii) alleviate any of the symptoms, or effects, of the disorder, is available for the patient”.\textsuperscript{162}

141. We note that the definition of medical treatment in the draft Bill is broader than in the current Act, and the Committee therefore believes that clause 9(6) would be inappropriate without the addition of a concept of therapeutic benefit. The purpose of mental health legislation must not be to detain people for whom no beneficial treatment can be found. We recommend that the Government amend the fifth condition at clause 9(6) of the draft Bill so as to include a test of therapeutic benefit as used in the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003.

142. Given the breadth of the proposed definition of treatment, we believe that the number of people with serious mental disorders who satisfy the other conditions but cannot benefit from any kind of treatment will be extremely small. We conclude that people with serious mental disorders who cannot benefit from treatment pose a very challenging problem, but recommend they be dealt with under separate legislation.

143. A final concern with regard to the fifth condition at clause 9(6) is that it does not require that the “appropriate treatment” is actually available locally to the patient. The Nottingham Senior Medical Staff Committee asked:

“[…] what would happen if the doctors thought that the treatment was not available locally[?] Would they have to determine whether it was available elsewhere? If that service was not willing to take the patient for whatever reason, what implication

\textsuperscript{160} See for example: Ev 13 (Mental Health Act Commission), summary, point 7; Ev 779 (King’s College London), para 2.4.4; Ev 259 (Sainsbury Centre for Mental Health), para 2.7; Ev 165 (Law Society), question 2(b); Ev 175 (Bar Council), para 11.7; Ev 189 (Mind), para 2.23; Ev 689 (Royal College of General Practitioners), para 2.7; Ev 682 (British Medical Association), question 2; Ev 1050 (Church of England), para 8; Ev 1103 (User Voice), para 3.5

\textsuperscript{161} Q 476 (Professor Eastman)

\textsuperscript{162} Health (Care and Treatment) (Scotland) Act 2003, s. 57(3)(b)
would this have with regards to the right to detain that individual under the Mental Health Act?\(^{163}\)

144. We have considered very carefully the concerns with regard to the clarity of the wording in clause 9(6). As we understand it, the clause requires (and should require) that treatment is available to the patient which is *appropriate to his specific individual case*. We therefore do not see a need to change the draft Bill to define what is appropriate but, in our view, the codes of practice must emphasise the essential requirement that the treatment available is appropriate to the *specific circumstances of the individual patient* rather than to the generic diagnosis of the patient. We are satisfied that the concept of “appropriate treatment” is broadly known and understood among practitioners and tribunal members, but we also believe that it is essential that the codes of practice should set out clear and thorough guidelines with examples to assist practitioners in their understanding of the notion of “appropriate treatment”. **We recommend that the codes of practice provide extensive guidance, with examples, assisting practitioners and tribunals in interpreting the notion of appropriate treatment. The codes should also emphasise the need for “appropriate treatment” to be understood as including culturally appropriate, and that services, as far as possible, should be provided in a culturally sensitive manner.**

**Clauses 9(7) and 9(8)**

145. The final two subsections of clause 9, clauses 9(7) and 9(8), both serve to restrict the five conditions for the use of compulsion in certain circumstances. Clause 9(7) provides that the fourth condition is disapplied in the case of patients aged over 16 who are “at substantial risk of causing serious harm to other persons”. In other words, patients who are deemed to pose a substantial risk of causing serious harm to others *must* be treated under compulsion, even where they voluntarily accept and fully comply with the treatment and care plan provided for them. We have already touched in this chapter on the fact that this qualifying clause in conjunction with clause 9(4)(b) creates two separate categories of dangerous patients.

146. A large number of representations received by the Committee argued that it is unethical and unacceptable that patients who voluntarily comply with their treatment should ever be subjected to compulsion.\(^{164}\) The Royal College of Psychiatry argued that “the principle of least restrictive alternative should apply to all categories of patient”\(^{165}\) whilst King’s College London explained that the provision at clause 9(7):

> “is a radical departure in mental health legislation, whose underlying philosophical basis has not been discussed. It is contrary to the ‘least restrictive alternative’ principle. Our concerns are further heightened by our understanding that the effect of clauses 16(4) and (5) when read together with clause 9(7) is to remove any discretion in relationship to the waiver. If the patient is judged to pose a ‘substantial risk of serious harm’, he or she *must* be formally compelled, not *may* be compelled, even when he or she is actually requesting treatment. This will prove a very effective

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\(^{163}\) Ev 1020, question 4

\(^{164}\) See for example: Ev 13 (Mental Health Act Commission), summary, point 6; Ev 779 (King’s College London), para 2.4.2; Ev 119 (Mental Health Alliance), para 4.8; Ev 805 (North East London Mental Health Trust); Ev 901 (Leeds Mental Health Trust), para 4.2.5; Ev 189 (Mind), para 2.25

\(^{165}\) Ev 50, section 2b - issues
means of deterring patients from seeking help from mental health services. The health benefit to the patient, in our view the primary purpose of mental health legislation, threatens to be subverted by the primacy of avoiding risk to others”.

The Mental Health Alliance furthermore argued that the provision at clause 9(7) is simply unnecessary:

“Case law makes clear that practitioners can impose compulsion on patients whose fluctuating or perhaps self-serving consent (as shown by past history) makes it unreliable. No extension to this should be permitted. It is also unnecessary since professionals can always use compulsory powers if cooperation changes to resistance. If people are partners in their care and treatment, they will take responsibility; coercion where it is not needed disregards personal autonomy and may contravene human rights”.

147. The Government’s response to these arguments was that:

“it may be necessary to take a cautious view of the likelihood of the mentally disordered person delivering the compliance he has expressed. […] The case law reflected uncertainty about the effects of the 1983 provisions which we seek to avoid in the new legislation”.

148. In our view, the Government’s argument on this point is far from convincing, given the effect of the change it proposes. The Government has not put forward any compelling evidence supporting the view that significant numbers of highly dangerous mentally disordered people accept treatment only to fail to comply with it. In practice, we believe it is likely that the treatment proposed by clinicians for people deemed to pose substantial and serious risks to others will be residential (rather than non-residential) and it follows that the monitoring of compliance is relatively straight-forward. If a dangerous patient in those circumstances changes from compliance to non-compliance, condition three at clause 9(4) will be met and clinicians can apply compulsory powers without resorting to clause 9(7).

149. In the absence of a compelling case to support clause 9(7) the Committee considers it unjustified that patients who accept and voluntarily comply with their treatment should be subjected to compulsory powers. **We recommend that clause 9(7) be removed from the Bill.**

150. Clause 9(8) states that “for the purpose of this Part, a determination as to whether a patient is at substantial risk of causing harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case”. The Government explained:

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166  Ev 779, para 2.4.2
167  Ev 119, para 4.8
168  Schedule of Comments: Government Response 9(r) (at annex 4)
169  Ev 764 (Dr Lodge), para 2.2; Ev 189 (Mind), 2.25; and see also Q 495 (Professor Eastman)
“clause 9(8) is intended to ensure that the reason for any disapplication of the fourth condition is part of the record of the examiners’ determination”.170

**Given our recommendation to remove clause 9(7), clause 9(8) would become obsolete.**

**Impaired decision-making**

151. In chapter 2 we recommended that the concept of “significantly impaired decision-making” should be included in the Bill as one of the key principles and as a criterion for the use of compulsory powers. The Expert Committee recommended that a new Mental Health Act should be based on the concept that, as far as possible, people with mental disorders should be treated equally with people suffering from physical disorders – in other words, their autonomy and choices should be respected. Based on that principle, the Committee recommended that people with mental disorders should only be treated under compulsion if they lack capacity.171 The Expert Committee conceded that, in some circumstances, this principle would have to be subordinated to a criterion based on risk to public safety. The Scottish Mental Health (Care and Treatment) (Scotland) Act 2003 contains a criterion of significantly impaired decision-making, which is a modified capacity criterion whereby patient autonomy has to be respected unless the patient’s ability to make decisions about the provision of medical treatment is significantly impaired as a result of his mental disorder.172 A wide range of submissions received by our Committee supported strongly the inclusion of an additional test of impaired decision-making.

152. The Government has explained its decision to exclude the concept of impaired decision-making as follows:

“A capacity based system (even one based on the more limited test of ‘impaired decision making’) would be ineffectiveto prevent the harm [by mentally-ill patients] to themselves or others which may result from their disorder.

“There would be a risk of people being able to refuse treatment until they were so seriously ill that they would then be covered by the incapacity/impaired judgement criterion and this would result in professionals feeling obliged to use a very wide interpretation of impaired judgement. A capacity based approach would also disadvantage people with fluctuating capacity as this could lead to inconsistent treatment with consequent relapses and recovery once compulsion was restored.

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170 Schedule of Comments: Government Response 9(u) (at annex 4)
172 The notion of “significantly impaired decision-making” is explained in detail in the Scottish Executive’s Consultation Document: Draft Code of Practice for the Mental Health (Care and Treatment) (Scotland) act 2003, Volume 1; 31, March 2004; Chapter 1, paras 33 – 38. It states that: “This concept is separate to that of ‘incapacity’ […] However, when assessing a person’s decision-making ability, it is likely that similar factors will be considered to those taken into account when assessing incapacity. Such factors could involve consideration of the extent to which the person’s mental disorder might adversely affect their ability to believe, understand and retain information concerning their care and treatment, to make decisions based on that information, and to communicate those decisions to others. One difference between incapacity and significantly impaired decision-making ability arguably arises out of the fact that the latter is primarily a disorder of the mind in which a decision is made, but is made on the basis of reasoning coloured by a mental disorder. Incapacity, by contrast, broadly involves a disorder of brain and cognition which implies actual impairments or deficits which prevent or disrupt the decision-making process. […] A person's decision-making ability should not be considered to be significantly impaired by reason only of a lack or deficiency in a faculty of communication. Similarly, it should not be taken as equivalent to disagreeing with the opinions of professionals”. 
“A capacity based Bill would also have the effect of making it impossible to provide treatment under compulsion for many people with personality disorder who have capacity.

“However, a person’s capacity to make decisions about their treatment, may still inform the three examiners, the clinical supervisor or the Mental Health Tribunal, in making a determination about whether the conditions for compulsion are met”.173

153. Many witnesses, however, saw the introduction of a condition of impaired decision-making partly as a means to prevent the definition from also covering many of the physical and neurological disorders mentioned above, and partly to refine “the scope of the Bill to ensure it is consistent with its intended purpose”.174 King’s College London argued that introducing a condition of impaired decision-making:

“would significantly assuage fears about the breadth of the scope of the Bill. It would also, in relation to an interest in the patient’s own health and safety, reduce the emphasis on the seriousness of risk to self in the third relevant condition. It would be preferable if patients could be treated if they suffered from impaired decision-making capacity, and treatment were available that was of therapeutic benefit having regard to all of the circumstances of the case (thus approximating the ‘best interests’ concept in the Capacity Bill)”.175

Dr Zigmond from the Royal College of Psychiatrists explained the nature of impaired decision-making and the difference between capacity and impaired decision-making thus:

“Clinical practice, supported, as I understand it, by the courts, have confirmed that the degree at which one is declared or one declares a patient to be incapacitated depends to quite a significant degree upon the seriousness of the potential consequences of that decision. The notion that there is a particular cut off point one side of which somebody lacks capacity, the other side they retain capacity, is of itself wrong. We are only adding to that variation. Why do we use the words we do? One of the acknowledged difficulties with the current definition of ‘incapacity’ is that it relies almost entirely on a person’s ability to think, what we call cognitive ability, and we recognise that in the field of mental health, of course, emotions play a large part, and so at a very practical clinical level we think that the notion of impaired decision-making by reason of mental disorder would be much easier for people to understand and relate to patients with mental health problems and, of course, it would keep us in line with the provisions in Scotland”.176

Dr Zigmond pointed out that adding a concept of impaired decision-making would help refine the condition relating to self-harm set out in clause 9(4)(a)(i), and maintained that it is profoundly discriminatory for compulsory powers to apply to mentally-ill people in danger of causing harm to themselves unless it is clear that their ability to make decisions about their disorder and treatment is impaired by the mental disorder. He pointed out that

173 Schedule of Comments: Government Response 9(c) (at annex 4)
174 Ev 901 (Leeds Mental Health Trust), para 4.2.2
175 Ev 779, para 2.4.5
176 Q 80 (Dr Zigmond, Royal College of Psychiatrists)
“people constantly fail to follow medical advice in relation to their physical healthcare”\textsuperscript{177} and that people with such illnesses are free to harm themselves, be it through action or inaction, even when this proves fatal. He maintained that:

“we accept the notion - whether it is right or wrong I do not want to enter into - but we accept the notion that people are autonomous and are entitled, as it were, to end their lives by refusing medical treatment. When you use the words ‘seriously mentally-ill’ it seems to me that either one is using those words saying that such people will have impaired decision-making, and, if they do, we believe the law enables a means to protect them. I do not know if there are people with a serious mental illness who do not have impaired decision-making, but, if they do exist, […] then it seems to us that the same rules should apply; otherwise one is just being discriminatory and rather stigmatising”.\textsuperscript{178}

154. Some witnesses pointed to a significant inconsistency in the Bill arising from the fact that capacity criteria and the basic principle of personal autonomy are accepted in some provisions of the Bill, namely in relation to ECT. Whilst ECT is surrounded by a great deal of fear, and sometimes moral objections, the same could be said for other medical treatments administered to people with mental disorder.\textsuperscript{179} Therefore, the nature of the treatment itself cannot be seen to justify the application of different, and more restrictive criteria for its application. King’s College London pointed out that:

“It is curious that capacity and consent become important in relation to ECT and psychosurgery but play no role in other parts of the Bill. This further points to a gap in the ‘relevant conditions’ that we have mentioned in relation to the value of a capacity-based criterion”.\textsuperscript{180}

155. We acknowledge the Government’s concerns about the use of a criterion of impaired decision-making, but we believe that most of those concerns can be overcome. We believe that compulsory powers should only ever be used as a last resort when people are very seriously ill, and we do not agree that a person would become too seriously ill before an impaired decision-making criterion is met.\textsuperscript{181}

156. The Committee accepts the argument that an additional condition requiring a person to have “significantly impaired decision-making” should be added to clause 9. We do believe, however, that impaired decision making should relate specifically to the decision to accept care and treatment. \textbf{We recommend that the Bill, as in the Mental Health (Care and Treatment) (Scotland) 2003 Act, include a condition at clause 9 that by reason of mental disorder the patient’s ability to make decisions about the provision of medical treatment is significantly impaired.}

\textsuperscript{177} Q 89 (Dr Zigmond, Royal College of Psychiatrists)
\textsuperscript{178} Q 81 (Dr Zigmond, Royal College of Psychiatrists)
\textsuperscript{179} Ev 13 (Mental Health Act Commission), para 6.14; Ev 279 (Mr Hewitt), para 6(1)(b)
\textsuperscript{180} Ev 779, para 6.1
\textsuperscript{181} Schedule of Comments, Government Response 9 (c) (at annex 4)
The combined effect of the proposed definition and conditions

157. The Committee has reviewed exhaustively the evidence with regard to the definition of mental disorder and the conditions for the use of compulsory powers. We have reached the conclusion that some of the provisions cannot be sustained or need to be modified. However, the majority of provisions are not inappropriate in themselves. As many witnesses have pointed out, it is when the definitions and conditions are taken together that many of the problems arise. The definition of mental disorder is not in itself problematic, but it does require tight and specific conditions for the use of compulsion in order to create an appropriate balance. We agree with the Institute of Mental Health Act Practitioners in their observation that, in its current form, the Bill could result in a situation in which:

“social interventions that most people do not think of as medical treatments, given to individuals who most people do not regard as mentally disordered, constitute medical treatments for mental disorder.” 182

158. We have accepted the broad definition of mental disorder as the best way forward, but we have proposed that specific exclusions should be inserted, and we have put forward recommendations for ways to tighten the conditions that have to be fulfilled for a person to be placed under compulsory powers. An over-inclusive Bill which could be used to justify compulsion other than as a last resort in respect of people who are desperately ill or pose a serious danger to others would be morally indefensible in the 21st century. A Bill which allows this to happen is not saved, ethically or practically, by having good safeguards. In fact over-inclusive definitions and conditions weaken the safeguards. As Professor Richardson persuasively explained:

“the effectiveness of any safeguard provided by the Tribunal under the Bill will be hugely dependent on the nature of the statutory conditions that it has got to police. Over-broad conditions will mean weak safeguards and they will mean an over-worked Tribunal because you will have an awful lot of people under compulsory powers.” 183

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182 Ev 92, section 2
183 Q 1 (Professor Richardson)
4 Interface with the Mental Capacity Bill

159. In addition to the draft Mental Health Bill, if it is enacted, the future framework for mental health legislation in England and Wales will include the provisions of the Mental Capacity Bill, which was going through Parliament while we were holding our inquiry. Both Bills provide legal authority for treatment without consent. The application of both Bills is dependent on the presence of “an impairment of, or a disturbance in the functioning of, the mind or brain”. The two Bills are, however, based on very different foundations, serve different purposes and will apply to different, but not mutually exclusive, groups of people. The draft Mental Health Bill authorises the treatment of mental disorder without a person’s consent where it is necessary to protect him or others from harm. The Mental Capacity Bill operates by providing a defence to anyone who gives treatment which is necessary in the incapable person’s best interests, and does not have the procedural safeguards surrounding compulsory treatment present in the Mental Health Bill. Amendments recently tabled to the Mental Capacity Bill will also provide a power, the scope of which will be defined in regulations, to detain by placing in protective care a mentally incapacitated person (see paragraph 181 below).

160. Since both mental health and capacity legislation affects mentally disordered persons, the interface between the two will be important for both patients and clinicians operating under the legislative framework. The interface between the Mental Capacity Bill and the draft Mental Health Bill was a topic which provoked a substantial amount of discussion during our inquiry. King’s College London stated:

“There is serious scope for confusion. We have found no mention of the Capacity Bill. Yet, despite two totally different approaches to the treatment of patients identically defined in both Bills (having ‘an impairment of, or a disturbance in the functioning of the mind or brain’), no attempt has been made to decide when one or the other legal regime is appropriate. There are substantial areas of overlap where either the Mental Health Bill or the Capacity Bill could apply”.

161. The potential for confusion was an issue raised by many witnesses. The Law Society considered the relationship between the two Bills to be “so complex that, in many cases, it would be practically impossible to work out when one Act should be used and the other should not”. The Mental Health Act Commission also expressed concern at the “grey area” that exists between the two Bills:

“[…] there are some patients who could be detained under either Bill, or could ping-pong back and forth between the Bills, depending upon whether they have capacity or not at a particular time”.

184 Mental Capacity Bill [Lords] [Bill 1 (2004-05)] (as amended in Committee on 8th February 2005), clause 2(1); draft Mental Health Bill 2004, clause 2(5)
185 Ev 779, para 8.1
186 See for example: Ev 119 (Mental Health Alliance), section 12; Ev 843 (Mr Leason); Ev 462 (West London Mental Health NHS Trust), theme 8; Ev 1047 (Bevan Brittan, Solicitors), question 8
187 Ev 165, question 8
188 Q 47 (Mr Heginbotham)
162. There are three principal areas where the interface between capacity and mental health legislation will be important:

a) where it would be possible to detain someone in protective care under the Mental Capacity Bill, in relation to the decision whether a person should be detained under mental health or mental capacity legislation;

b) whether treatment without consent for mental disorder should be given under mental health or mental capacity legislation; and

c) the extent to which advance decisions refusing medical treatment and advance statements requesting certain treatments for mental disorder should be recognised.

Detention

163. The Government intends to bridge the so-called “Bournewood Gap” by providing in the Mental Capacity Bill for detention of mentally incapacitated adults under protective care, rather than under mental health legislation. In relation to the decision whether a person should be placed in protective care rather than detained under mental health legislation the Government has tabled amendments to the Schedule to the Mental Capacity Bill to amend sections 3 and 20 the Mental Health Act 1983 (see paragraph 181 below). These provide that the Secretary of State may by regulation prescribe circumstances in which the fact that a person could be detained under the protective care regulations may be ignored in determining whether he should be detained, or continue to be detained, for treatment without consent under section 3 of the 1983 Act. The boundary between the respective powers of detention will therefore be determined by regulation. Since we have not seen any of these regulations we are not in a position to comment on the adequacy of the provisions for protective care or the provisions relating to the interface between the protective care provisions and powers of detention. On the assumption that the Mental Capacity Bill does bridge the so-called “Bournewood Gap” with provisions which deal effectively with protective care for certain persons lacking mental capacity, then nothing in the Bill should be considered capable of negating those provisions.

Treatment without consent

164. Clause 28 of the Mental Capacity Bill provides as follows:

“(1) Nothing in this Act authorises anyone –

(a) to give a patient medical treatment for mental disorder or

(b) to consent to a patient’s being given treatment for mental disorder,

if at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the 1983 Act”.

165. Paragraph 2.15 of the draft code of practice for the Mental Capacity Bill states that clause 28 will ensure that the mental capacity legislation “does not apply to any treatment for a mental disorder which is safeguarded in the provisions of Part 4 of the Mental Health Act. The procedural safeguards in that Act take precedence and must be followed when
treat patients to whom that part applies”.

However, clause 28 will only apply when the person is already liable to be detained under mental health legislation, and does not provide clear guidance as to which legislation to use where the person is not already detained or liable to be detained under the 1983 Act.

166. When we questioned the Government about the lack of clear boundaries between the two Bills, we were informed that there was indeed scope for overlap but that this was intentional in order to avoid inflexibility:

“[...] we want to preserve discretion for professionals to decide when compulsory treatment under the Mental Health Bill is to be preferred to treatment in a patient’s best interests under the Mental Capacity Bill. [...] We intend to use the Codes of Practice to guide decision-makers normally to use formal mental health powers where treatment needs to be given against patients’ objections (and the other conditions are met). But we do not want to create a rigid dividing line. Patients’ circumstances differ so greatly, we are wary of legislation that assumes that they can be neatly divided into those who comply and those who resist. To that extent, we doubt that the ‘distinct and coterminous boundary between the two Bills’ […] is actually what is needed”.

167. So is a clear boundary between the application of the two of the Bills really necessary? The balance of the evidence offered a very different view from that expressed by the Government. The clear preponderance of opinion was that leaving the decision to the discretion of clinicians would inevitably result in inconsistencies in the application of the two Acts. The Mental Health Alliance was concerned that:

“Staff may be very unclear as to whether to use common law, mental capacity or mental health legislation if they try and restrain the person from leaving. Staff may also attempt to use the [Mental Capacity Bill] for longer periods to detain someone in hospital if they perceive it as an ‘easier’ and less bureaucratic option than mental health legislation”.

168. The determination of which Bill will be applicable to a patient takes on further significance because the respective safeguards differ. The Mental Capacity Bill makes provision for advance statements and the appointment of a donee under a lasting power of attorney, or a court-appointed deputy who can be empowered to make some health and welfare decisions on behalf of the incapacitated person. These safeguards have, however, been viewed as more limited than those contained in the draft Mental Health Bill which, for example, has the requirement that compulsory treatment must be authorised by a tribunal. The Law Society warned that the lack of clear boundaries between the Bills would mean that many people who lacked capacity, but who also suffered from a mental disorder,

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189 Department of Constitutional Affairs, Mental Capacity Bill: Draft Code of Practice, September 2004, paragraph 2.15
190 Ev 505 (Minister of State at the Department of Health, Ms Rosie Winterton MP)
191 Ev 119, para 12.10
192 Clause 9 of the Mental Capacity Bill would provide that one person – the donor – may confer a lasting power of attorney on another, who in the Bill is called the donee.
would not enjoy the safeguards in the draft Mental Health Bill, because they could lawfully be treated under the Mental Capacity Bill.\(^{193}\)

169. Although we recognise that defining the boundaries between the operation of the two regimes will be a complex and challenging task, we consider it imperative that the interface is made clear. Accordingly, we recommend that, before Parliament is asked to assent to the Mental Health Bill, a clearer analysis of the interrelation between the two pieces of legislation be presented. The relationship between the Mental Capacity Bill and a future Mental Health Bill should be clarified primarily so that clinicians have a clear understanding of their application in each particular case. This could conveniently be a common part of the respective codes of practice.

**Advance Statements**

170. Although the safeguards in the Mental Capacity Bill have generally been viewed as inferior to those in the draft Bill relating to treatment without consent, there was support in the memoranda we received for a provision recognising the effect of advance decisions to refuse medical treatment, and advance statements requesting certain treatments in the event of the patient becoming ill and needing treatment for mental disorder. Clause 24 of the Mental Capacity Bill makes provision for a person to make an advance statement or decision to refuse treatment in defined circumstances.\(^{194}\) Advance decisions under the Mental Capacity Bill will extend to the refusal of life-sustaining treatment if the patient has made this specification clear in the advance decision. The Royal College of Psychiatrists described the right to make an advance decision as “empowering” for patients.\(^{195}\) Furthermore, the Joint Committee on Human Rights (JCHR), in its report on the 2002 draft Mental Health Bill, recommended:

> “the right of patients to give directions about their future treatment, during periods when they are capable of doing so, should be respected where doing so would not present a threat of death or serious harm to the patient or anyone else”\(^{196}\)

171. The draft Mental Health Bill does not make provision for advance statements or decisions and it is likely that any advance decision made under the Mental Capacity Bill would be over-ridden if a person becomes subject to compulsory powers. The different approaches taken in the two Bills to the subject of advance statements led the Mental Health Foundation to argue that:

> “This would therefore appear to discriminate against people with mental disorders who should have the same rights, unless there are exceptional circumstances such as the likelihood of causing imminent and serious harm to self or others, as people with physical disorders. This seems particularly anomalous when one of the Government grounds for defending the inclusion of advance refusals in the Mental Capacity Bill is that they can be used to enable people to exercise some dignity and control over their

\(^{193}\) Ev 165, question 8

\(^{194}\) In this report we generally use “advance decision” to apply to a refusal of treatment and “advance statement” to relate to wishes regarding the continuation of treatment.

\(^{195}\) Ev 76

\(^{196}\) Twenty-fifth report of the Joint Committee on Human Rights, Session 2001-02: Draft Mental Health Bill, 11 November 2002, HL 181, HC 1294, para 91
treatment and care at the end of their lives, yet [it] prevents advance refusals from being used by individuals in non-life threatening situations solely on the basis that they have a mental disorder”.197

172. We agree that advance statements and advance decisions are a valuable safeguard for patient autonomy. We recommend that the Government bring forward legislation – either in the Mental Health Bill or separately – which would enable people to make advance statements and to record advance decisions, particularly if there is a treatment they would prefer not to receive. We also recommend that the arrangements provide for these statements (in relation to any future mental health treatment) to be taken into account by, but not become binding on, clinicians in determining the provision of medical treatment for mental disorder under the Act.

The “Bournewood Gap”

173. The judgment of the European Court of Human Rights in the case of *HL v United Kingdom* (the Bournewood case)198 drew attention to deficiencies in the current mental health law. The issue before the Court was whether a mentally incapacitated person, L, who was not resisting admission or seeking to leave hospital could, nevertheless, be viewed as having been deprived of his liberty and therefore entitled to the safeguards provided by a procedure prescribed by law, including a review of his detention before a court with the power to order his discharge. The House of Lords had held, by a 3-2 majority that L had not been detained, but that, in any event, detention would have been in his “best interests” and thereby justified under the common law doctrine of necessity. Lord Steyn, however, in his dissenting speech in the case referred to the ‘lacuna’ which the House of Lords decision created, leaving compliant incapacitated patients without the safeguards enshrined in the 1983 Act. He stated:

“The general effect of the decision of the House is to leave compliant incapacitated patients without the safeguards enshrined in the 1983 Act. This is an unfortunate result […] The common law principle of necessity is a useful concept, but it contains none of the safeguards of the 1983 Act. It places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals”.199

174. This lacuna has come to be known as the “Bournewood Gap”.

175. The European Court of Human Rights found that removal of L to hospital, and his retention there without access to his carers, had amounted to a deprivation of liberty under the Convention, and had to be carried out in accordance with a procedure prescribed by law, as required by Article 5(1)(e) of the Convention.200 The European Court decision meant that the House of Lords decision in the case in favour of the Bournewood Community and Mental Health Trust and against L was no longer “good law”. The Court held that the common law lacked the essential safeguards which would permit detention in compliance with Article 5, namely:

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197 Ev 940, para 3.10
199 *R v Bournewood Community and Mental Health NHS Trust ex parte L* [1998] 3 All ER 289, at 308
200 See chapter 1
• formalised admission procedures which indicated who could propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions;

• a requirement to fix the exact purpose of admission (for example, for assessment or for treatment);

• limits in terms of time, treatment or care attached to admission;

• a specific provision requiring continuing clinical assessment of the persistence of a disorder warranting detention; and

• the nomination of a representative of a patient who could make certain objections on his behalf.

176. The hospital in which L had been detained had concluded that formal detention under the Mental Health Act 1983 was not necessary as L was compliant and had not resisted admission. Since L was admitted as an “informal patient” the procedural safeguards accorded to patients detained under the 1983 Act were not made available to him. The case brought to light the absence of procedural regulations and limits for patients who lacked capacity to consent to, but did not resist, detention.

177. When the Joint Committee on the draft Mental Incapacity Bill published its report, the European Court of Human Rights had not yet delivered its decision in *HL v UK*. The Minister told the Joint Committee on the draft Mental Incapacity Bill that the protections under the common law for compliant incapacitated patients were sufficient to comply with the Human Rights Act, but that additional protections would be included in Part 5 of the draft Mental Health Bill rather than in the capacity legislation. Part 5 of the 2002 draft Mental Health Bill proposed to extend a degree of statutory protection for the informal treatment of patients not capable of consenting to treatment. The safeguards included:

• a right to advocacy;

• the appointment of a nominated person; and

• access to a tribunal.

178. The JCHR considered that the new safeguards constituted “major protections for the human rights of patients who are unable to consent to treatment but do not require compulsory treatment”. It did, however, remain concerned that the provisions would not apply to two categories of patient:

• children under the age of 16; and

• patients being treated as non-resident patients, or patients in residential homes.

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201 Report of the Joint Committee on the Draft Mental Incapacity Bill, Session 2002-03, 17 November 2003, HL 189, HC 1083, para 224

202 Draft Mental Health Bill, Cm 5538, June 2002

203 25th Report of Session 2001-02 (HL Paper 118, HC 1294), para 78

204 Part 5 of the 2002 draft Mental Health Bill was only applicable to patients in hospital
The JCHR therefore considered that protections should be extended to children and to all patients who lacked capacity to consent to treatment.\textsuperscript{205}

179. The additional safeguards in the 2002 draft Mental Health Bill, for the informal treatment of patients not capable of consenting, have been removed from the current draft Mental Health Bill. The Government stated that the provisions had been taken forward in the Mental Capacity Bill.\textsuperscript{206} The Royal College of Psychiatrists believed:

“"The need for safeguards for people who lack capacity applies to a range of situations, both in and out of hospital. However, the problem with the Mental Capacity Bill, as it stands at present, is that it does not have sufficient safeguards (such as rights to second opinions and a clearly established system of appeal to Tribunals)."”\textsuperscript{207}

Mr Hewitt, solicitor, stated that the provisions in the Mental Capacity Bill did not include the key features identified by the European Court of Human Rights:

"In fact, those features more closely resemble the provisions for ‘informal treatment of patients not capable of consenting’ that were a central feature of the 2002 Draft Mental Health Bill […]. Those provisions seem to have disappeared from view”.\textsuperscript{208}

180. As a result of the decision of the European Court of Human Rights in \textit{HL v UK} the Government conceded:

“"[…] there is no doubt that we still lack sufficient procedural safeguards to prevent further breaches of Article 5.1 in cases where patients are, in effect, deprived of their liberty in their best interests.”}\textsuperscript{209}

181. The Government informed the Committee that it was committed to bringing forward proposals for appropriate safeguards and will be consulting interested parties, including representative groups, the NHS and local authorities.\textsuperscript{210} It has tabled amendments to the Mental Capacity Bill which will not be debated before we complete our deliberations and so we shall not know if these have been adopted before our report is published.\textsuperscript{211} Nor have

\textsuperscript{205} 25\textsuperscript{th} Report of Session 2001-02 (HL Paper 118, HC 1294), paras 79-81

\textsuperscript{206} Department of Health, \textit{Improving Mental Health Law: Towards a new Mental Health Act}, September 2004, p. 10

\textsuperscript{207} Ev 76

\textsuperscript{208} \textit{Effective, unqualified control}, \textit{New Law Journal} (Vol 154, p. 1553)

\textsuperscript{209} Stg Co Deb, Standing Committee A, Mental Capacity Bill, 28 October 2004, col 251 (Minister of State at the Department of Health, Ms Rosie Winterton MP)

\textsuperscript{210} Ev 505 (Minister of State at the Department of Health, Ms Rosie Winterton MP)

\textsuperscript{211} The key amendments tabled on 22 February 2005 for consideration on Report in the House of Lords provide that the power to restrain a mentally incapacitated person in clause 6 of the Mental Capacity Bill would not extend to allowing a deprivation of liberty for the purposes of Article 5(1). People who lack mental capacity and are deprived of their liberty would be dealt with under regulations. The amendments propose a new clause after clause 59 in the Mental Capacity Bill to confer a regulation-making power on the appropriate authority (the Secretary of State for Health in England and the Welsh Assembly in Wales). These regulations would authorise “the detention in prescribed circumstances, of prescribed descriptions of persons who lack capacity, for the purpose of providing them with treatment or care which is determined, in accordance with the regulations, to be in their best interests”. Any person detained under the regulations would be deemed to be in protective care, and detention would include any deprivation of liberty under Article 5(1). The Regulations would in particular be able to include provision:

(a) as to the premises in which protective care may be provided;

(b) requiring prescribed conditions to be complied with in relation to the provision of protective care;

(c) as to safeguards to be provided for, or in relation to persons in protective care;
we been able to see the regulations to which the amendments refer and so it is not possible for us to judge whether the amendments will prove effective cover for the lacuna identified by the ruling in _HL v UK_. In the interim, the Department of Health issued guidance to NHS bodies and local authorities treating incapacitated patients.\textsuperscript{212}

182. We welcome assurances from the Government that additional safeguards will be provided for compliant incapacitated patients who are treated informally.\textsuperscript{213} Although the safeguards in Part 5 of the 2002 draft Mental Health Bill would, to some extent, assist in closing the _Bournewood_ gap, we agree with the opinion of the JCHR that they fail to protect all patients in the position of the patient in _HL v UK_. We urge the Government to bring forward a comprehensive and universal set of proposals to deal with hospitalisation and treatment of patients affected by the Bournewood judgment, either as amendments to a Mental Capacity Bill (as it appears to be intending now), or, failing that, by introducing proposals in the Mental Health Bill, as soon as possible.

\begin{itemize}
\item[(d)] for a person’s protective care to be reviewed at prescribed intervals or in prescribed circumstances;
\item[(e)] as to the circumstances in which a person’s protective care must, and those circumstances in which it may, be referred to a prescribed court or tribunal for decision as to whether it should continue;
\item[(f)] as to the circumstances in which a person is to be discharged from protective care;
\item[(g)] as to the persons by whom powers conferred by the regulations may be exercised;
\item[(h)] as to the rights of persons in protective care to appeal to such court or tribunal as may be prescribed; and
\item[(i)] as to the powers and functions of a court (or tribunal to which a reference or appeal is made).
\end{itemize}

The regulations would be able to include provision similar to that in section 139 of the 1983 Act which provides protection in relation to acts done in pursuance of the Act, and could provide for the provisions of the MCB not to apply or to apply with prescribed modifications.

\textsuperscript{212} Department of Health, _Advice on the decision of the European Court of Human Rights in the case of HL v UK (the “Bournewood” Case) [Gateway Reference 4269], 10 December 2004 at http://www.dh.gov.uk/_

\textsuperscript{213} We note that this matter was under further consideration by the Government and Parliament and that as we were concluding our deliberations the Government were bringing forward further amendments to the Mental Capacity Bill.
5 Compulsory treatment in the community

Introduction

183. As we observed in chapter 1, the period after the Second World War has been characterised by a very significant shift in the treatment and care of people with mental disorders away from institutional settings and into the community. The scale of this transformation is clear from the fact that whereas there were 154,000 psychiatric beds in 1954, the current figure is around 33,000. In principle, if not in practice, this development has been confined to voluntary treatment because the 1983 Act, like its predecessors, links assessment and treatment under compulsion to institutional detention.

184. In reality, both the 1959 and the 1983 Acts, however, contained “back-door” methods which allowed scope for treating people under compulsory powers in the community. The 1983 Act contains three mechanisms: guardianship, extended leave and supervised discharge. Of these, extended leave is by far the most commonly used. When a patient is granted extended leave, the possibility of instant recall and renewed detention can be used as a lever to persuade the patient to comply with their treatment plan even when not detained. Patients who refuse medication, and thereby breach a condition of leave, may be recalled to hospital if necessary on the grounds of their health or safety or for the protection of others. We believe that is a commonly used tool for managing patients who frequently relapse (so-called ‘revolving door patients’) who keep perpetuating a cycle of getting better whilst receiving compulsory treatment, only to falter with their medication once discharged, relapse, and require re-admission to hospital. The Mental Health Act Commission estimated that under the current system:

“there is an unknown but probably relatively significant proportion of the approximately 13,500 patients detained under the 1983 Act at any one time whose care and treatment involves significant periods of leave from hospital”.

185. From the beginning of its reform of the Mental Health Act, one of the Government’s objectives has been the introduction of a more “mainstream” and straight-forward framework for the use of compulsory powers outside of institutional settings. The Government believes that:

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214 Q 514 (Mr Howlett, Zito Trust); Mind, Key dates in the history of mental health and community care, (at http://www.mind.org.uk/) says: “1954 … the resident population of psychiatric hospital beds reached a peak of 152,000”; HC Deb, 18 November 2003, col 871W: the average daily number of mental illness beds for England in 2002–03 was 32,753.

215 Mental Health Act 1983, section 17

216 Mental Health Act 1983 (as amended by the Mental Health (Patients in the Community) Act 1995) ss. 25A-25H

217 Ev 50 (Royal College of Psychiatrists), question 2C(c)

218 Ibid

219 Ev 13, para 2.36

220 Q 1 (Professor Richardson)
“the use of formal powers in the community will provide a positive alternative for the many patients who do not want or need to be detained in hospital and an opportunity to minimise the disruption to their lives”. 221

Furthermore, the Government argues, moving the use of compulsory powers into the community can help in:

“reducing the risk of social exclusion that can result from detention in hospital under the current Act”. 222

186. The 2004 draft Bill proposes the introduction of non-residential orders whereby a non-resident patient can be required under compulsory powers to:

a) attend at a specified place at specified times;

b) reside at a specified place;

c) make himself available for assessment during specified periods; and

d) not engage in specified conduct. 223

187. The Mental Health Act Commission has assessed the legal position of patients currently treated under compulsion in the community on the basis of provisions in the 1983 Act to “closely approximate those proposed as ‘non-residential’ orders” in the draft Bill. 224 The Commission argues that the provisions in the Bill primarily serve to consolidate and clarify the current position. Specifically,

“the proposed general power to use formal powers on a non-residential basis could provide something of a consolidation of existing but diffuse and uncertain legal powers”. 225

The draft Bill broadens the current provisions in allowing, in principle, assessment as well as treatment to take place in the community. 226 This provision is aimed at patients who are sectioned repeatedly, 227 but may not need a residential assessment on every occasion. The Bill provides regulation-making powers to limit the extent to which assessments are carried out on a non-residential basis. 228


223 Draft Mental Health Bill 2004, cl. 26 (5)(a) and (b)

224 Ev 13, para 2.36

225 Ibid

226 See Draft Mental Health Bill 2004, cl. 15(3) and (4); see also Ev 13 (Mental Health Act Commission), para 2.40

227 So called “revolving door” patients

The principle and efficacy of non-residential compulsory powers

The principle

188. Some witnesses believed that the concept of using compulsory powers in the community is fundamentally flawed because, if a person is mentally disordered to a degree where compulsory powers are warranted, that person is by definition sufficiently unwell to need care and treatment in an institutional setting. No Force said that:

“if a person satisfies all the conditions for compulsion, which includes that they may be at risk to themselves or someone else, then they should be in a safe hospital setting, where they can have 24 hour monitoring, treatment and care. If they are not at risk to themselves or someone else, they should not be under any compulsory mental health legislation. We know, that if compulsion in the community remains in the bill, then many people with mental health problems will be at an increased risk of suicide, and many will succeed because of the lack of mental health service provision in the community”.229

189. Others felt that the shift of compulsion into the community would “contradict […] not only patient choice but the whole ethos of recovery in the community”,230 and that carers and families might be placed in an unsustainable situation, having to care for someone sufficiently unwell to be under compulsory powers. Ms Oakley, a mental health service user and advocate, argued that:

“it is unfair and irresponsible to put […] family or friends in the position where they have to act as untrained, unpaid psychiatric staff trying to prevent the patient from attempting suicide, neglecting themselves or harming others while trying to make them comply with their treatment order. This will put an intolerable burden on carers who could be injured, become ill themselves because of the stress or experience terrible guilt if they ‘fail’ to prevent the patient from harming themselves or others. Compulsion in the community could therefore irreparably damage the patient’s relationships with those closest to them”.231

190. These views were not universal, however. Other witnesses argued that treatment in the community is preferable to hospital, as long as the appropriate care and treatment is available in the community.232 The British Psychological Society noted in particular that:

“the possibility for care plans to be implemented under compulsion in the community may offer a better ‘least restrictive alternative’ than the present Act, which permits only admission”.233

229 Ev 210, para 2.2; see also Q 161 (Mr Estop, Mental Health Alliance)
230 Ev 725 (Mr Kinsella), para 4
231 Ev 751, para 2.4
232 Q 271 (Ms Roberts, Hafal); Ev 50 (Royal College of Psychiatrists), question 2Cc
233 Ev 594, question 2
Efficacy

191. We heard evidence suggesting that whilst a number of Commonwealth jurisdictions have systems for compulsory treatment of mentally disordered patients in the community, research evidence is far from clear as to the efficacy of such treatment.\textsuperscript{234} King’s College London made important points when explaining that:

“the research evidence that community treatment orders are effective in reducing relapse and readmission to hospital is limited. High quality community services are essential if there is to be a benefit, but the better the services the less likely will be the need for community orders. We have research evidence that patients likely to benefit most in terms of preventing relapse and readmission will comprise a relatively small group of ‘revolving door’ patients, who presumably suffer from a psychosis which is responsive to treatment with medication. The range of treatments that can be compelled are limited, injectable medications being the most obvious. Some patients respect community treatment orders and will comply (sometimes because they have false ideas about what will happen if they do not). For those that do not, the consequences of non-compliance are important. Given the endemic shortage of psychiatric beds, readmission of a patient who has not complied with his or her treatment conditions but is not seriously symptomatic is unlikely. A brief admission for an injection would be an option, but may be difficult to arrange in practice. If restraint is used, a period of close observation will be required”.\textsuperscript{235}

Dr Patrick Power, Consultant Psychiatrist at the South London and Maudsley Mental Health Trust, indicated, on the basis of his own research in Australia, how the results of compulsory treatment in the community tend to vary significantly according to age and other socio-demographic characteristics:

“the group who did best on the community treatment orders were those people who had longstanding illness with clear evidence of poor adherence [to] treatment before the onset of the order. The group who did least well were the younger group in the early phase of their illness, maybe without the full experience and impact of the illness on their lives and maybe with less respect for mental health legislation generally, and I wonder whether it was, to a certain extent, a generational aspect, that the older group were maybe more respectful of legislation than the younger group. The younger group were a group often with dual disability, with substance use problems and a range of other complicated social problems for whom maybe respect for legislation and the law was less paramount”.\textsuperscript{236}

192. The evidence we received on the basic principle and efficacy of non-residential orders is finely balanced. We are not wholly convinced by arguments that such treatment is wrong or undesirable per se, but neither are we satisfied that compulsory treatment in the community is appropriate and satisfactory for anything other than a small minority of patients. In principle, we accept the case for non-residential treatment under compulsion is acceptable, although the evidence is mixed. We recommend that the use of non-
residential treatment under compulsion be explicitly limited to a clearly defined and clinically identifiable group of patients.

**The framework proposed in the draft Bill**

193. The most common concern aired by witnesses with regard to compulsory treatment in the community relates to the actual provisions in the draft Bill rather than the principle of non-residential treatment. Many witnesses felt that to make non-residential compulsion a “mainstream” part of the Bill *in conjunction with* the currently proposed broad and inclusive conditions for the use of compulsion would lead to significant increases in the numbers of people brought under compulsion, and indeed the numbers retained under compulsory powers.  

237 Ev 119 (Mental Health Alliance), para 5.5

238 Q 11 (Professor Richardson)

239 Ev 895 (Depression Alliance Cymru)

240 Q 40 (Mr Heginbotham, Mental Health Act Commission)

“you could have somebody who might come in under compulsory powers when they were really quite florid and really quite ill and they would become better and it would be appropriate to move them perhaps still into the community and the ability under this Bill would be to continue the compulsory powers into the community, and that is what worries me. It is a sort of lobster pot; it is easy to get in, but it is very difficult to get out because the broad conditions are very difficult not to meet”.  

194. Some went further, believing that the conditions for compulsion, with their emphasis on risk rather than impaired decision-making and therapeutic benefit, could make non-residential orders into a kind of mental health ASBO (Anti-Social Behaviour Order). The Mental Health Act Commission argued that:

“it could become a form of civil restriction order without end. The Tribunal would be in a position to say ‘We are going to place the person on this non-resident order and we are reserving to ourselves the power to end that’, so it would not be ended by a clinician, it would be ended by the Tribunal and you would have to keep coming back to the Tribunal. It seems to me that that is a danger […] Our serious concern would be that perhaps over time those clauses would start to be used in a way that would provide controlling arrangements, perhaps, for young black people who are thought to be drug addicts and they are placed on what would be the equivalent of an Anti-Social Behaviour Order but run under the Mental Health Act. I think that is a very serious concern”.  

240 Q 40 (Mr Heginbotham, Mental Health Act Commission)

Others expressed concern that non-residential orders could come to be used in a highly inappropriate manner. As the Institute of Mental Health Act Practitioners explained, the type of restrictions that can be placed compulsorily upon people in the community is in itself very wide:

“we could have a situation where a condition of non-residency is that the patient takes their medication. Fine. Another condition could be that they reside at a particular place. Another condition could be that they are inside their place of
residence during night time hours. They are not allowed out, a curfew, if you wish. Then you could go all the way and say they are not allowed out of their house at all. They have to stay in there 24 hours a day. They are not allowed to go out to a certain place to buy drugs or go to the pub and essentially they are under some form of house arrest, if you will. If the Bill is going to say, ‘We are going to impose conditions on people who are non-resident but subject to a compulsory order’ I think the Bill should be saying what those conditions may or may not be. I am not sure that we are in a position at the moment to say what those conditions should or should not be”.241

195. A number of organisations expressed more specific concerns with regard to the framework for the use of non-residential powers. The Mental Health Act Commission was concerned about the potential for patients to be subjected to assessment as well as treatment in a non-residential setting, something which was not possible under the 1983 Act. The Commission stated that:

“It is less clear how such powers might be used reasonably in a civil context to initiate a period of compulsory treatment. It seems possible that the practical thresholds for imposing some legal restraints on patients under non-residency powers may be lower than those for the use of residency powers. We remain sceptical over the implication that the decision whether to impose serious legal restrictions on a patient’s liberties could be taken through community-based assessment if the patient is known to services”.242

The Royal College of Psychiatrists made a similar point, arguing that “Community Treatment Orders should be available for patients only on authorisation of the tribunal after a period of in-patient assessment and whilst the person suffers impaired decision-making by reason of their mental disorder”.243

196. The Mental Health Alliance looked at the provisions used in other jurisdictions in order to target appropriately the use of non-residential powers. They pointed to the Canadian province of Saskatchewan where mental health legislation delineates in very clear terms to whom non-residential treatment can be authorized. The Saskatchewan criteria for the use of non-residential compulsory powers include a condition that the patient has:

a) “spent at least 60 days as an involuntary in-patient in a psychiatric facility, or

b) been an involuntary in-patient in a psychiatric facility on three or more separate occasions, (or previously been the subject of a community treatment order)”.244

197. We agree with many experts, service users and practitioners that, as the Bill currently stands, non-residential compulsion could be applied to a far wider population than is appropriate, and in circumstances which could be unacceptable. We therefore recommend the following series of amendments to the Bill which would focus the provisions of the Bill proper on a clearly defined and clinically identifiable group of

241 Q 117 (Mr Davis, Institute of Mental Health Act Practitioners)
242 Ev 13, para 2.40
243 Ev 50 (Royal College of Psychiatrists), summary section 2
244 Ev 119 (Mental Health Alliance), para 5.20; see also Ev 657 (Dr Bartlett)
patients - for example, patients who frequently relapse245 - and limit the scope and potential duration of non-residential compulsory treatment.

198. The primary legislation and its regulations should provide a robust safeguard against the emergence of any two-tier threshold for imposition of formal powers.

199. The following parameters for the use of non-residential compulsory powers should be included on the face of the Bill.

a) A non-residential order should not normally be imposed without previous hospitalisation at least for the purposes of assessment.

b) There exists evidence of previous responsiveness to, and co-operation with, proposed treatment before a non-residential order is imposed.

c) Provisions for non-residential orders should be simple and be used to specify only:

requirements or limitations on a person’s place of residence; and
medical treatment.

d) There must be a maximum time limit for treatment under a non-residential order – certainly of not more than three years in any five year period.

e) The non-residential order must not authorise the use of force on the patient in the community (i.e. outside hospitals or clinics) beyond the powers currently available in the 1983 Act which provide for a patient to be conveyed to the place he is required to attend for treatment or to be conveyed to hospital.

200. We are convinced that for non-residential orders to be successful, a high level of effective inter-agency co-operation is required. It is essential that all agencies involved with the patient are able to communicate and share information effectively, and that the involvement of many agencies is not used as an easy way of “passing the buck”. With respect to patients who have been involved in criminal proceedings in the past, or who exhibit challenging behaviour in the community, the effective involvement and communication with the police and courts is particularly important for the purposes of risk management and public protection.

_**A substitute for resources?**_

201. Finally, some witnesses expressed concern that resource management might be a key issue causing recourse to non-residential compulsion. We heard from Mr Christopher Heginbotham, Chief Executive of the Mental Health Act Commission, that, under the current Act:

“it is fairly evident that leave is used as a way of managing beds at the moment. Many psychiatric units, particularly in our inner cities, run at over 100 per cent bed occupancy. Beds are allocated to two or three patients simultaneously: one is in the bed, one is in the day room and one is out in the community. This is a very

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245 This group of patients is sometimes referred to as “revolving door” patients.
significant problem and we think that the non-resident order arrangement may well be used as a way of managing that.” 246

202. We see no evidence that the level of pressure on residential facilities is going to abate and, as a consequence, there is likely to be strong pressure for clinicians to use non-residential compulsory powers, even in cases where that might not be the most appropriate option. Citizens Advice highlighted the problems caused in community services by shortages of services and staff:

“It is of paramount importance that full health services in the community are available and properly complemented with advice and support to cover benefits, income and housing which helps people with mental health problems to manage their lives. Without these services people’s condition may deteriorate. This seems more than likely given the patchy and sometimes slow development of new critical services such as early intervention, assertive outreach and crisis resolution teams. Proposed multi-disciplinary teams offer alternatives to hospitalisation but shortfalls put people at risk of hospitalisation and the number of mental health trusts without any star rating has doubled.” 247

203. Dr Power, who has experience of working with Community Treatment Orders in Australia, was of the view that a significant injection of resources would be required in community services, in order to implement adequately the non-residential orders proposed in the draft Bill, and that this might be difficult to achieve in some areas. He said:

“I agree that there would need to be a significant increase in the resources in community services to meet the requirements of these new provisions, in order that community mental health teams can effectively provide a service in the community for people within the conditions of these orders. In some well-resourced areas, I am sure they can, with home treatment teams, assertive outreach teams and mobile rehabilitation team[s], meet the needs of these new provisions but, in other areas where they are poorly resourced, I would be very concerned that these orders would be implemented in a very simplistic and overly restrictive way because you will not be able to add in the richer components of service provision to support these orders.” 248

204. We shall discuss the shortages in terms of staff and funding and the implications for mental health services in chapter 10. However, in the context of the resource issues already set out above, it is worth noting the Mental Health Alliance’s conclusion regarding the efficacy of treatment under compulsion in the community:

“In studies where an arguably positive effect has been found, the community treatment order was combined with extensive community services. A lack of inter-agency working, communication breakdown, inadequate care planning and poor

246 Q 39 (Mr Heginbotham)
247 Ev 829, para 8
248 Q 637 (Dr Power)
risk management were more significant issues in a patient’s condition than the fact of being on an order.”

205. We have come down, on balance, in favour of limited compulsion in the community but we are clear that for this to operate satisfactorily it needs to be underpinned by high quality services to support those subject to non-residential orders. The way to risk failure of these arrangements will be to under-fund the services supporting the non-residential orders. As a method to prevent this from happening we found the Ontario model of reciprocity instructive. In Ontario, authorities are required by law to make services available to patients who are being subjected to compulsory powers in the community. We recommend that the provisions for non-residential orders be accompanied by a requirement on health and local authorities to provide adequate care. Further, adequate care means care other than that provided by families and carers, and any provision for non-residential orders must ensure that burdens are not placed upon families and carers that would fall more properly on clinicians and the health and social services.

249 Ev 119, para 5.15
250 Ev 657, (Dr Bartlett)
6 Child and Adolescent Mental Health Services

Background

206. A patient under 18 years of age may be detained for treatment under the Mental Health Act 1983. However, it is much more common for patients under 18 to be treated under common law or under the authority of those with parental responsibility who can override the young person’s refusal. Under the Mental Health Act 1983 a patient who is admitted for treatment under parental consent has no recourse to the Mental Health Review Tribunal to challenge detention or to a second opinion doctor to challenge treatment without consent.

207. The provisions in the draft Bill relating to under 18 year olds differ from the provisions of the 1983 Act in two main ways.

a) Young people aged 16 and 17 will be able to agree to or refuse treatment for mental disorder, and their decision will not be able to be overridden by parental consent (as is the case under the 1983 Act).

b) Under 16 year olds who are treated under parental authority and who, without parental consent, would meet the condition for the use of formal powers will be entitled to a range of safeguards not applicable under the 1983 Act.

208. Under the draft Bill compulsory powers could be used to treat a patient under 18 if:

a) the patient and the parents refuse to consent to treatment;

b) the patient is 16 or 17 and the patient alone refuses; or

c) the patient is 16 or 17 and is at substantial risk of causing serious harm to others.

A patient under 18 falling within any of the groups above will be liable to treatment under compulsion. If the patient is treated under compulsion, he will be treated under the same procedures as adult patients and will be entitled to the same range of safeguards as adult patients.

209. A patient under 16 who refuses treatment, but whose parents consent to treatment, will still be able to be treated under parental authority. The safeguards that the draft Bill provides for such patients include:

a) an individual written care plan, approved by an independent medical expert;

b) a regular review every three months;

c) representation by a nominated person;

d) the right to go to the tribunal to resolve disputes about the care plan and to review the lawfulness of detention in hospital; and
e) access to the special independent mental health advocacy service for the patient and the nominated person.

**Issues**

210. The 1983 Act did not separate the provisions relating to young people from those relating to adults. We very much welcome the approach of the draft Bill, which has a separate Part – Part 6 – dedicated to the treatment of mental disorder in young people and which recognises that separate and distinct arrangements for people under 18 are necessary.

211. Most of the evidence we received welcomed the new safeguards that will be available for patients who are being treated under parental authority. However, several key issues, which we consider in detail in this chapter, were raised:

a) whether the safeguards go far enough and whether children should have a right to be treated in age-appropriate accommodation and by specialists in child and adolescent mental health services (CAMHS);

b) how the legislation will work alongside other legislation pertaining to minors, e.g. the Children Acts 1989 and 2004; and

c) whether 16 is the right age above which to treat a young person as an adult and whether the provisions applying to under 16 year olds should be extended to 16 and 17 year olds.

**The position of 16 and 17 year olds**

212. Under the provisions of the draft Bill, 16 and 17 year olds are treated as adults. As a consequence of allowing them to make decisions that cannot be overridden by parental authority, the operation of the draft Bill means that, if they meet the relevant conditions in clause 9, there is no way they can avoid the process and stigma of compulsory treatment.

213. The Committee received a great deal of evidence that the safeguards proposed for under 16 year olds should be extended to 16 and 17 year olds. We heard several arguments for this:

a) to limit the risk of abuse of young people admitted to adult wards (see paragraph 225 below);

b) because 16 and 17 year olds are still undergoing developmental changes that require specialist clinical knowledge (see paragraph 226 and following below);

c) to make the Bill compatible with the Children Act 1989 which encompasses all people under 18 (see paragraph 232 and following below); and

d) to make it easier to “dovetail with other provisions and services” that relate to under 18s in order to secure the support systems that are needed.251
214. The Minister of State at the Department of Health told us: “The threshold is set at 16 to reflect the increasing autonomy of young people and to respect their ability to make their own decisions in life”. She argued that the threshold was a sensible one because the Mental Capacity Bill provides the legal framework for decision making in respect of people from 16 onwards who lack capacity to make treatment decisions; and because the Family Law Reform Act 1969 provides that from 16 years old anyone with the mental capacity to do so may consent to treatment and that consent is legal regardless of the parent’s views. However, she acknowledged that the Family Law Reform Act 1969 allows a refusal of treatment by a 16 or 17 year old to be overridden by a parent or by the court and that therefore the draft Bill goes a step further in granting 16 and 17 year olds the same rights as adults.

215. If the draft Bill were to treat 16 and 17 year olds in the same way as under 16 year olds, then it follows that their autonomy would be reduced. They could still be treated under parental authority. However, we believe that there are good grounds to extend the safeguards given to 16 and 17 year olds and therefore we recommend that the Bill provide 16 and 17 year olds who are being treated under compulsion with the same safeguards as under 16 year olds in addition to the rights which they enjoy as adults.

216. Clause 9(7) of the draft Bill applies to those aged over 16 and we have already considered at chapter 3 whether this provision is necessary. In the case of people who are at substantial risk of causing harm to others it disapplies the condition that compulsory powers can only be granted if medical treatment cannot lawfully be provided to the patient without the patient being subject to Part 2 of the Bill. We recommend at paragraph 149 that the provision should be removed from the Bill. If, notwithstanding our recommendation, the provision were to be retained, we consider here whether it should be applied to 16 and 17 year olds.

217. The effect of applying clause 9(7) would be that a person aged 16 or 17 who posed a substantial risk of serious harm to others could not be admitted voluntarily or with parental consent. The Mental Health Act Commission was particularly concerned about the application of clause 9(7) to 16 and 17 year olds and told us:

“[…] the provision appears to set a different standard for decision-making in respect of adolescent patients (i.e. aged 16-18) from that which is established under s[ection] 1 of the Children Act 1989. As compulsory psychiatric admission or treatment could be provided to adolescents under either the Children Act or the Mental Health Act, we question whether such differences of fundamental approach are appropriate.”

218. We do not accept the argument that clause 9(7) is necessarily inconsistent with the Children Act. Section 25 of the Children Act does not require the child to be mentally disordered. So either a secure accommodation order or the Mental Health Act could be used if a child is mentally disordered and poses a substantial risk of causing serious harm to others. If the child is not mentally disordered but poses a substantial risk, only section 25 could be used. Barnardo’s therefore argued that there is no need for new powers to detain

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252 Ev 523 (Minister of State at the Department of Health, Ms Rosie Winterton MP), question 7
253 Ibid
254 Ev 13, para 6.1
16 and 17 year olds who do not meet the criteria for formal treatment under mental health legislation but are a risk to others, and pointed out that "section 25 of the Children Act 1989 was written precisely to deal with these sorts of circumstances".255

219. We therefore recommend that, if, notwithstanding our recommendation to remove clause 9(7) from the Bill, it were to be retained, the provision in clause 9(7) do not apply to 16 and 17 years olds but only to those who are 18 or older.

**Under 18 year olds treated on adult wards**

220. Article 37(c) of the United Nations Convention on the Rights of the Child states that “every child deprived of liberty […] shall be separated from adults unless it is considered in the child’s best interest not to do so”.256 In other words, children should be detained in separate institutions designed for their needs.

221. We received evidence that there are insufficient specialised in-patient facilities for the treatment of children and young people. Dr Patrick Byrne, Adolescent Psychiatrist at the South London and Maudsley NHS Trust, told us that the distribution of adolescent in-patient beds round the country is variable and that in areas such as the north-east and the north-west local clinicians find themselves hard-pressed to provide an acute admission directly into a dedicated bed for a young person.257 The Mental Health Act Commission (MHAC) is notified of all young people under the age of 18 who are detained on adult wards. The MHAC receives approximately 260 notifications a year; it suspects this to be an under-estimate of the true level of such admissions.258

222. Neither the 1983 Act nor the draft Bill includes a requirement that patients who are under 18 must be treated in a specialist CAMHS unit. There are several reasons why this might be so. The Children’s Legal Centre suggested that such a requirement was not needed on the face of this Bill. They outlined a range of provisions that have recently been put in place which already provide a means of challenging any health authority which does not provide age-appropriate accommodation. These included: the duties in the Children Acts 1989 and 2004 to safeguard and promote the welfare of children; the new duties on the Commission for Healthcare Audit and Inspection (CHAI) to look at safeguarding and promoting the welfare of children during their inspections; and the National Service Frameworks.259

223. A requirement to provide age-appropriate accommodation would rely on the necessary trained staff being available. Unfortunately such resources do not currently exist across the country. Dr Brian Jacobs, Child Psychiatrist at the South London and Maudsley NHS Trust, pointed out that “there is no evidence that the people are out there at the moment, clamouring for the jobs”.260 The Royal College of Psychiatrists told us there was a shortfall in the number of specialist CAMHS psychiatrists. They told us that it would take

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255 Q 428 (Ms Kelley)
257 Q 384 (Dr Byrne)
258 Q 43 (Mr Heginbotham)
259 Q 438 (Ms Daly)
260 Q 386 (Dr Jacobs)
at least four or five years “to embed and encourage people to be recruited into this specialty.” 261

224. Currently, many children and young people in need of in-patient psychiatric treatment are treated in facilities far away from their family and friends because local specialist units do not exist. If the Bill included a requirement that children be treated in age-appropriate accommodation, then the number of children being separated by long distances from their communities could increase, at least until the local infrastructure has had time to develop. However, we received much evidence arguing that the draft Bill should include a requirement that under 18 year olds be accommodated in specialist CAMHS units.262

225. The MHAC has evidence of young people treated on adult wards being harassed by adults on those wards, having drugs pressed upon them and being abused in various ways.263 The background of patients on adult wards are not checked and it is possible that an adult patient with a history of child abuse could be in a bed next to a child patient. The National Children’s Bureau and Children’s Legal Centre suggested that children could also be at risk from the staff on adult wards because their background checks are not conducted to a standard comparable to those for staff on children’s wards.264

226. When under 18 year olds are treated on adult wards there is currently no guarantee that they will ever see a CAMHS specialist. It was argued that this could have serious consequences for the quality of the care they receive. Professor Susan Bailey, Chair of the Faculty of Child and Adolescent Psychiatry at the Royal College of Psychiatrists, emphasised the difference in the knowledge base needed when assessing under 18 year olds for mental health problems:

“child and adolescent psychiatrists […] are working with 20% of the population, children and adolescents, who from infancy to eighteen are going through […] unique and major maturational changes […] Our work is set in the context of hopefully working with families and looking at the child/parent relationship. We have a different set of contexts in terms of other important legislation, in the Children Act […] and other partnerships with social care, with youth justice and with education. The whole structure and framework is different […] In terms of the disorders, we know that some psychiatric disorders, like paediatric disorders, are unique to childhood […] Even where we share psychiatric disorders across the seven ages of man, the presentation, the aetiology and the treatment needs are different”.265

As well as specialist health knowledge CAMHS clinicians build up specialist legal knowledge in order for them to understand their responsibilities towards the children in their care. The Royal College of Psychiatrists told us that the legal provision for the assessment and treatment of mentally disordered minors is made more complex by the issues of:

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261 Q 104 (Professor Bailey)
262 Q 14 (Professor Richardson); Q 386 (Dr Byrne); Ev 316 (YoungMinds); Ev 50 (Royal College of Psychiatrists), question 6; Ev 230 (Rethink), section 6
263 Q 43 (Mr Heginbotham)
264 Ev 319
265 Q 103 (Professor Bailey)
a) parental rights and responsibilities;

b) assessment of competence in a growing child; and

c) other legislation relating to minors including the Children Acts 1989 and 2004 (see paragraphs 237 - 240 below).

227. YoungMinds recommended that a provision should be included in the Bill similar to that in section 23 of the Mental Health (Care and Treatment) (Scotland) Act 2003. That Act includes a requirement that any patient under 18 years of age who is admitted to hospital for the purposes of receiving treatment for a mental disorder will be provided with “such services and accommodation as are sufficient for the particular needs of that child or young person”.

228. The specialist nature of CAMHS means that there are significant benefits to being treated in an age-appropriate facility with specialist staff. We consider that a statutory duty to provide age-appropriate facilities will accelerate the development of such facilities across the country. While we acknowledge and welcome the provisions of section 11 of the Children Act 2004, which the Children’s Legal Centre argue, will place a duty on health care providers to accommodate children in appropriate facilities (see above), we think these duties should be re-enforced in this Bill with specific reference to the accommodation of young people with mental health problems.

229. We recommend that the Bill stipulate that under 18 year olds should be accommodated in age-appropriate facilities. This requirement could be modelled on section 23 of the Mental Health (Care and Treatment) (Scotland) Act 2003. If in exceptional circumstances under 18 year olds are treated on adult wards, the Bill should require the clinical supervisor to obtain advice from a Child and Adolescent Mental Health Services specialist during both the assessment and treatment of the patient in question.

Assessment of under 18 year olds

230. The evidence outlined above shows the specialist clinical and legal knowledge needed when working with patients who are under 18. As the draft Bill stands, a CAMHS specialist would not necessarily be consulted during the assessment of a patient who is under 18. Although clause 3 of the draft Bill allows local social services authorities to stipulate specific competencies for approved clinicians and mental health professionals, this only means that local authorities could, not must, impose a duty that mental health professionals assessing a child patient have specialist qualifications. Barnardo’s argued that it is “essential” that where a child or young person is assessed at least one of the assessors is professionally trained in child development or child psychiatry. The Royal College of Psychiatrists supported the idea that assessment of child patients should be by a CAMHS specialist. However, we are conscious that, despite having highlighted the resource issues, the Royal College of Psychiatrists were one of many witnesses who argued that a CAMHS specialist should be involved in the assessment of child patients. The Royal College also told us that

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266 Ev 321

267 Ev 50, question 6
the Government was addressing issues of recruitment (see chapter 10). We recommend that there be a requirement that at least one medical assessment of a person under 18 years of age prior to the imposition of compulsory treatment should be by a clinician specialising in Child and Adolescent Mental Health Services.

**Tribunals hearing the cases of under 18 year olds**

231. As noted above, witnesses suggested that, when a tribunal hears the case of a child patient, it should be assisted by a medical member of the Expert Panel who is a doctor specialising in CAMHS.\(^{268}\) This is consistent with the evidence we received regarding the specialist clinical and legal knowledge required when working with under 18 year olds in other respects, but as the draft Bill stands there is no requirement for a tribunal to seek the advice of a member of the Expert Panel, although they may do so if they wish (see chapter 8). We recommend that the Bill require that, when a tribunal is hearing the case of a child or adolescent patient, it has to seek the advice of a medical member of the Expert Panel who is a doctor specialising in Child and Adolescent Mental Health Services.

**The draft Bill and the Children Acts 1989 and 2004**

232. We were told that the Children Act 1989 is sometimes used to treat young people suffering from mental disorder.\(^{269}\) There are two main legal avenues for the compulsory admission of a child to in-patient treatment other than under the Mental Health Act 1983 or under parental responsibility. They are by using section 25 of the Children Act 1989, or by invoking the inherent (wardship) jurisdiction of the Family Division of the High Court.

233. We received evidence that there is often confusion about the interaction of the Mental Health Act 1983 and the Children Acts. Clinicians who practice in CAMHS build up expert knowledge on the different pieces of legislation, but the Children’s Legal Centre told us that working with the Mental Health Act 1983 and the Children Act 1989 was like “working in two different worlds with different languages, it is that difficult to translate from one to the other”.\(^{270}\) When a patient under 18 meets the criteria to be treated under the provisions of both the Children’s Act and the 1983 Act it is not always clear which Act applies.

234. The approaches of the draft Bill and the Children Act 1989 differ fundamentally. In contrast to the draft Bill, section 1(1) of the Children Act states the “paramountcy principle”, which provides that in cases directly involving the upbringing or the management of the property of a child, a court must treat as the primary consideration the welfare and best interests of the child. Section 1(3) of the 1989 Act also sets out a checklist of welfare principles that courts need to consider when making orders under that Act. These are:

“(3) In the circumstances mentioned in subsection (4), a court shall have regard in particular to—

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\(^{268}\) Ev 50 (Royal College of Psychiatrists), question 6; Ev 321, (Barnardo’s)  
\(^{269}\) Q 398 (Dr Byrne)  
\(^{270}\) Q 421 (Ms Daly)
(a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);

(b) his physical, emotional and educational needs;

(c) the likely effect on him of any change in his circumstances;

(d) his age, sex, background and any characteristics of his which the court considers relevant;

(e) any harm which he has suffered or is at risk of suffering;

(f) how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs; and

(g) the range of powers available to the court under this Act in the proceedings in question”.

The paramountcy principle is subject to limitations. For example, it does not apply to certain decisions under section 25 of the Children Act to place a child in secure accommodation. It can be expressly or implicitly excluded by statute. The latter could occur if the new mental health statute were to lay down guidelines which are incompatible with the paramountcy principle, as has been held to be the case in relation to section 25 of the 1989 Act itself.271

235. Our attention was drawn to section 11 of the Children Act 2004 which will impose a duty on health and social services agencies to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children. This applies also to any services provided by another person pursuant to arrangements made by the body in the discharge of its functions.

236. Many witnesses said that, unless the Bill re-enforced the child welfare principles in the Children Acts 1989 and 2004, new legislation would do little to simplify the situation by bringing mental health law into line with child welfare law. Ms Christine Daly, Social Policy Adviser at the Children’s Legal Centre, told us that, if the Bill were to contain a principle that the welfare of children was primary, then it would make “tribunals’ roles simpler and indeed clinicians’ roles simpler. There would be a common standard”.272 Ms Daly went on to argue that the inclusion of child welfare principles would not cause legal difficulties. In fact she told us that: “Our enthusiasm for introducing this type of concept is to give a consistency of experience for children as they are dealt with by the law”.273

237. The Minister of State at the Department of Health told us that it is the Government’s intention “that the code of practice will explain the relationship between mental health and children’s legislation, setting out how the principles of the Mental Health Bill will work alongside the principles in other Acts”.274 We welcome the Government’s intention to bring forward guidance on how the different pieces of legislation will work together.

271 Re M (a Minor) (Secure Accommodation Order) [1995] Fam 108
272 Q 421 (Ms Daly)
273 Q 424 (Dr Byrne)
274 Ev 523 (Minister of State at the Department of Health, Ms Rosie Winterton MP), question 6
However, as set out at paragraph 64 above, we believe that it is essential that the fundamental principles are set out in full on the face of the Bill. **We recommend that, in order to give a consistency of experience for children dealt with by the law, child welfare principles also be included on the face of the Bill.**

238. As noted above, some clinicians use the provisions of the Children Act 1989 to provide in-patient treatment for young people with mental health problems. In fact Dr Byrne told us that, if the provisions of the Children Acts could be used, then it might be less stigmatising to use those powers instead of the powers in the 1983 Act.\(^{275}\)

239. However, treatment of mentally-ill minors under the provisions of the Children Act 1989 would deprive the child of a hearing by a specialist mental health tribunal and of the other safeguards provided under the draft Bill. If our other recommendations relating to the treatment of young people are accepted, then we believe the draft Bill could provide an appropriately child-centred approach to the treatment of minors with a system of specialist safeguards to ensure that they are treated appropriately.

240. We are conscious of the complexity of adolescent life and are anxious that adolescents should not be brought under compulsion other than in exceptional circumstances. **We recommend that, where the predominant issue is the need for compulsory treatment for mental disorder, treatment of under 18 year olds be subject to the provisions in the draft Bill.**

### Care planning

241. The care planning process under the draft Bill is discussed in detail in chapter 9. The care plans required by the draft Bill focus on the compulsory element of the patient’s care. Many witnesses argued that care plans should include the wider needs of patients and that this requirement should be on the face of the Bill. This argument was made particularly strongly with regard to care plans prepared for under 18 year olds, who may well have pressing familial and educational needs. Barnardo’s argued that the care planning process under the Children Act 1989 was preferable to that proposed in the draft Bill because it is a “multidisciplinary, regularly reviewed, advocacy-based way of working.”\(^{276}\)

242. Section 121 of the Adoption and Children Act 2002 inserted a new section 31A into the Children Act 1989, which provides that, where an application is made by a local authority which might result in a care order, the appropriate authority must, within a time limit laid down by the court, prepare a care plan for the future care of the child. This care plan should reflect the Children Act principle of the primacy of the welfare and best interests of the child. The Government has stated that it does not intend that care planning in the Bill should be separate from the Care Programme Approach (CPA).\(^{277}\) It sees it is one element of the CPA process, which embraces the wider health and social care needs of patients in specialist mental health services. **We recommend, in respect of children and adolescents, that the care planning process reflect the process designed for a child...**

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\(^{275}\) Q 398

\(^{276}\) Q 453 (Ms Kelley)

\(^{277}\) Department of Health *Improving Mental Health Law: Towards a New Mental health Act*, September 2004, para 4.3
subject to a Children Act 1989 order i.e. a multidisciplinary, regularly reviewed, advocacy-based way of working.

Educational facilities

243. During our inquiry we visited the adolescent in-patient facility at the Bethlem Hospital in South London, which has an on-site school dedicated to teaching young people with mental health problems who require specially tailored classes delivered by teaching staff who are trained to work with children with mental health needs. The school has specially trained staff and the facilities to test for learning difficulties which are common in children with mental health problems. It is able to offer vocational training as well as schooling in standard subjects. We were told that the school was a “great asset and it is also an opportunity to develop training and good practice in meeting the special needs of young people and children with mental health disorders”.278

244. We were particularly impressed with this facility. But unfortunately only between half and two-thirds of the adolescent mental health units around the country have a school. Those which do not, have to make alternative arrangements for the education of children and adolescents.279

245. The provision of education is particularly important for children who are being treated for mental health problems and whose in-patient stays can be lengthy. Dr Byrne explained:

“One cannot help but emphasise that education is one of the key needs for young people. For young people who develop mental health problems, some of their chief handicaps in life accrue from the fact that they lose educational opportunities; they miss out on schooling for long periods of time; and, at the point where they need to be reintegrated into school, they encounter stigma and other difficulties”.280

246. We do not think it acceptable that some adolescent mental health in-patient facilities provide no access to specialised education services. If our recommendation about integrated care planning is accepted, then it would be a statutory requirement that the care plans of all young people include a reference to their education needs. If child welfare is to be at the centre of the provisions dealing with young people under mental health legislation then education, tailored to the needs of the child, must be made available.

247. We are also concerned about the position of 16 and 17 year olds who are being treated as in-patients and who wish to continue their education. We consider that education for these people is integral to their treatment. Under the Education Act 1996 local education authorities have a duty to provide that under 16 year olds are able to continue their education while in hospital. However, section 14 of the 1996 Act gives authorities discretion whether they should provide access to education for 16 and 17 year olds. Where a 16 or 17 year old wants to continue with his education it is totally unacceptable that he would not be able to do so because he is receiving treatment for a mental disorder. We
recommend that there be a duty, where the patient is 16 or 17 years of age, to ensure appropriate educational provision. Appropriate provision will usually mean specialised education to deal with adolescents who are being treated as in-patients for mental health problems and sufficient to meet their educational needs.

**Electroconvulsive therapy (ECT) for under 18 year olds**

248. The draft Bill sets out special safeguards in relation to electroconvulsive therapy (ECT) for patients under 16, regardless of whether they are subject to the formal powers of the Bill. While many of our witnesses welcomed these safeguards, some suggested ECT should never be given to those under 16. Other witnesses suggested the safeguards should be available to all young people under 18 years of age.

249. Clauses 186 and 188 set out the safeguards available to under 16 year olds for whom ECT is a proposed treatment. These include provision that no child under 16 may be given ECT unless it is authorised by a tribunal or a court. The tribunal must appoint a medical expert to prepare a report dealing with the merits of the application. The medical expert must visit, interview and examine the patient, and consult (a) another doctor in circumstances to be specified in regulations, (b) a nurse, (c) another person who has been professionally involved with the patient and (d) each person with parental responsibility. The medical expert does not have to consult each person with parental responsibility if he thinks it would be inappropriate to do so. Under clause 188, ECT may be given in an emergency to a child on the authority of a certificate from the clinical supervisor or the approved clinician responsible for his assessment or for supervising medical treatment. The certificate may only be issued with the agreement of a registered medical practitioner of a description to be specified in regulations. The treatment conditions that have to be met are:

- a) that the course of ECT is immediately necessary to save life;
- b) that the course of ECT (not being irreversible) is immediately necessary to prevent a serious deterioration in the condition; or
- c) that (not being irreversible or hazardous) it is immediately necessary to alleviate serious suffering.

250. We received some evidence arguing that ECT should never be given to those under 16. Mind asserted: “Children and young people are more vulnerable to the risks of ECT; their brains are still developing up to age 18. Every effort must be made to address their needs through psychological and supportive means. ECT should never be given to children or young people”. However, we also received evidence that occasionally ECT is an important part of the treatment armoury for patients under 16. Professor Bailey from the Royal College of Psychiatrists argued that clinicians should have discretion to use ECT on under 16 year olds in exceptional circumstances:

“I think to deny that form of treatment to a very small number of children under 16 […] would be wrong. In my clinical career I have used ECT in children under 16 on

281 Ev 189, para 6.8
two occasions. It is very rare to do it, but to withdraw it as a treatment, I think, would be unwise.”

251. We consider that, although ECT should only be used to treat under 16 year olds in exceptional circumstances, there are occasions on which it may benefit the patient. We therefore support the proposal in the draft Bill that it should be possible to administer ECT to under 16 year olds in line with the stringent safeguards set out in clauses 186 and 188.

252. We also received evidence that the safeguards available to protect those under 16 for whom ECT is a proposed treatment should extend to 16 and 17 year olds. The Mental Health Alliance argued for this extension because it believes that young people are more vulnerable to damage from ECT. Such an amendment to the draft Bill would be in line with our recommendation at paragraph 215. **We recommend that it only be possible to administer electroconvulsive therapy (ECT) to 16 and 17 year olds in line with the safeguards currently proposed in the draft Bill for those under 16.**

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282  Q 85 (Professor Bailey)

283  Ev 119, para 10.7
7 Patients concerned in criminal proceedings, restricted patients and victims

Introduction

253. Part 3 of the draft Bill deals with patients in criminal proceedings. It follows the pattern set by the 1959 and 1983 Acts by including provisions for the sentencing of mentally disordered offenders to a hospital and for the transfer of prisoners to hospital.

254. Part 3 of the Bill is particularly complex, with many significant provisions contained in Schedules 5, 8, and 9 which are themselves difficult to read. The Schedules must be read very carefully in conjunction with the clauses to avoid misunderstandings as to the rights of different categories of offender patient. For example, many witnesses were concerned that for people subject to the provisions of Part 3 there was no reference to consultation with nominated persons about care plans. We received much evidence suggesting the draft Bill should provide for such consultation. In fact, Schedule 8 provides that unrestricted patients under Part 3 have broadly the same rights to a nominated person as civil patients under Part 2, though restricted patients do not. We are worried that the consequence of such confusing drafting could be that the final Act will be subject to litigation where the courts will constantly be asked to rule on the interpretation of the legislation. We recommend that the Government give serious consideration to ways of improving the drafting so that the provisions of the whole Bill, and particularly Part 3, can be more easily understood, and can be read easily in conjunction with the Criminal Justice Act 2003.

255. A large proportion of the differences between Part 3 and the 1983 Act are intended to tidy up existing provisions and to provide mentally disordered offenders with many of the new safeguards which the draft Bill introduces for civil patients in Part 2. Witnesses generally welcomed Part 3 of the Bill. The Royal College of Psychiatrists told us:

“In general we believe that Part 3 of the draft Mental Health Bill is an improvement on the old Act. There is increased flexibility throughout a defendant’s progress through the criminal justice system from arrest to conviction and sentence.”

256. Anyone who requires acute mental health care should be in hospital rather than in prison and we believe that the provisions in the draft Bill will help to achieve this. However, witnesses had concerns about several areas, including the following:

a) The draft Bill’s definition of mental disorder, coupled with the wide definition of treatment and the “loose” criteria for compulsion, could have a significant impact on the number of people subject to the provisions of Part 3. Professor Maden told us:

“I have seen no sensible discussion within the Department of Health of how the mental health services will guard against the wholesale transfer of prisoners, for
example - most of whom have a mental disorder - straight into health service beds.  

b) During our visit to Broadmoor staff told us that there were already problems finding enough beds to cater for patients who needed to be transferred from prison for treatment. Staff and patients were concerned that there was no protection for prisoners with mental health problems who could not be found a hospital bed. Many patients, who had experienced mental health facilities in prisons, expressed concerns that they were inadequate with an over-reliance on medication and no therapy available. They suggested that the Bill should give protection to prisoners who were in need of psychiatric treatment unless there was a guarantee that a bed would be found for them in a hospital within a reasonable period.

c) Part 3 does not extend the full range of safeguards to people involved in criminal proceedings. In particular, there was concern that the care plans of such people are to be examined by courts rather than specialist tribunals.

d) The opportunity has not been taken to amend the procedures relating to the transfer and leave of mentally disordered offenders, which some witnesses considered to be outdated and obstructive.

257. Part 3 is split into five chapters. The first deals with patients on bail or remand, the second concerns sentencing disposals and the third deals with the transfer of prisoners to hospital.

**Bail and remand provisions**

258. The bail and remand provisions give Magistrates’ and Crown Courts powers to remand to hospital defendants suspected of suffering from a mental disorder. They can remand the patient to hospital for the purpose of obtaining psychiatric reports and, under certain conditions, they can commit defendants to hospital as an alternative to the Crown Court.

259. A new aspect of the bail and remand provisions is that they provide that a court remanding a patient for psychiatric reports may authorise the provision of medical treatment to him. The court can do so if satisfied, on the evidence of two doctors, that the person is suffering from mental disorder of a nature or degree so as to warrant the provision of medical treatment, and that appropriate treatment is available. This is a welcome change from the 1983 Act under which patients remanded for reports have often then been subject to simultaneous detention for treatment under the civil provisions to ensure that there was lawful authority for treatment without consent.

260. The draft Bill’s bail and remand provisions tidy up the existing situation for the provision of treatment to people remanded for psychiatric reports. They provide that people on bail and remand, who are being assessed or treated for a psychiatric disorder, receive the same safeguards as civil patients in terms, for example, of care plans.

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285 Q 461 (Professor Maden)

286 Draft Mental Health Bill, Cm 6305-I, September 2004, cls. 86 - 113
Sentencing disposals

261. There are three types of sentencing disposal available under Part 3 of the draft Bill. In order for one of these disposals to be imposed on an offender, it is not necessary for his mental disorder to have affected his responsibility for the offending behaviour. The key question is whether he is suffering from a mental disorder at the time of sentencing. The three types of sentencing disposals are:

a) Mental Health Orders287 – These are similar to hospital orders and guardianship orders under section 37 of the 1983 Act. When making a mental health order, the court will be opting not to impose a prison sentence but instead to order that the offender receive treatment, either as a resident or non-resident patient. Four conditions must be met:

the person is suffering from mental disorder;

the mental disorder is of a nature or degree as to warrant the provision of medical treatment;

medical treatment is available; and

arrangements have been made for admission.

The conditions differ from the conditions for compulsory treatment for civil patients. Courts dealing with convicted offenders will have the option of either a resident or a non-resident mental health order. Magistrates’ courts will be empowered to make an order without a finding of guilt if they are satisfied that the person committed the act or was responsible for the omission constituting the offence. The court making the order must be of the opinion that, having regard to all the circumstances (including the nature of the offence and the person’s character and antecedents and other available methods of dealing with him) that the most suitable way of disposing of the case is by means of a mental health order.

b) Restriction Orders288 - These exist under the 1983 Act. If a mental health order is made by a Crown Court, it may also impose a restriction order if it appears to be necessary to protect the public from serious harm. One effect of a restriction order is that the patient may not be transferred, or granted leave, without the consent of the Home Office Mental Health Unit. Another effect is to limit access to the range of safeguards available to offenders who are only subject to a mental health order. If a restriction order is imposed, the patient automatically becomes a resident patient. Patients subject to restriction orders are referred to as “restricted patients”.

c) Hospital Directions289 - This is a possibility not available under the 1983 Act, although a similar power is available under the Crime (Sentences) Act 1997 for patients with psychopathic disorders. Under the provisions in the draft Bill, hospital directions may be made by a Crown Court. The Crown Court must, first, have considered making a mental health order, but instead have decided to sentence the person to imprisonment. The status of such offenders is, therefore, first and foremost that of prisoner. Hospital

287 Draft Mental Health Bill (2004), cls. 114 - 124
288 Draft Mental Health Bill (2004), cls. 124 - 129
289 Draft Mental Health Bill (2004), cls. 130 - 132
directions require the same conditions to be met as for a mental health order. Importantly, no non-resident option is available. The effect of the direction is that, instead of being removed to, and detained in, a prison, the person is removed to, and detained in, a specified hospital, and becomes subject to the same regime as a restricted patient. If the conditions for compulsory treatment are no longer met, the patient is remitted to prison to serve out the prison sentence. A court may not make a hospital direction under clause 130 unless it has first considered making a mental health order.

262. It is worth noting in this context that no special types of orders are being proposed in the Bill for mentally disordered offenders suffering from dangerous and severe personality disorders (DSPD). However, the Government’s policies for dangerous people with severe personality disorder have seen the development of 250 places in four high security DSPD units. We visited Broadmoor and some Members were able to meet patients in the pre-pilot project. Offenders meet the criteria for admission to DSPD high secure services if they are assessed as being more likely than not to re-offend, resulting in serious physical or psychological harm from which the victim would find it difficult or impossible to recover. The risk of re-offending must be linked to the presence of a severe personality disorder. These arrangements have been made under the existing legal provisions for the transfer of prisoners to hospital and for the management of offender patients under Part 3 of the 1983 Act.

263. We heard evidence when we visited Broadmoor that, on occasion, where courts wish to make an order sending an offender or person on remand with a mental disorder to a hospital, disputes can arise as to which hospital the offender or person held on remand should be sent - typically about whether medium or maximum security is required. If the parties cannot reach agreement, there is no means of resolving the matter and it can end up with the judge imposing a prison sentence. We recommend that, where a court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contain a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute.

264. Clause 137 of the draft Bill, which broadly replicates section 47 of the Mental Health Act 1983, allows the Home Secretary to make a direct direction to transfer a prisoner or person on remand with a mental disorder to hospital for treatment. The person has to meet a number of conditions and the Secretary of State has to be of the opinion that it is in the public interest to make such a direction. We recommend that, where those exercising the functions of clinical supervisor form the view that a prisoner or person on remand meets the conditions at clause 137 and recommend that he is transferred to hospital, the Bill proper contain a duty requiring the Home Secretary to order his transfer to hospital.

Transfer of prisoners

265. The draft Bill replicates the Secretary of State’s powers in the 1983 Act to direct the transfer of those on remand and sentenced prisoners to hospital for treatment.290 It adds a

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290 Mental Health Act 1983, ss. 47 and 48; Draft Mental Health Bill (2004) cls. 135 and 137
new power to transfer to hospital for a mental health report.\textsuperscript{291} This is a welcome change which will allow for the assessment of individuals who cannot have a sufficiently rigorous assessment carried out in prison.

266. Under the draft Bill, compulsory treatment can only be authorised by the clinical supervisor and tribunal or the court, and so all compulsory treatment for sentenced prisoners is subject to the order of the tribunal after the direction of transfer.\textsuperscript{292} In the event that the tribunal finds the conditions for compulsion are not met, the result will be automatic transfer back to prison, or release in the event that the sentence is served.

**Criteria for compulsion in Part 3**

267. Clause 116 sets out the conditions that will be used by courts to assess patients before making a mental health order (clause 130 replicates these conditions as the criteria for making a hospital direction). These conditions differ from those that tribunals will use when assessing civil patients, as set out in clause 9, in two key respects.\textsuperscript{293} First, under clause 116, the court will not have to be satisfied that compulsion under the Bill is the only way to treat the patient. Secondly, clause 116 does not require that treatment is necessary to protect the patient or others from harm.

268. The Government argue that the first difference is necessary because, if the court were required to be satisfied that compulsion under the Bill was the only way to treat the patient, then a mental health order could not be made for offenders who had indicated they were willing to accept treatment on a voluntary basis. This would mean the court would have to impose a prison sentence.\textsuperscript{294}

269. The Government argues that the second difference is necessary for two reasons.

a) For a civil patient subject to Part 2, the need to prevent harm would be the sole justification for the infringement of his liberty.\textsuperscript{295} However, for an offender, the right to infringe the liberty would arise from the judgment of the court, and no further justification would be needed. So with regard to offenders, the first question that would need to be decided at the point of making a mental health order or hospital direction is whether the mental disorder is severe enough to substitute compulsion for punishment.\textsuperscript{296}

b) If a condition for making a mental health order were the protection from harm, then it could be argued that, by placing the offender in prison, that risk would have been removed. The Parliamentary Under-Secretary of State at the Home Office, Mr Paul Goggins MP, explained:

\textsuperscript{291} Draft Mental Health Bill (2004) cl. 133
\textsuperscript{292} Draft Mental Health Bill (2004) Schedule 9 paras 7 and 11 and cls. 31 and 38
\textsuperscript{293} Whether clause 9 or clause 116 criteria are used to assess persons subject to criminal proceedings depends on the circumstances. Clause 116 criteria are to be used by courts when making an initial mental health order or an initial hospital direction. Clause 9 criteria are used by the tribunal in extending and reviewing compulsion under a mental health order (Schedule 8, para 8)
\textsuperscript{294} Department of Health: *Improving Mental Health Law: Towards a New Mental Health Act*, September 2004, para 6.7
\textsuperscript{295} Ev 529 (Home Office)
\textsuperscript{296} Ibid
“In removing this, what we want to make sure is that the proper judgment is made […] that people get the treatment that they need and that that treatment cannot be compromised by the fact that the risk has been removed because they are in prison”.

Other witnesses argued that the criteria for compulsion for civil and criminal patients should be as similar as possible. Maca, a national mental health charity, told us that it should not be possible for mental health orders to be used to:

“…give compulsory treatment to people who could not otherwise be made subject to it, and whose mental disorder is not considered to have been a factor in their offending behaviour, nor likely to lead to future offending behaviour”.

297. We accept that courts should not have to be satisfied that compulsion under the Bill is the only way to treat the patient. However, evidence we received suggests that one of the conditions for making a mental health order should be that it is necessary to do so for the protection of the patient or others. For example, Ms Scott-Moncrieff told us that nothing in Part 3 made it certain that a risk assessment would be carried out before a mental health order can be made. It was her view that:

“…the criteria for compulsory treatment for those in the criminal justice system are astonishingly wide, so much so that it is difficult to see how a HRA [Human Rights Act] challenge, on grounds of lack of proportionality, could fail”.

270. Although there is no express risk condition under section 37 of the 1983 Act, the sentencing court must take risk factors into account in deciding whether the offender’s mental disorder is of a nature or degree which makes detention in hospital for medical treatment appropriate, or, in the case of a guardianship order, which warrants his reception into guardianship. Under the draft Mental Health Bill, an offender can be made subject to a resident mental health order if he suffers from a mental disorder that warrants medical treatment which is available. Nothing in the draft Bill requires that there should be a judgment that the disorder is of a nature or degree that makes detention or non-resident treatment appropriate before a mental health order can be made. We think these conditions are too loosely drawn. **We recommend that, when courts are considering whether to make a mental health order or hospital direction, there be a requirement that the mental disorder of the offender/patient should be of a nature or degree which makes treatment under compulsory powers appropriate. If the offender/patient is to be resident, then the disorder should be of a nature or degree warranting detention.**

272. We question the basis of the Government’s reasoning that it would be impracticable to have necessity for protection from harm as one of the conditions of making a mental health order under Part 3 because it could be argued that by placing the offender in prison

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297 Q 854 (Parliamentary Under-Secretary of State at the Home Office, Paul Goggins MP)
298 Ev 92 (Institute of Mental Health Act Practitioners) theme 3; Ev 119 (Mental Health Alliance) para 4.17-4.20; Ev 1043 (MACA) para 25-26
299 Ev 1043, para 25
300 Ev 282, para 29
301 Ev 282, para 28(d)
302 Mental Health Act 1983, s. 37(2)(a)
the risk would be removed. It should not be overlooked that prison staff and fellow prisoners are members of the public. *We recommend, in the interests of non-discrimination, that the Bill proper and accompanying codes of practice be drafted in such a way as to make clear that courts, in making a mental health order or hospital direction, should base their assessment on whether the offender’s mental disorder renders him a risk to self or others, irrespective of whether that risk could be minimised by a prison sentence.*

273. The 1983 Act requires that, before a restriction order can be imposed, the court must hear oral evidence from one of the psychiatrists giving evidence, and that a restriction order can only be imposed if it is necessary to protect the public from serious harm. These requirements are replicated in clause 125 of the draft Bill, so there is a risk criterion in relation to making a restriction order.

**Transfers and leave of absence**

274. The draft Bill does not alter the position in the 1983 Act that tribunals can only *recommend* transfer of restricted patients. The power to *authorise* transfer remains with the Home Secretary.

275. Ms Scott-Moncrieff told us that since 1983 there has been a significant increase in the availability of places in medium secure units. As a result, there is a view that special hospital patients should usually be transferred to a medium secure unit as a prelude to discharge. This has led to a large increase in the number of transfer applications. She added that “the Home Office is entirely capable of holding up transfer for years”. The delay not only adversely affects the patient in question but means that they become “bed-blockers”, preventing the admission of seriously mentally disordered prisoners. Ms Scott-Moncrieff also contended that the Home Office:

> “has a shocking record of decision-making; it has no people working for it who are qualified to make risk assessments, and yet it frequently and routinely rejects risk assessments made by professionals and substitutes its own over-estimation of risk.”

276. The staff and patients whom we met at Broadmoor expressed disappointment that, although the tribunals could discharge patients, the draft Bill did not empower tribunals to move patients from high to medium secure conditions. Patients and staff argued that tribunals should be able to authorise the transfer of restricted patients between different categories of facility. It was felt that currently the recommendations of tribunals in relation to the transfer of restricted patients were “not worth the paper they were written on”. Because transfer was a necessary precursor to discharge, a tribunal without power to order transfer would offer no protection for high security patients. It was argued that the Bill should place a duty on the Home Office to direct transfer if the tribunal advised such a move.
Professor Richardson was concerned that not giving the tribunal the power to authorise transfer and leave might be a breach of Article 5(4) of the European Convention on Human Rights: 304

“transfer from high security to medium security and on down is really an essential precursor to ultimate discharge from compulsory powers [...] we now have a tribunal that can order the discharge of somebody from a restriction order, but we do not have a tribunal that can order the essential precursors to discharge”. 305

The Government, however, responded by arguing that:

“The tribunal is not constituted to perform risk assessments, but to protect the patient’s rights. It is only on the basis of independent risk management for restricted patients that they can be diverted from prison sentences. The current system works exceptionally well with low rates of recidivism, and effective protection for the rights of restricted patients”. 306

277. We accept the argument that the primary purpose of the tribunal is to protect patients. However, we fail to see why, given advice from the Expert Panel, the tribunal should not be able to order transfer from high-security to medium-security units. Given that since 1983 transfer has become the usual precursor to discharge, we believe, the transfer provisions need to reflect these changes and we recommend that the Mental Health Tribunal be given the power to order the transfer and leave of absence of restricted patients.

The role of courts in approving care plans

278. Clause 118 specifies that, when making a mental health order the court will have to approve a care plan for the patient and will have the power to make modifications to that plan. The care plan will be submitted by an approved clinician and any modifications to it will have to be agreed by the approved clinician. The court may appoint a member of the Expert Panel to assist in determining whether to approve or modify the care plan.

279. Some witnesses were concerned that courts will lack the expertise to consider care plans. 307 The Law Society told us “that criminal courts will lack the benefit of the experience and expertise of the Mental Health Tribunal”. 308 It was argued that, for this reason, the duty to approve care plans should be taken away from courts and given to tribunals. 309 The Mental Health Alliance asserted that: “In principle, criminal courts should not be able to make care and treatment orders. These should, in all cases, be made by a Mental Health Tribunal”. 310

304 For further information about the European Convention on Human Rights see chapter 1
305 Q 18
306 Schedule of Comments, Government Response 127 (at annex 4)
307 Ev 119 (Mental Health Alliance), para 9.7; Ev 822 (Bexley Mind), para 3; Ev 189 (Mind), para 5.14; Ev 957 (National Voices Forum), para 3.3
308 Ev 165, question 5
309 Ev 1043 (Maca), para 24
310 Ev 119 (Mental Health Alliance), para 9.11 (recommendation 2)
280. We do not believe that it would be practical to separate the power to approve care plans from the power to make a mental health order. Both of these duties should reside with the court that is considering the offence. We welcome the provisions in the draft Bill that make it clear that courts should not construct care plans and that to do so is the duty of the approved clinician. We do, however, agree that judges and criminal advocates are unlikely, without expert assistance, to possess the specific expertise needed to assess a care plan.

281. The Law Society told us: “We are particularly concerned that the court is not under a duty to appoint a member of the Expert Panel to assist in [the approval of care plans].” 311 We agree with the Law Society that this is a cause for concern. If the court were under such a duty it might serve to allay some of the fears of witnesses who argued that only tribunals have the necessary expertise to consider care plans. **We recommend that there be a duty on judges to consult a member of the Expert Panel when considering a care plan.**

**Role of nominated persons**

282. Under clause 31(4) (and subject to certain conditions) the clinical supervisor must, when preparing the care plan of a patient subject to compulsion under the non-offender provisions of Part 2, consult the patient, the parents of a patient under 16, the patient’s nominated person and any carer. The nominated person is appointed by the Approved Mental Health Professional as soon as practicable after registration, which, it is hoped, would be before the care plan for a patient subject to assessment is drawn up. Similar duties to consult carers apply, subject to the conditions in clause 12.

283. Offender patients subject to a mental health order are only registered when admitted to hospital, and the care plan will already have been approved by the court. Schedule 8 puts a duty on the AMHP to appoint a nominated person as soon as practicable after registration, and to notify the nominated person and the patient of the help available from mental health advocates. This duty does not apply in relation to restricted patients. If the clinical supervisor applies for an extension of the mental health order, a new care plan must be submitted to the tribunal, and the patient (unless inappropriate or impracticable), the nominated person (if practicable) and the carer (subject to the conditions in clause 12) must be consulted.

284. No such consultation requirement applies to restricted patients. In fact, they are expressly excluded by paragraphs 3 and 5 of Schedule 8. We see no reason why a restricted patient should not be entitled to a nominated person and to consultation with his carer and nominated person about the contents of his care plan.

285. The Revolving Doors Agency told us that this resulted in a “wholly unsatisfactory level of patient involvement in the process”. 312 Mind suggested that this lack of consultation was particularly worrying given that it is proposed that the courts, without specialist expertise, will be approving the care plan which has been drawn up without consultation. 313

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311 Ev 165, question 5
312 Ev 348, section 2
313 Ev 189, para 5.14
286. We were given no reason why the court should not be required, either directly or indirectly via the member of the Expert Panel, to ensure that consultation over the care plan for all Part 3 patients, takes place with the carer and the nominated person (if the mentally disordered offender has a carer or nominated person). We believe that, just as for civil patients, it is important for patients subject to criminal proceedings to have specially tailored care plans, informed by those who know the patient best. There is no reason why a mentally disordered offender should have a less carefully constructed care plan than any other mentally disordered person. **We recommend that, when drawing up care plans for patients involved in criminal proceedings, courts (directly or indirectly via the member of the Expert Panel) and clinical supervisors be subject to the same duties to consult as apply to non-offender patients.**

**Victims**

**Victim statements**

287. The draft Bill does not address the role or needs of victims of mentally disordered offenders. The word “victim” is not used anywhere in the draft Bill.

288. Mrs Jayne Zito, patron of the Zito Trust, told us that victims have needs which should be addressed in the Bill and may be able to provide information that is vital to the treatment and the care of mentally disordered patients.\(^\text{314}\) She told us that, as things stand, victims are “a socially excluded group” in terms of mental health policy.\(^\text{315}\) In terms of the needs of victims, she explained:

“The consequences of being ill or disordered at present mean that the victim’s right to information is restricted because of patient confidentiality. As soon as an offender becomes a patient we have no rights to information [...] We are seeking to address the balance in terms of rights to information [...] We request that we have rights to information about whether an offender has been admitted to hospital, whether that offender has been charged with an offence and admitted to hospital, whether that offender is going to be discharged from that hospital and whether that offender is going to be discharged with restrictions attached to their discharge.”\(^\text{316}\)

289. We are sympathetic to the view that a victim of a mentally disordered offender should not be deprived of all the rights to information that he would have had access to had the offender not been mentally-ill. However, under the Domestic Violence, Crime and Victims Act 2004, victims of mentally disordered offenders subject to treatment under the 1983 Act can access certain information relating to the discharge and status of the offender.\(^\text{317}\) We expect the Bill, as introduced, to incorporate the rights outlined in the Domestic Violence, Crime and Victims Act 2004, making these rights available to victims of offenders treated under the new legislation.

\(^{314}\) Q 521
\(^{315}\) Q 516
\(^{316}\) Q 516
\(^{317}\) Ev 523 (Department of Health), question 3
290. The Zito Trust argued that the Bill should provide a “structured system to engage victims proactively with a view to reducing risk […] and that] there should be a statutory duty on professionals working with MDOs [Mentally Disordered Offenders] to liaise with victims or potential victims in order to improve their assessment of the risk of harm”.

They told us that mental health professionals often think they cannot, or should not, engage with people who report harassment or incidents involving mentally disordered patients, and ascribed this perception to a belief that to engage with victims might breach patient confidentiality and a belief that victims belong to the criminal justice system while patients belong to the health care system. Mrs Zito argued that victims should have the right to make legal representations to the tribunal. She explained that:

“[…] the failure to engage with victims in terms of enhancing accurate risk assessments and accurate risk management is very much restricting the accuracy of the information that clinicians receive about the offending behaviour of the patient, whether that patient be a relative of yours or a member of the public or a patient in a hospital”.

The Minister of State at the Department of Health, Ms Rosie Winterton MP, told us:

“We do indeed see merit in the Committee’s point about victim personal statements informing the Courts’ sentencing decisions. The Court will already be informing itself on the basis of medical reports and pre sentence reports. It may be that the latter will include victim statements. We need to consider whether any further steps should be taken and whether it is appropriate to introduce a requirement”.

291. We recommend that, in cases where there is a victim of violence which has resulted in death or serious injury, the authorities be obliged to place a written victim impact statement before the court or tribunal so as to aid in the assessment of risk.

292. We recommend that the Bill define the term “victim” in a way that covers people who are subject to threats or attacks from mentally disordered people, and the family of anyone who has been killed or seriously injured by a mentally disordered offender.
8 Institutional safeguards

Introduction

293. One of the Government’s stated aims in the draft Bill is to strengthen the safeguards available to protect patients from the inappropriate use of compulsory powers. Any legal provision for persons to be detained or treated under compulsory powers by the state needs to be accompanied by effective safeguards for the rights of the individual. This is all the more vital when the people to whom the provisions apply are at their most vulnerable as a result of serious mental disorder.

294. The 1983 Act contains a broad range of safeguards for people brought under compulsory powers. The draft Bill differs from the current Act in making the proposed Mental Health Tribunal the pivot around which most other safeguards extend, at least in respect of civil patients. For example, the care plan can be seen as a safeguard in itself, but it is only through the powers of the tribunal that it acquires its full significance.

295. We consider below the safeguards proposed in the draft Bill, and also those safeguards from the current Act which are discarded, altered or reduced by the proposals in the draft Bill. We have divided this task into two chapters, starting with the proposed institutions designed to provide safeguards: the Mental Health Tribunals, the Mental Health Appeal Tribunal and the Commission for Healthcare Audit and Inspection (CHAI). In the next chapter we will consider other types of safeguard such as advocacy, care plans and the nominated person.

Mental Health Tribunals

296. Clause 6 of the draft Bill will abolish the Mental Health Review Tribunal (MHRT) system currently provided under the Mental Health Act 1983. Under the 1983 Act an application for the discharge from an assessment or treatment order can be heard by a MHRT or, in some cases, hospital managers. In place of the current system, clause 4 of the draft Bill will establish separate Mental Health Tribunals (“tribunals”) for England and Wales, which will provide judicial authority for the use of formal powers for all cases beyond 28 days not authorised by the courts. The Government have stated that the introduction of tribunals will provide a:

“[…] single procedure [which] will be clearer and simpler to understand; will ensure that patients’ applications are considered by an independent judicial body with specialist expertise and will avoid the duplication of the current system”. 324

The tribunals are meant effectively to sweep up and unify the safeguards provided by a range of different provisions and arrangements under the current Act. For example, the power currently invested in nearest relatives to discharge a patient under sections 23 and 25 of the 1983 Act without a tribunal will be replaced by a right of the patient’s nominated person to apply to the tribunal for discharge. The nominated person will not be able to

323 Department of Health, Improving Mental Health Law: Towards a new Mental Health Act, September 2004, para 1.8
324 Schedule of Comments, Government Response 35(a) (at annex 4)
order a discharge without a tribunal decision. We will elaborate on the changes in the rights of relatives and carers in chapter 9 below.

297. Each tribunal will consist of a President, and a number of other members, who will be appointed by the Lord Chancellor. The constitution of the tribunal and the qualifications necessary for membership are set out in Schedule 2 to the draft Bill.

**The Functions of the Mental Health Tribunal**

298. The tribunals will provide the legal authority for compulsory treatment beyond 28 days for all cases. Its functions will include:

a) making orders for assessment and treatment;

b) reviewing cases, and authorising the discharge or transfer of patients;

c) determining the status of a patient as resident or non-resident;

d) dealing with applications concerning nominated persons;

e) authorising specific treatments such as ECT; and

f) making determinations in cases involving children.

299. The provisions in the draft Bill, requiring tribunals to authorise any treatment or other intervention of a compulsory nature beyond 28 days, were generally seen as a welcome safeguard by witnesses.325 There were, however, serious concerns that the expansion of the role of tribunals would require such a significant increase in resources and staff training that the proposals may not be workable in practice. The Tees and North East Yorkshire NHS Trust warned:

“If this major proposal, which is effectively the fulcrum on which most other proposals in the Bill will balance, were not able to be effectively implemented then the whole of the reforms will inevitably fail and leave patients in a much worse position”.326

**Resources**

300. We have heard three key concerns in relation to the Government’s resource calculations for the new tribunals: first, that the Government has underestimated the resource requirements of the new system; second, that an insufficient number of medical practitioners will be prepared to come forward as tribunal members; and, third, that administration and functioning of the current tribunal system has serious shortcomings which are likely to be carried over into the new system.

301. The Government has estimated that there would be 41,900 tribunal hearings under the draft Bill, compared with a current combined total of 22,800 MHRTs and hospital

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325 See for example: Ev 50 (Royal College of Psychiatrists), question 4; Q 353 (Jonathan Coe – POPAN); Q 737 (Ms Letts, Council of Tribunals)

326 Ev 458
managers’ hearings. The associated increase in medical members is put at 83 per cent, from 60 whole time equivalents (WTE) under the current Act, to 110 WTE under the draft Bill.

302. In calculating these workforce figures, the Government assumed that hearing times would remain unchanged. We have received evidence questioning this assumption. The Law Society asserted that “each hearing will take at least 50 per cent longer, due to the tribunals’ extended remit to include consideration and approval of the care and treatment plan.”

303. The Government has told us that it expects improvements in organisation, efficiency and the better use of technology to drive down the total tribunal time spent on each patient, and that it has commissioned a study of the MHRT service which will review the current systems and processes to determine the potential impact of the Bill on the duration of hearings. It is frustrating that the study of the Mental Health Review Tribunal Services’ current systems and processes was not completed before the drafting of the Bill. On the basis of virtually no evidence, tribunal members and service users are being asked to make a leap of faith. We do not consider that this is a sensible way to proceed.

304. We recommend that the Government expedite the completion of its studies into the expected length of hearings under the Bill, taking into account the concerns we have raised regarding the extended remit of the tribunals and consulting the tribunals and representative user groups. Once these studies are complete, we expect the Government to recalculate and re-publish the workforce and funding implications of the new system in the Regulatory Impact Assessment when it presents the Bill proper to Parliament.

305. A number of witnesses believe that the current tribunal system is stretched, and we have considered whether or not the system can deliver the requirements set out in the draft Bill. Problems identified include the cancellation of hearings at short notice and doctors failing to write their patients’ medical reports within statutory limits in half of all cases. Many of these issues stem from a shortage of medical members. The British Medical Association (BMA) noted:

“[…] the current difficulties in relation to Mental Health Review Tribunals, with as many as 95% of reports being delayed. The BMA understands that the Department of Health is also incurring costs as a result of legal action in relation to unacceptable delays in holding tribunals. The BMA understands that the current delays are primarily due to the shortage of psychiatrists.”

327 “Hospital managers” in this context refers to the board of the hospital Trust. In most cases, the board sets up a Committee responsible for the application of the Act in the Trust, and a number of external non-board members are often appointed to sit on this Committee alongside board members. Hospital managers have the right to discharge patients under s. 2, s.3, or s. 37 of the 1983 Mental Health Act, and patients can appeal their detention and request a hearing with managers.

328 Department of Health, Mental Health Bill Team, “Meeting the Workforce Requirements of the Mental Health Bill”, November 2004

329 Ev 165 (Law Society), question 10

330 Ev 473 (Department of Health), qq 32 and 33

331 Ev 828 (Hospital Managers’ Committee, North East London Mental Health NHS Trust (NELMHT)), para 10

332 Ev 424 (Regional Chairs of Mental Health Review Tribunals and Judge Sycamore), para 6

333 Ev 682 (British Medical Association), question 10
306. In rejoinder, the Government told us that initiatives developed in consultation with psychiatrists have reduced vacancy rates among medical members to only 4 per cent, as shown in Table 4, and that they were confident that all vacancies will be filled in the near future.334

Table 4: Membership and vacancies for Mental Health Review Tribunals: England and Wales

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Membership</th>
<th>Medical Vacancies</th>
<th>Medical Vacancy rate</th>
<th>Legal Membership</th>
<th>Legal Vacancies</th>
<th>Legal Vacancy rate</th>
<th>Lay Membership</th>
<th>Lay Vacancies</th>
<th>Lay Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>183</td>
<td>125</td>
<td>68%</td>
<td>202</td>
<td>45</td>
<td>22%</td>
<td>207</td>
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</tr>
<tr>
<td>2002</td>
<td>190</td>
<td>130</td>
<td>68%</td>
<td>288</td>
<td>54</td>
<td>19%</td>
<td>237</td>
<td>94</td>
<td>40%</td>
</tr>
<tr>
<td>2003</td>
<td>234</td>
<td>110</td>
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<td>27</td>
<td>7%</td>
<td>297</td>
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</tr>
<tr>
<td>2004</td>
<td>310</td>
<td>12</td>
<td>4%</td>
<td>478</td>
<td>0</td>
<td>0%</td>
<td>284</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Mental Health Bill Team response to the Committee, 21 December 2004, Q30

307. While we accept the force of the Government’s statistics on this point, it has to be pointed out that these vacancy rates relate only to Mental Health Review Tribunal (MHRT) hearings, which in 2004 amounted to 12,735. The Government has been unable to produce similar figures for hospital managers’ hearings335 and we have no indication whether suitably qualified staff could be found to support 44,000 tribunal hearings per year.

308. The evidence we heard about the current operation of the tribunal system was far from encouraging. In their carefully considered evidence, the Regional Chairs of the Mental Health Review Tribunals themselves said that “it is important that we place on record our evidence-based observation that [at least in England] the MHRT administration is regularly failing to deliver a reliable, professional service to tribunal users, a failure that it will require a long time to turn around”.336 Lucy Scott-Moncrieff, a mental health practitioner and joint chair of the Mental Health and Disability Committee of the Law Society told us:

“The tribunal system is in melt down at the moment. The Department of Health is trying to do something about it but they have been trying to do something about it for years. Every time they reorganise it, it just gets worse. Maybe this time they will get it right and maybe they will get it right with the 11,000 tribunals they are having at the moment and maybe that will also work with the 50,000 tribunals they will be having when the new Act comes in. There is no evidence to that effect”.

A member of the North East Lancs Association for Mental Health told the Committee that:

“After consulting with colleagues still serving on the present Review Tribunals, I have serious doubt whether enough professionals can be recruited for the much more frequent sittings of the Mental Health Tribunals. It is not a matter of adequate training or finance, the numbers are just not there, and will lead to endless delays and difficulties”.

309. The Government has told the Committee that it is commissioning a study of the options for meeting the demand for extra tribunal members which will look at the views of

334 Ev 523 (Department of Health), question 5
335 Ev 473 (Department of Health), question 30
336 Ev 424 (Regional Chairs of Mental Health Review Tribunals and Judge Sycamore), para 7
337 Q 194 (Ms Scott-Moncrieff, Law Society)
338 Ev 761 (North East Lancs Association for Mental Health), para 4
those in the potential “market”. Again, we are surprised that such research has not previously been undertaken.

310. Not only does the journey ahead appear rough, but the vehicle the Government proposes to set out in appears to be in need of a major upgrade before it can set off. We recommend that the opinions of medical practitioners on the best way forward be sought as a matter of urgency. Prior to the publication of any future Mental Health Bill and the introduction of the new Mental Health Tribunal system, we expect the Government to publish realistic plans detailing exactly from where the increased number of members of tribunals will be drawn, and explaining in detail how the new Mental Health Tribunal system will administer more than 40,000 hearings a year.

311. The BMA believed that: “the success of the Bill will depend upon the effectiveness of these Tribunals. If, as a result of practical difficulties in relation to the availability of expertise, the tribunals are ineffective, the Bill’s safeguards will be compromised”. We recommend that no new Act be brought into force until the Government can demonstrate that sufficient resources are available, both financial and human, to allow for the proposed extensions in hearing numbers and remit.

**Role and functions of the tribunals**

**An independent judicial body?**

312. A number of submissions were critical of aspects of the role of tribunals under the draft Bill. Particular criticism was directed at the apparent blurring of the functions given to the tribunal as a detaining authority and as a review body. Judge Phillip Sycamore, liaison judge for the current Mental Health Review Tribunals, was concerned:

“about the change of the tribunal’s role from one which is reactive to applications and references to one which is proactive, and a particular concern is the difficulty which would arise as the tribunal becomes the detaining authority and the issues then of independence and impartiality when it subsequently acts as a reviewing body on an application by the patient”.

Bevan Brittan Solicitors questioned the independence of a tribunal which exercised the dual functions of authorising and reviewing detention and warned that the proposals would create an opportunity for challenge under Article 6 of the European Convention of Human Rights which provides a right to a fair trial “by an independent and impartial tribunal established by law”.

313. The Government have responded to these criticisms by drawing a distinction between appeals against earlier tribunal decisions and applications for a review of a case:

“This is an important distinction because, in hearing patient applications, the new Tribunal will not revisit an earlier decision but will consider the patient’s case afresh.

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339 Ev 473 (Department of Health), question 34
340 Ev 682 (British Medical Association, question 10
341 Q 724 (Judge Sycamore)
342 Ev 1047 (Bevan Brittan Solicitors), question 9
and make a new decision according to the up-to-date facts and circumstances prevailing at the time. In the unlikely event that a patient application is heard by the same panel of Tribunal members as dealt with an earlier application, this would not give rise to a conflict of interests. The Bill establishes a separate Mental Health Appeal Tribunal to hear appeals on points of law which will consider whether an earlier decision was lawful.343

314. The Government’s indication that it will be “unlikely” that the same tribunal will review an earlier application does little to allay the concerns raised by the evidence. We agree that giving a tribunal the dual functions of an authorising and a review body will undermine its independence. We recommend that, in the interests of ensuring that hearings are both fair and seen to be fair, there be a clearer distinction between the roles of the tribunals as a detaining body and as a review tribunal. So, for example, a member of a tribunal that has imposed an order for assessment or treatment should never hear the review or appeal of that order.

Discretionary discharge

315. Under clause 72 of the 1983 Act, MHRTs retain discretion to discharge civil patients, even where the conditions for the use of compulsory powers are met. This discretion is not replicated in the provisions for tribunals in the draft Bill. The Government have stated that the “new Tribunal system will provide an important safeguard for patients and the public”344 but the removal of the power for discretionary discharge led witnesses such as Professor Richardson to doubt the tribunal’s potential as a genuine safeguard.345 The Bar Council regarded the current discretion as “a vital safeguard for the patient’s right to liberty” and described the change in the law as “striking”. It warned that the effect of the Government’s decision would be to make it more likely that those who did not require compulsion would be compelled to receive treatment.346 Evidence we received indicated that there would be a greater need for a discretionary discharge power under the draft Bill. Ms Penny Letts, from the Council of Tribunals, argued that the broadly drafted relevant conditions ensured that patients could easily fulfil the criteria but that it was difficult to see where those conditions might no longer be met.347

316. The Government has argued that the tribunals do retain a discretion at the point at which they determine whether the relevant conditions for compulsion are satisfied:

“The Tribunal may, for example, find that the patient is not disordered, is not sufficiently disordered, that compulsion is not necessary, or that available treatment is not appropriate in all the patient’s circumstances. Unless satisfied that compulsion is appropriate on all those counts, they must discharge the patient from compulsion”.348

343 Schedule of Comments, Government response 8(a) (at annex 4)
344 Department of Health: Improving Mental Health Law – Towards a New Mental Health Act, September 2004
345 Q 13 (Professor Richardson)
346 Ev 175 (Bar Council), para 11(12)
347 Q 740 (Ms Letts, Council of Tribunals)
348 Schedule of Comments, Government response 45(a) (at annex 4)
A duty to determine whether the relevant conditions are met provides no discretion at all. Once the relevant conditions have been met, compulsion must follow. The “catch all” nature of the conditions was starkly illustrated by the Law Society’s example that a smoker could potentially meet all the conditions in clause 9 in that they have a diagnosable disorder (nicotine dependency), that the health risks of smoking are well established and that appropriate treatments are available. Furthermore, despite the Government’s insistence that the tribunals do have discretion, the draft Bill does not provide any criteria as to how that “discretion” should be exercised.

We consider that the Government has failed to justify the removal of the tribunal’s discretionary power to order the discharge of a patient. We recommend that the current discretion in section 72 of the 1983 Act, which permits the Mental Health Review Tribunal to discharge patients even where the detention criteria are met, be included in the Bill.

Composition of the tribunals

Paragraph 4(1) of Schedule 2 to the draft Bill provides that tribunals may sit as panels of one, two or three members chosen by the president of that tribunal. In the case of a one member panel, the President must choose a legal member; otherwise the panel must include one legal member. Neither the draft Bill nor the Explanatory Notes indicate when it would be appropriate for a tribunal to sit as a panel of less than three members. The Regional Chairs of the MHRT found it “difficult without further information from the department to see how single member panels could operate on substantive issues”. We received a number of submissions which opposed the idea of any matter being heard by a panel of one or two members. Other witnesses conceded that it would be appropriate for case management issues to be heard by less than three members. The Regional Chairs of the MHRT believed that:

“[…] given the role of the tribunal and particularly the proposed role of the involvement in care plans, we would find it difficult to envisage circumstances in which, beyond case management […] single member adjudications would be appropriate”.

They further added that, since the draft Bill would expand the remit of the tribunals to include the care and treatment plan, it would be unfair for a patient to have a sole legal member, without clinical expertise, adjudicating on such matters. We agree that it would be wholly inappropriate to ask a lawyer sitting in a judicial capacity to decide on clinical issues.

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349 Ev 165 (Law Society), question 2(b)
350 Draft Mental Health Bill (2004), Schedule 2, para 4(3)
351 Q 738 (Judge Sycamore)
352 See for example: Ev 798 (Welsh and Nursing Midwifery Committee), section 7; Ev 873 (S Johnson), para 10; Ev 877 (Westminster Users Group)
353 Q 738 (Judge Sycamore)
322. The Government has stated that further work is being carried out to examine what types of case might be appropriate for one or two member panels. We recommend that, in order to ensure a fair hearing, tribunals, when hearing substantive matters and sitting as a panel, sit only as a panel of three members. Furthermore, we consider it to be wholly inappropriate for a single member panel, consisting of a lawyer sitting in a judicial capacity, to decide substantive clinical issues. A panel only should be permitted to sit with fewer than three members at case management hearings.

**Mental Health Appeal Tribunal**

**A right of appeal**

323. Clause 8 of the draft Bill establishes a separate Mental Health Appeal Tribunal (MHAT) to hear appeals from determinations of the tribunals on points of law. Part 9 and Schedule 4 to the draft Bill set out further provisions concerning appeals to the MHAT.

324. The evidence we received did not, on the whole, raise many substantial issues concerning the provisions for MHAT. Bevan Brittan Solicitors, however, noted that the draft Bill does not make provision for a detaining NHS Trust to appeal to the MHAT where it believes there has been an error of law. Clause 249 provides a right of appeal to the MHAT for a patient; the patient’s nominated person; any person with parental responsibility (where a patient is aged under 16); the appropriate authority; or hospital managers authorised to detain a patient subject to a deferral order. Tribunal decisions are subject to judicial review by the High Court and this mechanism will still be available. However, there appears to be no obvious justification for providing some parties with a right of appeal, but not NHS Trusts. We recommend that clause 249 of the draft Bill also include provision for NHS Trusts to appeal to the MHAT on a point of law.

**Abolition of the Mental Health Act Commission and transfer of responsibilities to the Commission for Healthcare Audit and Inspection**

**Background**

325. Part 10 of the draft Bill provides for the abolition of the Mental Health Act Commission (MHAC), the body responsible for monitoring the use of the powers in the 1983 Act. The duty to monitor the use of the new legislation will be amalgamated into the responsibilities of the Commission for Healthcare Audit and Inspection (CHAI). The Government assert that this will “ensure that a single organisation can address issues about all aspects of the patient’s care and treatment e.g. legal issues, clinical quality, safety, cleanliness, food standards, in a way that is more effective and efficient.”

326. The key issues we have considered are:

a) whether the duties that the draft Bill proposes for CHAI are adequate to ensure that the implementation of the legislation is rigorously monitored; and

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354 Schedule of Comments, Government response, schedule 2 (at annex 4)
b) whether an organisation with as wide a remit as CHAI will be able to give adequate attention and resources to its duties under mental health legislation.

**Duties of the Commission for Healthcare Audit and Inspection**

327. The details of CHAI’s functions are left to regulations and we were not able to see a draft of those regulations. However, the role that the draft Bill sets out for CHAI differs from the duties of the MHAC.

328. Witnesses were most concerned about the proposed changes to the visiting function. The MHAC has a pro-active visiting regime involving announced and unannounced visits. They have a duty to visit routinely mental health facilities and interview patients. CHAI will have the power to undertake the same visiting functions but it will not be under a duty to visit routinely establishments and interview patients. MHAC saw their special visiting function as vital to their role.

329. Professor Anselm Eldergill, Professor of Mental Health Law at the University of Northumbria, argued that the standards set for mental health services in England and Wales should be comparable with those adopted by other European countries and those ratified under international conventions and declarations. He believed that the observance of draft recommendations agreed by the Committee of Ministers of the Council of Europe will require the existence of an independent and adequately funded authority with responsibility for the implementation of mental health legislation. In his evidence, Professor Eldergill suggested in detail the functions such an authority would need. We found it useful to compare directly his proposals with the powers proposed for CHAI in the draft Bill and we have done this in Table 5 below.

**Table 5: Powers of the inspection body: comparison of the provisions in the draft Bill with the proposals of Professor Eldergill**

<table>
<thead>
<tr>
<th>Prof Eldergill’s proposals</th>
<th>Provision of the Draft Bill</th>
</tr>
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<tbody>
<tr>
<td><strong>KEEP THE OPERATION OF THE LAW UNDER REVIEW</strong></td>
<td>CHAI would be tasked with keeping the operation of the proposed new Act under review. However, Tribunals will be subject to separate scrutiny by the Council of Tribunals (see clauses 258, 259 and 260)</td>
</tr>
<tr>
<td>To keep under review the exercise of the powers and duties exercisable under the Mental Health Act, the implementation of the Human Rights Act 1998 in respect of incapacitated patients and patients subject or liable to compulsion, and the implementation of any international legal standards or principles prescribed by regulations.</td>
<td>CHAI would not have the power to review the implementation of other legislation which might affect patients liable to compulsion.</td>
</tr>
<tr>
<td><strong>LEGALITY OF COMPULSION</strong></td>
<td>The routine inspection of documents authorising compulsory powers is not a duty proposed for CHAI.</td>
</tr>
<tr>
<td>To scrutinise all statutory documents completed by or under the Act that are received by the Commission, to advise those furnishing them of any irregularities, and</td>
<td></td>
</tr>
</tbody>
</table>

356 Ev 458, (Tees & NE Yorks NHS Trust), para 5.2; Ev 442 (Association of Directors of Social Services & Local Government Association) para 5.4

357 Ev 13 (Mental Health Act Commission), para 5.10

358 Council of Europe: Draft Recommendation of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder, CDBI/INF (2004) 5, Article 36(2)

359 Ev 1146 (Professor Eldergill)
<table>
<thead>
<tr>
<th>Prof Eldergill's proposals</th>
<th>Provision of the Draft Bill</th>
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<tbody>
<tr>
<td>to correct or amend them where appropriate and in whatever way is deemed appropriate. Having been notified that a person is subject to compulsion, the Commission would write to the patient, with an information leaflet, following up with contact by telephone.</td>
<td>This power will be given to CHAI (see clauses 262 and 270).</td>
</tr>
<tr>
<td>VISITING OF PATIENTS</td>
<td>However, CHAI will not be able to visit patients subject to restriction orders. In fact patients subject to restriction orders will be entirely excluded from the remit of CHAI.</td>
</tr>
<tr>
<td>Unless the patient objects, whenever requested by a person or body specified in regulations, to review the care and treatment of an incapacitated patient or a patient subject to compulsion under the Act.</td>
<td></td>
</tr>
<tr>
<td>VISITING OF HOSPITALS</td>
<td>This power will be given to CHAI (see clauses 260, 270 and 271)</td>
</tr>
<tr>
<td>Whenever reasonably requested by a person or body specified in regulations, to review the way in which the Mental Health Act is being applied in respect of incapacitated patients or patients subject to compulsion under it by any person, group of persons, establishment or body.</td>
<td></td>
</tr>
<tr>
<td>ILL-TREATMENT, NEGLECT</td>
<td>This power will be given to CHAI (see clauses 260, 270 and 271)</td>
</tr>
<tr>
<td>To review any case where it appears there may be ill-treatment, neglect in care or treatment, or the improper detention, compulsion or supervision of any person who may be suffering from mental disorder; and, where appropriate, to undertake or order their independent investigation.</td>
<td></td>
</tr>
<tr>
<td>PATIENT DEATHS, HARM TO PATIENTS</td>
<td>CHAI will be empowered, but not under a duty, to investigate the circumstances of the death of a patient who dies while subject to formal powers under the Act or while subject to special safeguards (see clause 262).</td>
</tr>
<tr>
<td>To review the circumstances surrounding the death or physical harm of any person of persons subject to compulsion; and, where appropriate, to undertake or order their independent investigation.</td>
<td></td>
</tr>
<tr>
<td>USE OF SOLITARY CONFINEMENT OR RESTRAINT</td>
<td>This power will be given to CHAI (see clauses 259, 260 and the complaints procedure in clauses 266-9)</td>
</tr>
<tr>
<td>To review, and where deemed appropriate to order the termination of, any use of solitary confinement (seclusion) and mechanical restraint.</td>
<td></td>
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<tr>
<td>RESTRICTIONS ON RIGHT TO COMMUNICATE</td>
<td>CHAI would have this duty to review decisions about withholding mail (see clause 291).</td>
</tr>
<tr>
<td>To review, and where deemed appropriate to order the termination of, any restrictions placed on patients’ rights to communicate with others.</td>
<td></td>
</tr>
<tr>
<td>PROSECUTION OF OFFENCES</td>
<td>CHAI will investigate possible offences and local authorities will prosecute them.</td>
</tr>
<tr>
<td>To investigate and prosecute offences under the Act (ill-treatment, neglect, etc)</td>
<td></td>
</tr>
<tr>
<td>CODE OF PRACTICE</td>
<td>This will be done by the Secretary of State and the National Assembly for Wales (see clause 1)</td>
</tr>
<tr>
<td>To publish a code of practice on the Act.</td>
<td></td>
</tr>
<tr>
<td>ANNUAL REPORT</td>
<td>This power will be given to CHAI (see clause 275)</td>
</tr>
<tr>
<td>To publish an annual report.</td>
<td></td>
</tr>
<tr>
<td>SAVING PROVISION</td>
<td>This power will be given to CHAI (see</td>
</tr>
</tbody>
</table>
Prof Eldergill’s proposals | Provision of the Draft Bill
---|---
To perform such other functions in relation to mentally disordered persons as may be prescribed by regulations. | clauses 265))

330. We consider that the list of tasks suggested by Professor Eldergill has much to commend it, with the exception of the proposal that the codes of conduct should be published by the monitoring body. (We believe that the power to produce the codes should remain with the Secretary of State and the National Assembly for Wales.) **We recommend that the Bill set out powers and duties that will ensure the preservation of a specialised system to monitor patients subject to compulsion.** In doing so, we suggest that the Government pay particular attention to the duties proposed by Professor Eldergill, save the proposal relating to the codes of practice. This includes duties in relation to all patients subject to the powers in the Bill, including restricted patients.

331. **We recommend, too, that the body charged with monitoring patients subject to compulsion have a duty similar to the visiting duty already imposed on the Mental Health Act Commission.** That role includes a duty to visit routinely mental health facilities to interview patients. In addition, we see no reason why the responsibilities of the Mental Health Act Commission should not include investigating and reporting on the Secretary of State’s management of restricted patients. **We recommend that the responsibilities of the reformed Mental Health Act Commission include investigating and reporting on the Secretary of State’s management of restricted patients.**

**Resources**

332. The draft Bill provides for an increase in compulsory powers, and it was argued that it is therefore inappropriate that it also abolishes the *specialist* body whose role it would have been to monitor the use of those powers.360

333. Some witnesses argued that the abolition of Mental Health Act Commission and the transfer of its role to a department within a much larger organisation would be damaging. The Institute of Mental Health Act Practitioners contended that:

“getting rid of a small, standalone, semi-independent, specialist Mental Health Commission will do enormous harm [...] The danger is that the constitutional imperative will be consumed by the larger political imperatives if the MHAC becomes one small division within a super-Commission dedicated to monitoring compliance with the NHS programme. When CHAI budgets are set, ‘mental health legal money’ will compete with NHS performance-targets, and be diverted to the inspection of acute care - in the same way that funds announced for mental health initiatives are now sometimes diverted by Health Authorities to reducing waiting list times”.

Other witnesses were also concerned that the transfer of duties to CHAI would lead to a loss of knowledge and expertise:

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360 Ev 1146 (Professor Eldergill); see also Ev 895 (Depression Alliance Cymru)
361 Ev 92 (Institute of Mental Health Act Practitioners) question 7; see also: Ev 957 (National Voices Forum), para 17; Ev 1050 (Church of England), para 18
“MHAC members and Non-Executive Trust Board Directors, along with Associate MHA Managers, provide a largely volunteer workforce of hundreds of individuals across the country who have developed considerable expertise in making non-judicial judgments which are an aid to both patients and local managers. Is all that expertise and considerable public spirit to be lost, and at what cost to the process of delivering an effective and equitable mental health service in England and Wales?”

Professor Eldergill contended that the nature and extent of the functions that need to be performed make it impractical for a service quality commission, like CHAI, to perform them.  

334. We agree that the nature and extent of the functions that need to be carried out make it impractical for CHAI to perform them. It seems to us almost inevitable that, once the duties to monitor mental health legislation are subsumed into a large healthcare organisation, they will be diluted. Experience shows that mental health services rarely do well in competition for resources and attention. It is vital that, if the monitoring of compulsory powers is to be effective, patients know who is doing it and how they are doing it. This is more likely to be the case if there is a focused stand-alone body with a high profile and clear title.

335. We recommend that the powers set out in paragraphs 329 and 330 above be given to a reformed Mental Health Act Commission. In order to take on the new powers, the new Commission will need more resources.

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362 Ev 1023 (Nottinghamshire Healthcare NHS Trust) para 3.3; see also Ev 1060 (Songhai) , para 5.6

363 Ev 1146 (Professor Eldergill)
9 Other rights and safeguards for patients, carers and relatives

Introduction

336. The draft Bill centres more heavily than the current Act on the key institution of the reformed and strengthened Mental Health Tribunals. There are other important non-institutional safeguards in the draft Bill, notably the introduction of mental health advocacy. In this chapter, we consider these non-institutional safeguards, and some of the key components of the rights and safeguards in the 1983 Act. We also consider the rights of carers.

The right to an examination, assessment, and aftercare

Right to an examination and assessment

337. The draft Bill provides that “any person” can request from the “appropriate authority”364 a determination as to whether all of the relevant conditions for the use of compulsory powers “appear to be met in a patient’s case”.365 It is difficult to gauge how the appropriate authority will be able to form a view on whether the relevant criteria are met. Some witnesses have said that they can foresee authorities having to tie up considerable resources responding to requests,366 some of which may be improperly motivated. Some witnesses contended that this possibility may be used by neighbours in cases where a person with a learning disability or a mentally disordered person, who is voluntarily accepting treatment, is behaving strangely or causing minor nuisances.367 The Government told us that it will work to establish procedures for dealing with requests for examinations, and that the NHS body concerned in any individual case will be responsible for satisfying itself that the conditions appear to be met and will appoint examiners only if there is evidence to support that decision368 We sympathise with the concerns expressed, and we recommend that the widening of the number of people who can request an examination be tempered by a test or safeguards in the Bill to prevent vexatious, malicious or frivolous requests.

338. If the outcome of the examination is that the conditions do not appear to be met, no assessment takes place. Where the request for assessment came from the patient’s carer, and the authority determines that not all the conditions appear to be met, they must notify the carer of that determination as soon as practicable after making it.369 In addition, as soon as practicable after making a determination the appropriate authority must make a record of it and the reasons for it.370 The Mental Health Alliance expressed concern that when

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364 England: Primary Care Trust; Wales: Local Health Board
365 Draft Mental Health Bill (2004), cl. 14(1)
366 Ev 50 (Royal College of Psychiatrists), question 5; Ev 575 (British Association of Social Workers), para 4.20
367 Ev 50 (Royal College of Psychiatrists), question 5; Ev 754 (Welsh Assembly Government’s Learning Disability Implementation Advisory Group); (Ev 210, No Force), para 6.4
368 Schedule of Comments, Government response 14(d) (at annex 4)
369 Draft Mental Health Bill (2004), cl. 14(7)
370 Draft Mental Health Bill (2004), cl. 14(9)
someone is found not to fulfil all the criteria for compulsion, but is nonetheless either mentally-ill or in other serious need, the examiner:

“[...] must consider a referral of the patient for an assessment of health and social service need or alternatively, make a determination to refer the patient to the Community Mental Health Team or the tier 3 team with reference to children and young people”. 371

339. We recommend that where the outcome of the examination is that the conditions for compulsion are not met but that the person appears mentally-ill, the examiners have discretion to refer for a mental health assessment. 372

340. The Government acknowledged the importance of providing preventative mental health services in the National Service Framework for Mental Health. One of the central aims of the framework is “to ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible”. 373 However, a wide range of witnesses argued that access to mental health services remains patchy, and that many instances of compulsion could be prevented if patients were able easily to access appropriate services at an earlier stage of their illness. Hafal described how:

“Typically patients and families who seek help at the early stages of illness receive too little help too late: subsequent deterioration frequently leads to the use of compulsion. It is staggering to note that 50% of people with psychosis find compulsion their first experience of specialist care. More than a third of patients who are treated under the 1983 Act have previously been refused treatment which they sought voluntarily. Long experience tells our members that the quality of support (if any) when it counts at the early stage never matches the methodical and relatively consistent application of legal compulsion (which of course will always also win the case for resources)”. 374

“Rights to early treatment would create a more humane and cost-effective service, steering patients quickly towards recovery and social integration and reducing the need for compulsion. Extending rights to aftercare treatment following discharge (beyond the suggested very limited requirements over six weeks) would also assist patients in making a successful recovery and avoiding relapse”. 375

341. The Mental Health Alliance made very similar points and concluded that, “although Government policy supports both statutory joint assessments and a Care Programme Approach that integrates health and social care on discharge from hospital, there is nothing in the Bill to promote preventive services and early intervention”. 376 This is all the more important in the light of the concerns of the Mental Health Alliance that implementation

371 Ev 119 (Mental Health Alliance), para 7.8(1)
372 A mental health assessment is not the same as an assessment under the draft Bill. It has nothing to do with compulsion.
373 Department of Health: A National Service Framework for Mental Health, 1999 p 41
374 Ev 244 (Hafal), para 6
375 Ibid
376 Ev 119 (Mental Health Alliance) para 7.4
of the draft Bill would risk “diverting even more resources into compulsory care at the expense of voluntary patients”.377

342. The NHS and Community Care Act 1990378 already places local authorities under a statutory obligation to assess people who appear to them to be in need of community care services and to decide which of their needs should be met. The evidence presented to us of people seeking help voluntarily, only to be turned away and then committing an offence and ending up detained under the Mental Health Act leads us to recommend that service users have the right to ask for an assessment of their need for mental health care as a resident or non-resident patient, and that the authorities be required to justify in writing any decision to decline such voluntary assessment.

343. The Committee believes that there is a compelling argument for balancing the draft Bill by including in it a duty to provide appropriate and adequate mental health services which are easy to access and focus on prevention and early intervention. We recommend that the Bill should include a duty on public services to assess and to seek to meet the mental health need of people with mental health problems.

Right to aftercare

344. There is currently a statutory duty imposed jointly on health and social services to ensure that those who have been detained on long term “sections” are offered the extra support that they require when discharged.379 The duty continues until the person is considered by both health and social services to be no longer in need of after-care services.

345. Provisions in the draft Bill guarantee free statutory aftercare for only six weeks. The Mental Health Alliance argued that when compulsion has been imposed, the “NHS and Social Services should ensure that a person’s mental health needs are met in a timely fashion”.380 The Alliance continued:

“People with mental health problems have greater obstacles in receiving care than do people with physical health problems. The National Service Framework for Mental Health requires primary care services to assess a person’s needs, yet in practice many GPs do not have the time or skills to make a full assessment. GPs are not under a duty to make social service referrals, and they gate-keep access to the community mental health service and hospital specialists”.381

346. When society imposes the exercise of compulsory powers on a person, there is a reciprocal right for that person to have services provided to help them get better. Similarly the state should have an obligation to provide continuing aftercare and treatment for as long as the person needs it. We recommend that there be a duty on health and local authorities in each case to draw up a discharge plan and to provide the care in the plan,
and that the provisions of section 117 of the Mental Health Act 1983, relating to free aftercare based on need, be included in the Bill proper when introduced.

The care plan

Content and format

347. One significant change from the 1983 Act is that the draft Bill provides that a care plan has to be drawn up for each patient within five days of admission under compulsion, and that this plan must be authorised by the tribunal. The required content of the care plan is:

“(a) a description of the medical treatment which is to be provided to the patient during the period for which the plan is in force; and

“(b) such other information relating to the care of the patient during that period as may be prescribed by the appropriate authority in regulations”.

348. We received extensive evidence supporting the introduction of care plans, and there was no significant body of opinion opposing this proposal. Many witnesses had a strong preference for the care plan produced through the Care Programme Approach to be put on a legal footing and for it to replace the care plan proposed in the draft Bill. The Care Programme Approach (CPA) was introduced in England in 1991 to "provide a framework for effective mental health care". The approach emphasises a “holistic” approach to care which identifies needs and interventions extending beyond the narrowly medical to encompass social needs such as housing as well. Both patient and carer are consulted in the creation of the care plan under this approach, and the resulting care plan contains an indication from the patient of his acceptance (or otherwise) of the contents of the plan.

349. The Government has argued that the care plan proposed under the draft Bill should not be seen as separate from the Care Programme Approach, but rather as part of it:

“We do not intend that care planning in the Bill should be separate from the CPA. The care plan focuses on the compulsory element of the patient’s care but this is only one element of the CPA process, which embraces the wider health and social care needs of patients in specialist mental health services”.

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382 Draft Mental Health Bill (2004) cl. 31
383 Draft Mental Health Bill (2004) cl. 31(3)(a) and (b)
384 See for example: Ev 594 (British Psychological Society), question 2; Ev 119, Mental Health Alliance, para 8.13
385 See for example: Ev 729 (Mr Craig); Ev 575 (British Association of Social Workers), para 13; Ev 119 (Mental Health Alliance), para 8.13; Q 153, (Mr Farmer, Mental Health Alliance); Q 290 (Ms Greatley, Sainsbury Centre for Mental Health); Ev 575 (British Association of Social Workers), para 13
386 Department of Health: Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach, para 4, [http://www.dh.gov.uk](http://www.dh.gov.uk)
387 Q 153 (Mr Farmer, Mental Health Alliance)
388 Department of Health: Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach, para 4, [http://www.dh.gov.uk](http://www.dh.gov.uk)
389 Department of Health: Improving Mental Health Law: Towards a new Mental Health Act, September 2004, para 4.3
Some evidence was critical of the narrow focus of the care plan proposed by the draft Bill, arguing that the care plan should be aligned with the Care Programme Approach in covering wider social care needs and not simply medical aspects of treatment.\textsuperscript{390} The importance of a team approach to constructing a broad care plan was noted by Touchstone, who emphasised the value of multi-agency planning.\textsuperscript{391} The Mental Health Alliance commented:

“The approach to care and treatment […] should be holistic, incorporating a service user’s social care needs as well as medical treatment. A multidisciplinary approach should be central to patients’ care and treatments as provided in the care plan”.\textsuperscript{392}

They continued:

“[…] the statute itself should specify that the care plan will cover social care issues as well as the ‘compulsory element’ of medical treatment which the patient would like to receive. In the case of children, educational and family needs should be addressed. A good starting point would be the form of care plan prescribed under the Children Act 1989”.\textsuperscript{393}

The particular needs of children in relation to care plans, was another issue raised by a number of those submitting evidence. This is discussed at chapter 6.

350. Apart from concerns about the narrow medical focus of the care plan, some witnesses also had anxieties that the draft Bill was insufficiently specific in setting out “the essential nature, scope and content” of the care plan.\textsuperscript{394} The Mental Health Act Commission, in referring to the function of the care plan as a safeguard, pointed out that without adequate guidance the care plan could be rather nominal and:

“[…] the protections afforded by the Tribunal authorisation could be easily compromised by the adoption of generic care plans [allowing] for wide discretion concerning prescription, medication and other treatments in the absence of consent.”\textsuperscript{395}

Finally, some witnesses called for the Bill to set out the principles that should underpin the drawing up of the care plan. The Gloucestershire Survivors’ Forum called for “patient-centred care plans and facilities which ensure the safety, privacy and dignity of those using them”.\textsuperscript{396}

351. We have no doubt about the importance and efficacy of balanced, comprehensive, and multi-disciplinary care plans as currently used in the Care Programme Approach (CPA), but we are not convinced by the call to enshrine the CPA in law. We believe the CPA needs to be allowed to develop and change over time, and that enshrining the CPA

\textsuperscript{390} Ev 119 (Mental Health Alliance), para 8.13; Ev 839 (West Sussex County Council), para 4.12
\textsuperscript{391} Ev 865 (Touchstone)
\textsuperscript{392} Ev 119 (Mental Health Alliance), para 2.9
\textsuperscript{393} Ev 119 (Mental Health Alliance), para 8.14
\textsuperscript{394} Ev 594 (British Psychological Society), para 7
\textsuperscript{395} Ev 13 (Mental Health Act Commission), para 5.5
\textsuperscript{396} Ev 867 (Gloucestershire Survivors Forum)
approach in legislation that may have to last a generation could halt change and stifle innovation. We support the Government’s intention that care planning under the Bill should be part of the wider CPA approach. It is essential that unnecessary duplication of care planning processes is avoided, and we are concerned that some of the broader issues covered by the CPA should be included in the considerations of tribunals. **We recommend that the Bill include a requirement on tribunals, when they are examining care plans, to consider wider concerns and considerations than purely medical matters - for example social and housing needs.**

352. Advice on the details of drawing up care plans is needed for the care plan to function as an effective safeguard for patients. **We recommend that the codes of practice contain guiding principles for drawing up care plans which will govern the treatment and, for example, the privacy, safety and dignity of the patient.**

**Patient involvement**

353. Under the Care Programme Approach practitioners are required to provide a copy of the care plan to the patient and nearest relative or carers. This is seen as invaluable in supporting the therapeutic relationship between patient and practitioners.397 Furthermore, it is vital for tribunals to know the extent to which the patient accepts or objects to specific elements of the care plan in order for them to safeguard adequately the patient’s rights and best interests. The Mental Health Act Commission stated that:

> “We recommend that care-plans submitted to Tribunals in respect of patients with mental capacity must be required, as a matter of primary legislation, to state what treatment, if any, the patient consents to, as well as those treatments for which authority in the absence of the patient’s consent is sought. This information should be required by provision on the face of the Bill, with requirements for its submission by statutory form established within regulations”.398

**We recommend that, in the interests of safeguarding patients’ rights and involving the patient in his own treatment, the care plan be discussed with him. Except in those cases where the patient does not have capacity, the patient should be asked to sign the plan to prove that he has seen and discussed it, indicating whether he agrees with it. If the patient disagrees with specific aspects of the plan, this should be indicated on the plan either by the patient or the clinical supervisor prior to the patient signing the plan.**

**Availability of treatment**

354. Clause 9(6) of the draft Bill requires that “medical treatment is available which is appropriate in the patient’s case”. This gives rise to the question whether ”available” should be understood to mean practically accessible as well as theoretically possible. Does ”available” refer only to the existence of an appropriate treatment or does it also refer to the **local availability** of such appropriate treatment?399 The West Yorkshire Mental Health

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397 Q 153 (Paul Farmer, Mental Health Alliance); Q 610 (Ms Richards, Powys Agency for Mental Health)
398 Ev 13 (Mental Health Act Commission), para 5.5(a)
399 Ev 807 (North East London Mental Health Trust); Ev 462 (West London Mental Health NHS Trust), para 2.2
Alliance argued that, “while on the one hand there will be compulsion on patients, there is no legal obligation to provide treatment and support as agreed in a care plan”.  

355. The Department of Health and Home Office indicated in their initial response to the Committee that local accessibility is a legitimate factor in the assessment of the availability of appropriate treatments and that “[…] where relevant that would include questions of geography”. Nonetheless, we consider that it would provide an additional safeguard if the Bill itself was explicit on this issue. Where treatments that are generally available nationally at a Trust level but are not locally available this should not be accepted as a reason for treatment not to be provided. **We recommend that the Bill as introduced place an obligation on health authorities and local authorities to provide the care specified in a patient’s care plan, provided that it is in line with normally accepted national standards.**

**Treatment**

356. The Mental Health Act 1983 regulates medical treatment for mental disorder: Part 4 sets out the powers to administer treatment without consent to people who are liable to detention under the Act but only with the agreement of another or “second” doctor; and the Act restricts the giving of emergency treatment. Medication may, however, be administered to a detained patient without consent for up to three months before the patient becomes entitled to a second opinion. ECT may not be given without consent at any time (other than in an emergency), unless approved by a second opinion appointed doctor (SOAD). The second opinion system is administered by the Mental Health Act Commission (MHAC), which appoints the SOAD to visit each patient.

357. The draft Mental Health Bill proposes a new system for authorising treatment without consent. As the Mental Health Act Commission (MHAC) is to be abolished, the function of regulating treatment without consent will be transferred to the Mental Health Tribunals (“tribunals”), supported by the Expert Panel. The inclusion of medical treatment in a care plan which has been prepared by the clinical supervisor and approved by a tribunal will provide the authority to authorise treatment without consent. Special safeguards will, however, remain for ECT and what the draft Bill defines as Type A and Type B treatments.

**Type A treatments - psychosurgery**

358. Type A treatments include psychosurgery and “such other treatments” as may be described in regulations. Type A medical treatments are generally prohibited by clause 192 unless the patient validly consents and the treatment is authorised as being in his best interests by three members of the Expert Panel. This is very similar to the procedure which currently applies under section 57 of the 1983 Act. The difference which the draft Bill seeks to introduce is that psychosurgery may be authorised by the High Court in the case of a patient who is incapable of consenting.

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400 Ev 728 (West Yorkshire Mental Health Alliance), para 7(o)
401 Schedule of Comments, Government response 9(m) (at annex 4)
402 Draft Mental Health Bill (2004) cl. 199
359. The Church of England argued that, despite the “best interests” argument, “type A treatment should never be authorised without informed consent”, and the Mental Health Alliance told us that:

“[...] having an irreversible and/or hazardous treatment like psychosurgery should only ever be decided by the person having the operation, not by another person on their behalf. This is particularly so where there is no clear evidence for the treatment’s benefit in general, or for its likely success in the individual concerned. Service users are likely to feel under threat if there is no clear-cut prohibition on psychosurgery/N[eurosurgery] for M[ental] D[isorder] without consent. The Alliance therefore considers that this provision should not be included in the Bill, and the current restrictions on its use should be maintained”.

360. We believe that treatments such as psychosurgery should only ever be used as a last resort in exceptional circumstances, and then only under the best possible safeguards. We recommend that Type A treatments at clauses 191 to 195 of the draft Bill be under no circumstances used for patients lacking capacity, not even with the consent of the High Court. Where the patient has capacity we recommend that Type A treatment only be given with the patient’s informed consent and furthermore that, given the nature of these procedures, Type A treatments be subject to the ratification of a tribunal, even if the patient is able to give informed consent.

**Type B treatments**

361. The draft Bill, at clauses 196 and 197, refers to “type B medical treatments” but these will be defined in regulations which will also specify the circumstances in which a Type B treatment may not be given. In other words, it is not yet known what treatments will fall into this category, nor what conditions and safeguards will apply. The regulations will be able to specify exceptions where, for example, Type B treatments may be given with consent.

362. The Law Society was critical of the fact that the identity of the treatments classified as Type B, as well as the criteria for administering Type B treatments, have been left to regulations. Various proposals have been put forward in evidence supplied to us about different types of treatment that should be included in the Type B category. One such suggestion from the Mental Health Act Commission was that naso-gastric feeding of patients subject to formal powers should be made a Type B treatment. The Government responded:

“The category is not formally defined to allow for the inclusion of other treatments requiring safeguards in the future, should evidence suggest other treatments need such safeguards. There are, however, no plans at present to use this power. The

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403 Ev 1050 (Church of England), para 20
404 Ev 119 (Mental Health Alliance), para 10.4; see also Ev 50 (Royal College of Psychiatrists), section 6b; Ev 682 (BMA), section 6; Ev 957 (National Voices Forum), para 6(1)(a)
405 Draft Mental Health Bill (2004), cl. 197(3)
406 Ev 165 (Law Society), section 7
407 Ev 13 (Mental Health Act Commission), summary point 20
government believes that levels of prescribing, multi-drug prescribing/polypharmacy and the types of drugs prescribed are issues that are best dealt with as matters of best practice, rather than through legislation.”  

363. It would thus appear that the Type B category might remain “empty” for some time, and that it is simply a provision enabling the Government or the National Assembly of Wales to set out special conditions and safeguards for specific treatments should they so wish at a later date. It is clear from the Government’s response that it believes the range of treatments that will fall into Type B is dynamic and likely to change over time. We take the Government’s point that it currently has no plans for using the Type B category and we accept that treatments cannot be placed on the face of the Bill. The same does not, however, apply to the safeguards and we recommend that the main safeguards which will apply to Type B treatments at clauses 196 and 197 of the draft Bill be listed in the Bill. The safeguards should follow the model of the safeguards for ECT and thus should introduce a requirement to establish whether or not the patient has capacity and can give consent.

**Electroconvulsive therapy (ECT)**

364. The draft Bill, at clause 178, contains a general prohibition on administering ECT to involuntary patients over the age of 16. However, this is qualified by clauses 179 to 184 which set out exceptions to this principle. The exceptions are that:

a) if the patient is capable of understanding the nature purpose and likely effects of ECT and has consented (clause 179);

b) if the patient is incapable of understanding the nature, purpose and likely effects of ECT and the tribunal approves the treatment following a visit and report from a member of its Expert Panel (clauses 180 and 181); and

c) if there is an emergency, the clinical supervisor may certify that ECT should be given whether the patient is capable or not (clauses 183 and 184).

365. This means that ECT may only be given to a capable patient without his consent if it is an emergency. The capable patient would have to be “given a reasonable time to consent to the course of ECT” (or not to do so). The emergency conditions are that the course is immediately necessary to save the patient’s life, immediately necessary to prevent a serious deterioration in his condition (and is not irreversible) or (not being irreversible or hazardous) immediately necessary to prevent serious suffering.

366. The proposals in the Bill represent a tightening of the existing arrangements for the administration of ECT, including the recognition of the need for consent. We believe the safeguards and procedures are adequate, and we therefore make no recommendations with regard to non-emergency ECT.

367. The Mental Health Alliance thought that the “definition of emergency is drawn quite widely” whilst the Law Society told us that they found it difficult to envisage an

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408 Schedule of Comments, Government Response 196(a) (at annex 4)
409 Ev 119 (Mental Health Alliance), para 10.6
emergency where the patient would retain capacity.\textsuperscript{410} The Government estimates that as many as 10 per cent of all administrations of ECT given without consent are given in emergency situations, so it is possible that the emergency power will come to be used extensively”.\textsuperscript{411}

368. For that reason we believe it is essential that the Bill should set clear limits for ECT administered in emergency situations. Where a course of electroconvulsive therapy is prescribed under the emergency procedure, we recommend that the Bill specify the maximum number of treatments which can be given, to prevent emergency treatments becoming a route to a full course of treatment and bypassing the general requirements on ECT. We recommend that the maximum number of treatments under emergency procedures be limited to two.

\textbf{Other treatments}

369. The Mental Health Act Commission has expressed concerns about the fact that the draft Bill provides special safeguards only for ECT and psychosurgery. Apart from the Government reserving the right to propose\textsuperscript{412} new Type B treatments with specific safeguards attached (unspecified), all other medical treatment remain uncategorised and without special safeguards. The Commission explained:

“Under the Bill’s proposals, psychiatric medication would be classified in the catch-all category of ‘other treatments’ (i.e. those that are neither ECT nor type A nor type B treatments). For such treatments, the Bill provides simply that such patients’ consent ‘is not required’ in the initial 28 days or for any treatment plan subsequently authorised by the Tribunal or court. Therefore, any patient who consents to his or her medication whilst otherwise subject to compulsion under the Bill will do so, and may receive it, under the general powers of the common law. The Bill also provides that care-plans submitted to the Tribunal will only require a record of psychiatric medication (and any other treatment) for which the patient has not consented or cannot consent. The recording of either details of the treatment being given under consent, or the details of the consent itself, will be a matter outside the provisions of the Mental Health Act and a matter of policy guidance at best”.\textsuperscript{413}

The Commission continued:

“[…] all psychiatric treatment, such as detention in hospitals, as well as the administration of psychiatric medication, has potential for ‘aggressive’ misuse, and it is of course part of the purpose of mental health law to provide a framework to safeguard against this”.\textsuperscript{414}

370. The Commission’s concerns become particularly pressing in the light of the fact that a tribunal can only modify the medical treatment in a care plan with the consent of the

\begin{footnotes}
410 Ev 165 (Law Society), question 6
411 Schedule of Comments, Government Response 182(b) (at annex 4)
412 Draft Mental Health Bill (2004) cl. 196(1)
413 Ev 13 (Mental Health Act Commission), para 6.15
414 Ev 13 (Mental Health Act Commission), para 6.5
\end{footnotes}
patient’s consultant. This effectively removes the right that patients detained for treatment presently have to a binding second opinion on their drug treatment from an independent consultant psychiatrist appointed by the Mental Health Act Commission. **We recommend that the Bill transfer to the new Expert Panel the safeguarding function of the current second-opinion doctor (SOAD) system, which includes the power to veto proposed treatment.**

371. In order to keep a clear and accurate audit trail of medication administered to the patient, with or without consent, we attach particular importance to the complete recording of all treatment. **We recommend that the Bill make provision for the recording of details of the treatment being given under consent during the assessment period and of the details of the consent itself. We believe that treatment should be audited under all circumstances, and we believe this to be particularly important in relation to treatment under the proposed new system of non-residential orders.**

372. The National Voices Forum argued that “all psychiatric medication has side-effects - some causing severe illnesses such as diabetes, osteoporosis, heart problems etc”415 but this is particularly the case with very large doses. They believed:

> “Doses above British National Formulary Levels should only be given with the authorisation of Mental Health Tribunals if lower [d]oses are not working and there is a life-threatening situation. Also Mental Health Tribunals should only authorise medication outside product licence, if all other treatments have failed, and in addition the Tribunal should authorise polypharmacy” 416

We agree. **We recommend that doses of medical treatment above the British National Formulary levels only be allowed in exceptional circumstances. Medication dosage above BNF levels should be authorised by the tribunals only when all other options have been exhausted.**

373. It is unclear in the current draft Bill whether interventions such as seclusion or control and restraint would need to be anticipated in care plans authorised by the tribunal. **We recommend that the Bill regulate the use of seclusion and mechanical restraint by requiring the same kind of safeguards provided in the current Code of Practice to ensure that decisions to seclude or restrain are only made when absolutely necessary, are subject to regular monitoring and review and that the seclusion or restraint is brought to an end immediately the intervention is no longer needed for the protection of others. There should be a requirement to report such interventions to the Mental Health Act Commission and, if seclusion or restraint is prolonged, a member of the Expert Panel should visit the patient.**

**Emergency drug treatment**

374. The Mental Health Act Commission argued that the draft Bill should be amended to include provisions for the emergency administration of medication for mental disorder, modelled upon the clauses providing such powers in respect of ECT.417 The current

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415 Ev 957 (National Voices Forum), para 6.1(d)
416 Ev 957 (National Voices Forum), para 6(1)(c)
417 Ev 13 (Mental Health Act Commission), para 6.18
provisions under section 62 of the 1983 Act authorise emergency treatment without compliance with the second opinion procedure. We accept that there is considerable force in the argument that medicines may be just as invasive and controversial as ECT, especially if given in large doses, and therefore that there should be similar safeguards in relation to emergency sedation, with the retention of the current limitation that treatment is immediately necessary, to prevent the patient behaving in a manner dangerous to himself or to others, and that it must be neither hazardous nor irreversible. **We recommend that the Bill provide a framework for the review of the emergency administration of medication for mental disorder. In our view the review should be carried out by tribunals, although we accept that such reviews may be carried out retrospectively after emergency treatment has been administered.**

**The mental health advocacy service**

375. The draft Bill provides for a new specialist independent mental health advocacy service. Where a patient is liable to assessment under Part 2, the Approved Mental Health Professional will inform the patient and nominated person that help is available from an Independent Mental Health Act (IMHA) Advocate. In the Government’s view, the advocate’s role is to provide the patient or the nominated person with help in obtaining and understanding information and their rights, and help with exercising those rights, which will include challenging treatment under formal powers where the patient believes that he has wrongly been brought under compulsion.\(^\text{418}\)

376. The overwhelming weight of the evidence we received endorsed the provision of an advocacy service.\(^\text{419}\) Nearly all concern focussed on resources and on whether the proposed service would be fit to meet the Government’s objectives. In the view of the Committee, to decide whether the proposals are fit for the purpose, there are three tests that should be applied.

a) Will IMHA advocates be adequately funded to meet the requirements of the draft Bill?

b) Are the role and responsibilities given to IMHA advocates sufficient to enable them to meet the objectives set by the Government?

c) Will the quality of service provided by IMHA advocates meet the needs of patients?

**Funding for the mental health advocacy service**

377. We agree with the view of Mental Health Alliance that “access to an advocate is a significant safeguard, but becomes meaningless if the person under compulsion is unable to access an advocate when they need them”. In our view, the starting point therefore has to be the money which the Government has ear-marked for the new service. In the Regulatory Impact Assessment (RIA) the Government estimates that it will need 140 whole time equivalent advocates and that the costs will be £5 million for the Independent Mental

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\(^{418}\) Draft Mental Health Bill: Explanatory Notes, Cm 6305-II, September 2004, para 426 and annex A and Regulatory Impact Assessment (RIA), para 69

\(^{419}\) For example: Ev 50 (Royal College of Psychiatrists), question 6; Ev 210 (No Force), para 6.2; Ev 119 (Mental Health Alliance), para 1.14
Health Act Advocacy service;\textsuperscript{420} we suspect these estimates to be seriously inadequate. As Action for Advocacy pointed out, “given that there are some 50,000 uses of the Mental Health Act each year the figure of 140 advocates with a duty to provide information and representation appears somewhat conservative”.\textsuperscript{421} We share the misgivings about these figures, which would allow for less than one advocate per Mental Health Trust in England and Wales.\textsuperscript{422} In addition, as Mind in Birmingham pointed out, there must be concern “as to whether the 140 advocates proposed under the Bill will meet demand and reflect the diversity among black and minority ethnic populations”.\textsuperscript{423} Particularly bearing in mind that the service is not just available to patients at the point of assessment under Part 2 but, as the Government acknowledges, “the IMHA advocate could be involved at any time during the patient’s treatment”,\textsuperscript{424} we lack confidence in the Government’s figures.

378. The problems which we identified at chapter 10 below with the Regulatory Impact Assessment appear to be repeated with the Government’s assessment on advocacy services: assumptions are unsupported by any detailed and convincing evidence. There is a cogent challenge by experienced practitioners to the Government’s analysis, and an absence on the Government’s part of a sensitivity analysis. \textbf{We recommend that, before the Government introduces the Bill proper to Parliament, it review the costs of setting up a discrete mental health advocacy service, as distinct from the new advocacy function to be introduced under the Mental Capacity Bill 2004.} This review should be undertaken in consultation with those providing advocacy services and the Regulatory Impact Assessment should be expanded to ensure that it reflects detailed and robust costings, and a sensitivity analysis taking account of, for example, possible variations in the number of persons detained and the provision of advocacy services at examination stage, to “voluntary” patients and to those under compulsion in the community.

\textbf{Quality and independence of the mental health advocacy service}

379. Under the 1983 Act there are no statutory provisions for any advocacy service for patients subject to compulsion. The services provided for in the draft Bill will not, however, be starting from scratch. We received evidence from advocates and their representative organisations testifying to vibrant and developing services across a range of areas.\textsuperscript{425} It is important to ensure that the new service for people with mental illnesses complements and does not disrupt existing services. We also recognise the need to ensure that advocacy services meet demand and reflect the diversity among black and minority ethnic populations to ensure that patients “might be able to have a male or a female advocate who speaks a different language”.\textsuperscript{426} To underpin the planning, provision and development of advocacy services we are therefore attracted to the suggestion made by the Association for Mental Health Advocates for a statutory requirement for a local advocacy plan. \textbf{We recommend that local authorities and health authorities be placed under a statutory

\begin{thebibliography}{99}
\footnotesize
\item \textsuperscript{420} RIA table 4 and para 52
\item \textsuperscript{421} Ev 623 (Action for Advocacy), para 2.9
\item \textsuperscript{422} Ev 791 (Camden & Islington AIM Advocacy Partnership), para 7
\item \textsuperscript{423} Ev 532 (Turningpoint), para 62
\item \textsuperscript{424} Schedule of Comments, Government Response 247(b) (at annex 4)
\item \textsuperscript{425} Ev 627 (Association for Mental Health Advocates), para 1
\item \textsuperscript{426} Q 1069 (Mr Munn, Cymar)
\end{thebibliography}
obligation to produce local advocacy plans for the development and funding of independent health advocacy services to meet the needs of all service users, including mental health service users.

380. The standards and quality of service that IMHA advocates will provide was also raised. Revolving Doors told us that “the Mental Health Alliance estimates that 2000 people are currently involved in advocacy work for this client group” and suggested that the Bill could also make provision for minimum standards of training for advocates.427 Others went further:

“The role of the advocate will be officially recognised at last, but the Bill places the responsibility upon the Government to ‘set up a scheme of independent Mental Health Advocates’. These advocacy services must be truly independent […] A uniform national system of accredited training should be established and the services should be fully funded, provided that they meet the required standard within a period of, say, one year”.428

“There should be a new agency tasked with overseeing quality measures, ensuring effective scrutiny and overseeing standards setting in mental health advocacy and this should be independent but governed by statute and accountable to government. This is already happening in Scotland in the form of the Advocacy Safeguards Agency. Any such new agency must ensure that people who use services and advocacy workers themselves are involved in developing standards”.429

381. We put the proposal for an agency to the Government who responded:

“Arrangements for the assuring the quality and appropriateness of advocacy will depend on the arrangements for the commissioning of advocacy services which have still to be decided, and will be considered by the project on IMHA [advocates] commissioned by [the Department of Health] from the University of Durham. They will reflect:

“the requirements for advocacy to be specified in regulations under clause 247(6);

“the duty of the commissioners of advocacy services to ensure that advocacy services are delivered to the standards they have specified; and

“the responsibilities for CHAI which will have specific responsibilities under the Mental Health Bill to audit and inspect all aspects of the services within their remits”.430

382. We have reservations about the Government’s response. First, given that proposals for advocates were in the 2002 draft Mental Health Bill,431 we are surprised that the arrangements to ensure the quality of the service to be provided by advocates are not more
advanced. Secondly, since the 2002 draft Bill the Government has added the adjective “independent” to provisions for advocates in the 2004 draft Bill and in the explanatory notes has stated explicitly that a “new specialist independent mental health advocacy service will be available”.\(^{432}\) We welcome this change but question the need to qualify the independence of advocates at clause 247(7) of the 2004 draft Bill “so far as practicable”.

383. To ensure the quality and independence of the service provided by advocates, both of which we consider are essential to underpin patients’ rights and the exercise of those rights, we consider that it is essential for one institution to oversee standards of advocacy services across both England and Wales. We do not, however, believe that it is desirable to set up a new institution charged solely with the function of monitoring advocates. The Government suggests that the Commission for Healthcare Audit and Inspection (CHAI) may play a quality control role\(^{433}\) in relation to advocacy services, but that these arrangements are not yet fully settled. We have already recommended in chapter 8 that the Mental Health Act Commission (MHAC) should remain in place, and we believe that monitoring and quality control of advocacy services would form a natural extension of the functions of the MHAC. We recommend that the Bill charge the Mental Health Act Commission with duties to set national standards for mental health advocates, provide accreditation and to investigate complaints.

**Meeting the needs of service users**

384. The tight finances appear to be matched by a tightly drawn “right to advocacy”. The draft Bill does not provide a general right to advocacy for mentally-ill patients. Instead, the draft Bill introduces a duty to provide specialist independent advocacy services for people subject to formal powers.\(^{434}\) This duty is placed on health authorities which are required to arrange advocacy to such extent as they consider necessary “to meet all reasonable requirements” for patients subject to the legislation.\(^{435}\) In the view of the Government once someone is being treated under the formal powers in the Bill, they have a particular need to both understand the legal procedures and what rights they have and, most importantly, to be able to make the safeguards work for them by articulating their own views and engaging with the clinical team.\(^{436}\) When we asked for the Government’s view on the suggestion that the right of access to specialist mental health advocacy should be available when a person arrives at the place of safety, whether it is a psychiatric hospital or police station, it replied that:

“[…] evidence from advocates has shown that there are a number of reasons why advocacy involvement at this early stage may be difficult. When an individual is removed to a place of safety it is often in very difficult circumstances, and the person may be too ill to understand the role of the advocate. There is also a risk that

\(^{432}\) Draft Mental Health Bill (2004): Explanatory Notes, para 6
\(^{433}\) Schedule of Comments, Government response, other comments on “Overseeing advocacy” (at annex 4)
\(^{434}\) Draft Mental Health Bill (2004), RIA, para 9.5
\(^{435}\) Draft Mental Health Bill (2004), cl. 247(1)
\(^{436}\) Schedule of Comments, Government Response 247(b) (at annex 4)
association with the act of compulsion being imposed can damage the future relationship of the advocate and service user”. 437

385. None of the main advocacy organisations that submitted evidence to us shared this view. Action for Advocacy believed that the Bill should provide the right to access specialist mental health advocacy at a reasonable point within the 120 hour limit of the examination process. The evidence the Committee received on this point focussed on two concerns. The first was the need for a right to advocacy. The second was that access to advocacy should be available from the point a person is conveyed to a place of safety or the examination stage, as opposed to the assessment stage as proposed in the draft Bill. The following points were made:

“[...] the provisions fall short of providing the individual with a legally enforceable right to an advocate. [The Association of Mental Health Advocates] considers an enforceable right is essential because access to advocacy at all stages has a crucial role to play in safeguarding the rights of people subject to the new regime”. 438

“We welcome the creation of a new role of Independent Mental Health Act Advocate. We are disappointed, however, that access to advocacy is not proposed until after the examination stage. This leaves some of the most vulnerable patients without access to a most important source of support at a critical time”. 439

“Our experience suggests that the assessment process can be made less traumatic for the detained person by offering access to an independent advocate. If one is requested by the patient, the advocate can assist with communication between the patient and clinical/care staff, as well as reassuring her/him and helping to safeguard her/his rights. We feel there should be an enforceable right to IMHA advocacy throughout the examination/assessment process. From our clients’ point of view, we feel this would be most beneficial”. 440

“Advocacy should be a right from when a Section is being proposed (before and during examination period) and it should be available to all people irrespective of whether they are under the mental health act or not. You do not have to be on a Section to be affected by the Act. If you are a voluntary patient and want to leave a ward you have to consider if you may be sectioned, as staff do not agree with your wish. Everyone in the community living with a mental health problem is affected by the Act. When they see professionals and are offered medication their consent is tempered by the knowledge that refusal could lead to being put on a Section”. 441

386. Some submitting evidence also drew comparison with the provisions in Scotland concerning which the Scottish Deputy Minister for Health Services and Community Care, Rhona Brankin MSP, said in her memorandum places “a duty on local authority and Health Boards to secure the availability of independent advocacy services in their areas to

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437 Schedule of Comments, Government Response 229(a) (at annex 4)
438 Ev 627 (Association of Mental Health Advocates), para 1.2
439 Ev 259 (Sainsbury Centre for Mental Health), para 5.1
440 Ev 791 (Camden & Islington AIM Advocacy Partnership), para 1
441 Ev 874 (Steven Richards, Mental Health Advocate for Matrix Advocacy), para 7
ensure that every person with a mental disorder (that is, not merely those who are being treated on a compulsory basis) has a right of access to independent advocacy”. 442

387. The rights of people with mental illness need stronger safeguards than those proposed in the draft Bill. The duty as provided in the Bill, although welcome, may not secure that advocates become widely available. Placing a responsibility on a hard pressed health authority to arrange for advocates to be available “to such extent as it considers necessary to meet all reasonable requirements”, may not put the advocacy service on a sound footing. **We recommend that there be a duty in the Bill on the appropriate authority to provide independent mental health advocates to meet the reasonable requirements of patients as soon as any statutory procedure with regard to the potential exercise of formal powers in their case is commenced.**

388. Nor do we see any justification for withholding access to advocacy service until the assessment stage. Professor Richardson said that “the difficulty the Government seems to have got itself into in attaching advocacy to the presence of compulsion means that it is not prepared to propose advocacy earlier in the system”. 443 While we accept that someone under compulsion may have a pressing need for advocacy, we cannot see that this need should push out the right of people who are being held for examination or those who are “voluntary” patients to have the right of access of advocacy services. **We recommend that there be a duty in the Bill on the appropriate authority to ensure that independent advocacy is available to all people with a mental disorder and that they have an opportunity to use the service. We recommend that patients have the right to an independent mental health advocate from the start of the initial examination stage or upon arrival at a place of safety and that the Bill place a duty on the authorities to remind patients of the availability of the advocacy service at key stages.**

389. The Association for Mental Health Advocates expressed concern that the right to meet in private, proposed in the 2002 draft Bill, had been removed from the 2004 draft Bill. 444 When the point was put to the Government it said that “the provision of private facilities for meetings between the patient and their advocate, nominated person or carer is a good practice issue, and will be included in the code of practice”. 445

390. The Committee cannot see why it was acceptable to include a provision in the 2002 draft Bill which provided that “any mental health advocate may, for the purposes of providing that help, at any reasonable time … meet with the patient in private” 446 but not to replicate the provision in the 2004 draft Bill. We consider that the approach taken by the Government in 2002 was the correct one and we see no change in circumstances to justify dropping the provision from the 2004 draft Bill. Providing a patient with the right to meet his or her advocate in private is a useful safeguard. **We recommend that the right of patients to meet their advocates in private, unless it is unsafe to do so, be reinstated in the Bill.**

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442 Ev 408 (Scottish Deputy Minister for Health Services and Community Care), para 9(5)
443 Q 26 (Professor Richardson)
444 Ev 627 (Association for Mental Health Advocates), para 2.7
445 Schedule of Comments, Government Response 247(i) (at annex 4)
446 Draft Mental Health Bill (2002), cl. 159(3)
The role and responsibilities of the mental health advocacy service

391. The draft Bill provides that IMHA advocates will have a right to see any records relating to the patient. In deciding whether an IMHA advocate should have access to a patient’s records, hospital managers must have regard to any wishes and feelings expressed by the patient about this.447 The Government believes that, in order to provide help to the patient, the advocate should be able to ask the hospital managers for access, to the patient’s records. The hospital manager would be able refuse the advocate access, if appropriate, and in deciding what is appropriate the manager must take into account the patient’s wishes and feelings.448

392. Evidence we received raised concerns with this provision. Sheffield Mental Health Advocacy Service pointed out that an advocate’s role was to help the patient to access his records. They considered that the proposal authorising advocates to have access to medical records should be scrapped. Instead patients’ access to records should be safeguarded and improved, if this is needed.449 UKAN said that one of the indispensable fundamental principles of advocacy is that an advocate only acts on behalf of a service user as the service user wishes, and that in no circumstances should advocates be given access to a patient’s records without the consent of the patient.450

393. Even against the constrained framework for general principles at clause 1(3), which requires patients to be involved in the making of decisions and requires restrictions to be kept to a minimum, we find it incongruous that hospital managers should control access to patients’ records. The incompatibility of this arrangement is sharpened because, as the Institute of Mental Health Act Practitioners points out, advocates will be appointed by the NHS – and in practice, probably often by the detaining Trust and the hospital managers in the detaining Trust may refuse the advocate access to the particular patient’s records.451 In our view, the arrangements proposed in the draft Bill could put an advocate in an awkward position and undermine the independence of the advocate in the eyes of a patient.

394. In our view, the starting point has to be that the right of access to records is vested in the patient. We see no convincing case for disturbing this general principle when it comes to the records of a person with mental illness. In our view advocates should only be given access to records with the patient’s informed consent. Where the patient is not able to give informed consent, there needs to be a proxy arrangement. The Association for Mental Health Advocates suggested that for people whose decision-making in this regard is impaired the nominated person should be given this right.452 When this was put to the Government, it responded that “the nominated person is there to represent the wishes and feelings of the patient, and as such does not depend on them having access to the patient’s records. The patient could request to see their records and share them with the nominated

447 Draft Mental Health Bill (2004), cl. 247(5)
448 Schedule of Comments, Government Responses 247(j) and (k) (at annex 4)
449 Ev 803 (Sheffield Mental Health Advocacy Service), para 3
450 Ev 639 (UKAN), para 2.4
451 Ev 92 (Institute of Mental Health Act Practitioners (IMHAP)), theme 6
452 Ev 760 (Mr Campbell), para 2.2
person should they wish to do so – details on the patient’s right to access records will be given in the code of practice”. 453

395. We do not accept the Government’s view. There will be patients who are not capable of making a request to see records, let alone decide who should have access to them. The draft Bill makes provision for nominated persons to act on behalf of patients subject to compulsion – for example, clause 35 provides for a nominated person to make an application to the tribunal for an order discharging a patient’s liability to assessment. In the Committee’s view empowering the nominated person to give or withhold access to an advocate of the records of a patient with impaired decision-making abilities would sit well with the functions and responsibilities of the nominated person. **We recommend that the independent mental health advocate have no access to patient records without the patient’s informed consent and, for people whose decision-making is impaired, the nominated person be asked to make the decision for the patient.**

**Carers and nominated persons**

**Nominated persons**

396. Under the Mental Health Act 1983, and previous legislation going back to the 19th century, one of the major safeguards for the patient’s rights is the nearest relative. The draft Bill proposes abolition of nearest relative status. Many of the powers associated with the role would be replaced in the nominated person, along with rights for carers to be consulted and given information. The nearest relative currently has extensive powers in relation to the decision to impose compulsion. They include:

a) the right to ask for an assessment of the need for compulsory powers to be applied;

b) the power to apply for detention or guardianship; 454

c) the right to be consulted about any decision to detain;

d) the right to object to, and block, compulsory admission for treatment (unless displaced by a county court on grounds of the unreasonableness of the objection);

e) the right to direct the patient’s discharge by giving 72 hours notice to the hospital managers; the hospital managers must then discharge unless the patient’s psychiatrist gives notice that the patient if discharged is likely to act in a manner dangerous to himself or others; 455 and

f) the right to apply to the Mental Health Review Tribunal if discharge is blocked. 456

397. Rethink described these rights as:

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453 Schedule of Comments, Government Response 247(k) (at annex 4)
454 Mental Health Act 1983, s. 2
455 Mental Health Act 1983, s. 23(2)
456 Mental Health Act 1983, s. 25
“[...] part of the carefully thought out checks and balances designed to give the family some powers to counter balance those of the professionals, which could be used in the interests of both patient and carer”.457

However, the Government’s hand has been forced by the ruling of the European Court of Human Rights that the current system contravenes Article 8 of the ECHR on the right to privacy because the patient has no right to seek the displacement of an abusive or unsuitable nearest relative.458 Consequently, the draft Bill proposes to replace the “nearest relative” role with that of a “nominated person”. Patients will have the right to choose their nominated person “unless the person that they select is unsuitable, unwilling or disqualified from fulfilling the role”.459 Although the nominated person will have reduced rights and powers compared to the nearest relative under the 1983 Act,460 the Government says that they will “provide an important safeguard to the patient”.461 The nominated person will have a right to:

a) express the patient’s wishes and feelings: “the matters about which a nominated person is consulted must include whether it appears to him that the patient’s wishes and feelings about that step are known or can be ascertained and, if so, what appear to him to be those wishes and feelings;”462

b) apply to the tribunal on behalf of the patient;463 and

c) visit the person at any “reasonable time”.464

398. Many witnesses were concerned about the reduction in the rights of the nominated person as compared to the nearest relative.465 Much of this concern was focused on the failure to transfer to the nominated person the current right of the nearest relative to initiate the patient’s discharge.466 Mr Marsen-Luther, Chief Executive of the Institute of Mental Health Act Practitioners, told us that:

“What we are terribly concerned about is [...] the proposals [to] get rid of the opportunity for the nearest relative to discharge the patient if they are not a danger to themselves or others which [...] we think is throwing out the baby with the bathwater”.467

457  Ev 230  (Rethink), para 5.2
458  JT v United Kingdom
460  Q 193 (Lucy Scott-Moncrieff, Law Society)
462  Draft Mental Health Bill (2004) cl. 238
463  Draft Mental Health Bill (2004) cl. 35(3)(b)
464  Draft Mental Health Bill (2004) cl. 238(3)
465  See for example: Ev 230 (Rethink), para 5.3; Ev 119 (Mental Health Alliance), para 7.9
466  Q 193 (Mr Bowen, Bar Council); Ev 119 (Mental Health Alliance), para 7.17; Ev 926 (LifeCraft), para 4.2
467  Q 123 (Mr Marsen-Luther, IMHAP)
Some also felt that the nearest relative should retain the current right to object, within reason, to a hospital admission, whilst others were in favour of retaining the right of a nominated person to request an examination. However, in light of the draft Bill’s provision that “any person” can request from the “appropriate authority” a determination as to whether a person meets the conditions for the use of compulsion, we see no reason to provide the nominated person with a specific right to apply for an assessment of the patient.

399. We have received no evidence that the rights of the nearest relative under the 1983 Act to block detention or initiate discharge have led to abuses or serious problems. It may be tidier to transfer these powers to the tribunals but this is not, in our view, a compelling reason for removing these provisions entirely from the Bill. To do so would be to erode the position of families and carers to take responsibility for the care needs of the service user, and to avoid admission to hospital. Nor are these rights and powers incompatible with the new arrangements in the Bill. We recommend that the nominated person have broadly the same rights and powers currently exercised by the nearest relative under the 1983 Act. In particular, the nominated person should be able to:

a) make an order for the discharge in respect of a patient where the patient is liable to be detained in a hospital in pursuance of an application for admission to hospital, and

b) make an order for the discharge of a patient who is detained in a hospital, subject to 72 hours notice. The clinical supervisor would then be able to block discharge by certifying that, if discharged, the patient would be likely to act in a manner dangerous to himself or to others. If that happens, the patient, carer or nominated person should have a right to appeal to the Mental Health Tribunal for discharge on the same basis as patients detained for assessment.

400. We recognise that if, as we propose, the right to discharge a patient were transferred to the nominated person, problems might occur in cases where the nominated person is not synonymous with the nearest relative or carer. The nearest relative’s authority in the 1983 Act reflected a social structure where the majority of patients lived with, and were cared for by, their families. This meant that the nearest relative usually also took responsibility for the care of the patient following discharge. This type of family structure can no longer be assumed, and the draft Bill reflects this social shift by providing separately for the roles of carer and nominated person. For some patients, the two roles may be embodied in the same individual but this is no longer universally the case. If a nominated person who is not also the patient’s carer or nearest relative, had the right to order the patient’s discharge (as we propose), there would clearly be a risk that a nominated person could seek the discharge of a patient against the wishes of the nearest relative or carer, who might nonetheless feel obliged to care for the patient if he returned to the family home. We do not believe that this problem is of a magnitude as to warrant the scrapping of the

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468 Ev 210 (No Force), para 6.10; Ev 92 (IMHAP), theme 6
469 Ev 119 (Mental Health Alliance), para 7.17
470 Draft Mental Health Bill (2004) cl. 14(1)
471 Mental Health Act 1983, s. 23(2)
472 Mental Health Act 1983, s. 25(1)
nominated person’s right to discharge, but rather that it can be overcome by a careful construction and counterbalancing of the right to discharge and taking into account the rights and needs of carers so as to take account of these issues.

401. Under the draft Bill the rules governing the appointment of the nominated person are complex, and it may be some time after compulsion is imposed before the nominated person is appointed. Many witnesses welcomed the new right for the patient to choose his representative, but some were critical of the absence in the draft Bill of any recognition for an advance nomination by a patient of his nominated person and pointed out that there is such a provision in the Mental Health (Care and Treatment)(Scotland) Act 2003. The problem is compounded because, in the absence of any arrangements to allow appointment in advance, the patient is then being asked to choose a nominated person when his autonomy is considered to be sufficiently impaired to warrant the use of compulsory powers under mental health legislation. The Mental Health Alliance pointed out that the problem could be alleviated at least in part by ensuring that the “nominated person [can] remain in post after discharge from an order subject to the agreement of the patient, though their powers would be held in abeyance”.

402. We consider that the rights and interests of a patient would be better safeguarded if a nominated person were able to act at the point at which compulsory powers are first used. **We recommend that patients be able to appoint an enduring nominated person. This could be done through an advance statement, as explained in chapter 4, if the Government brings forward proposals for advance statements or, if it does not, through a simple process and free-standing instrument.**

403. Under the draft Bill, the nominated person does not have to be appointed at the initial examination stage. According to the Government, this is because:

> "An initial examination very often needs to take place quickly, particularly in emergency cases. The process of appointing a nominated person may take a little time because of the need to discuss the options available with the patient and those potentially in view to fulfill the role”.

However, some organisations made representations to us that in many cases it would be perfectly feasible to appoint nominated persons in time for supporting the patient at the examination stage, not least given that the examination can last up to seven days. **We recommend that a nominated person be able to exercise his powers from the start of the examination stage and be entitled to participate at the time of the examination.**

404. In order to facilitate involvement at the stage where the use of compulsory powers is being contemplated, and where the patient has not appointed an “enduring” nominated person, we are attracted to the suggestion of Rethink that there should be a similar “default arrangement” to that which applies under the Scottish Act where the carer becomes the

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473 Ev 230 (Rethink), para 5.3; Ev 928 (South Cambs User Forum (SCUF)), para 5.3; Ev 957 (National Voices Forum), para 5.1(a)

474 Ev 119 (Mental Health Alliance), para 7.12

475 Department of Health: *Improving Mental Health Law: Towards a new Mental Health Act*, September 2004, para 4.10

476 Ev 189 (Mind), para 4.14; Ev 779 (King's College London), para 3.2
nominated person, and if there is no carer, the nearest relative takes this role. We recommend that, where the patient lacks capacity to appoint a nominated person and has not nominated someone previously, there be a default provision along the lines of the Scottish Act whereby the carer is the default first choice with the nearest relative as the default second choice.

405. There was concern among some witnesses about the ability of mental health professionals to judge a person unsuitable to be a nominated person. We recommend that, to safeguard the interests and autonomy of the person under compulsion, the Approved Mental Health Professional be able to disqualify a person’s choice of nominated person only if the nominated person is exploitative or lacks capacity.

Carers – role and rights

406. Under the 1983 Act, the nearest relative would, in most cases, be the carer and the carer would therefore be entitled to information and consultation by virtue of that role. Under the draft Bill, the carer will not necessarily be the nominated person. Carers UK outlined the problem which might arise:

“[with] the way that this Bill has now been drafted, there is a decreased chance that the carer is the nominated person. […] Our concern is that, if the carer is not the nominated person, there could be key instances when they are not given vital information. One example is not having copy of the care plan”.

407. In the draft bill, carers are given rights to information and to be consulted in their own right. However, these are limited and there is a range of potential exceptions. The provisions require consultation with the carer:

a) when reviewing the status of the resident/non-resident patient;

b) when reviewing any requirements imposed on a non-resident patient;

c) during the preparation of the initial care plan and subsequent care plans;

d) at the time of applications to the tribunal for an order or further order authorising further assessment or treatment;

e) about the transfer of patients (to a different hospital or cross-border); and

f) before making an application to a tribunal to authorise the use of Type A treatment (psychosurgery).

Carers also have to be notified at various points, including:

477 Ev 230 (Rethink), para 3.1

478 Ev 279 (David Hewitt, Solicitor), para 9.3; Ev 729 (Mr Craig); Ev 119 (Mental Health Alliance), para 7.10

479 Lack of capacity should be understood as defined in the Mental Capacity Bill.

480 Ev 607 (Carers UK), para 4.7

481 Draft Mental Health Bill (2004) cls. 26(6), 27(3), 29(4), 31(4), 39(6), 40(6), 42(6), 76(11), 77(13) and 193(4)

482 Draft Mental Health Bill (2004) cls. 45(3) and 28(6)
g) if the relevant conditions are not met at any point and the patient is to be discharged (either by order of the tribunal or by the clinical supervisor); and

h) if there is a change in status of a patient between resident and non-resident.

408. A range of witnesses expressed concerns about the diminution of the rights of carers to be informed. Rethink did “not believe that either ‘examination’ or ‘assessment’ can be carried out effectively unless there is an obligation to consult with carers”,483 whilst the Eating Disorders Association emphasised the importance of carers being informed in order for them to take an active role in supporting the patient.484 However, Rethink argued that problems are likely to arise if clinicians are required to seek permission from the patient in order to consult carers. The reason they gave was that:

“[…] symptoms like paranoia are often focussed on those closest to the patient. So a patient, when unwell, could veto consultation with the carer despite accepting the carers involvement when well, which will make it impossible for the appointer to know the carer’s perspective of the situation and to gain important information without which a full assessment would not be possible”.485

409. On the other side of the argument, UKAN maintained that carers should never be consulted without the express permission from the patient because:

“The interests of patients and carers should not be assumed to be compatible. Where the interests of patients and carers are incompatible, the interests of the patient should be of paramount concern”486

410. We appreciate that sometimes the relationship between patient and carer can be difficult, but we believe that in the majority of cases, it is in the interests of the patient and the carer that the carer is kept informed as to the patient’s situation. Also, it is a two-way communication in the sense that the carer can provide background information which is crucial to the patient’s care and treatment. Clause 12(2) provides that carers cannot be consulted without first ascertaining the patient’s wishes and feelings, unless it is inappropriate or impractical to do so. We recommend this be strengthened so as to contain a presumption to consult a patient’s carer when examinations and assessments are carried out, unless the patient is expressly opposed to it.
10 Resources and professional roles

Resources

411. The question of resources is central to the implementation of the draft Bill. It is a theme which has run through much of the evidence we have received.\(^\text{487}\) We have dealt with resource issues in other parts of our report but we consider it necessary to bring together our main conclusions in one chapter. Put simply, all the good intentions in the world are doomed to remain a wish-list in the absence of realistic cost analysis and resource provision.

412. The Government itself has properly placed resources at the centre of its three-pronged mental health services strategy. Under the strategy the Government is committed to:

a) substantially increasing investment in mental health services;

b) developing new and innovative community services; and

c) improving mental health law.\(^\text{488}\)

As a Committee we have sought to answer two questions:

d) how much will it cost to implement this draft Bill?

e) what would happen if the Government’s assumptions and calculations were wrong?

Trends in mental health

413. Resources within mental health services have undergone significant changes in recent years. In September 1999, the Government set out the National Service Framework for Mental Health (NSF), which detailed targets in relation to the quantity and quality of front-line services. The NSF was backed by new money totalling £700 million over three years, compared with the 1999/2000 baseline.\(^\text{489}\) In July 2000, the Government’s NHS Plan pledged a further annual investment of £300 million over the three years from 2000/01 to “fast forward the National Service Framework”.\(^\text{490}\)

414. These developments have been well received, by users and practitioners alike. The South Westminster User Involvement Group, for example, told us that “the NSF seems based on real knowledge of the needs [of users] and addresses them effectively”,\(^\text{491}\) while we heard from the Royal College of Psychiatrists that it welcomes:

\(^{487}\) See annex 1: Joint Committee Press Notice no 1. In its first press notice, the Joint Committee asked ten key questions about the draft Bill, one of which sought evidence relating to resources. It asked about, first, the likely human and financial resource implications of the draft Bill and, secondly, whether the Government was making sufficient resources available for implementation.

\(^{488}\) Department of Health: Improving Mental Health Law: Towards a new Mental Health Act, September 2004, p 5

\(^{489}\) Department of Health: A National Service Framework for Mental Health, September 1999 p 5; see http://www.dh.gov.uk

\(^{490}\) Department of Health: The NHS Plan: A plan for investment, A plan for reform, July 2000, para 14.28; see http://www.dh.gov.uk

\(^{491}\) Ev 877
“the many important Government initiatives (including making mental health a priority, the NHS plan, the National Service frameworks, the additional financial investment, the Mental Capacity Bill, the Disability Discrimination Bill and the report on social exclusion report) in mental health”.

While the NSF has led to improvements in funding, staffing and services, the developments in mental health services must be viewed in the wider context of overall investment in health services. Applying this comparison, we find that some improvements in mental health services have not kept pace with those elsewhere in the NHS. Table 6 shows that mental health funding has increased at a greater rate than the NHS average, but staff increases have not matched those achieved elsewhere within health services. For instance, at 31 March 2004 the vacancy rate among consultant psychiatrists in England was 9.6 per cent, more than twice the average for medical and dental staff of 4.3 per cent. In Wales the number of psychiatrist posts vacant for over three months for has risen from 7.5 per cent to 23.7 per cent.

### Table 6: Expenditure on mental health services as a proportion of total health and social services spending: England.

<table>
<thead>
<tr>
<th>Year</th>
<th>Mental health</th>
<th>Total HCHS</th>
<th>Proportion (%)</th>
<th>Social Services</th>
<th>Mental health</th>
<th>Total PSS</th>
<th>Proportion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-00</td>
<td>3,411</td>
<td>27,633</td>
<td>12.34</td>
<td>633</td>
<td>12,048</td>
<td>5.25</td>
<td></td>
</tr>
<tr>
<td>2000-01</td>
<td>3,826</td>
<td>30,099</td>
<td>12.71</td>
<td>677</td>
<td>12,848</td>
<td>5.27</td>
<td></td>
</tr>
<tr>
<td>2001-02</td>
<td>4,062</td>
<td>31,977</td>
<td>12.70</td>
<td>721</td>
<td>13,598</td>
<td>5.30</td>
<td></td>
</tr>
<tr>
<td>2002-03</td>
<td>4,598</td>
<td>35,087</td>
<td>13.11</td>
<td>815</td>
<td>15,199</td>
<td>5.36</td>
<td></td>
</tr>
</tbody>
</table>

Sources: HC Deb 1 Nov 2004 c139W; DH, Gross and net PSS expenditure in England 1994-95 to 2002-03, February 2004

We also received evidence to indicate that there is a long way to go before mental health ceases to be the “Cinderella” service of the NHS. Mr Niall Dickson, chief executive of the King’s Fund, told us:

“"The truth is that the mental health world has consistently suffered from under-investment under successive governments and its reputation in the wider world […] has been that it is not deemed an attractive and exciting place in which to work. […] Of course, we have had wider shortages of health staff in all the major professions across all specialties, but it is the *Cinderella* specialties where it has been difficult to recruit both the numbers and quality of staff, and mental health is a classic example of an area which has been not given the prominence or support that has been needed”.

The history and current state of mental health services crucially affects the ability of the system to accommodate the new legal framework proposed in the draft Bill. The Association of Directors of Social Services and the Local Government Association told us:

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492 Ev 50,Introduction

493 Department of Health, *NHS Workforce Vacancy Survey*, various years; see http://www.publications.doh.gov.uk

494 Q548, (Ms Hutt AM, then Welsh Assembly Minister for Health and Social Services)

495 Q 310 (Mr Dickson, King’s Fund)
“Without further resourcing it is unlikely that mental health services will be equipped to implement this legislation; nor will they be able to achieve the right balance between public and individual safety, and the provision of quality care for vulnerable people that reduces the need for use of compulsion”.

**How much will it cost?**

417. We carefully examined the Regulatory Impact Assessment (RIA) for the answer to our question about the cost of implementing the draft Bill and we invited those submitting evidence to consider whether the Government had analysed the effects of the Bill adequately and subsequently earmarked sufficient resources to cover the costs of implementation. Despite additional data and memoranda from the Department of Health we conclude that costs of implementing the draft Bill have not been vigorously or robustly assessed or firmly established. First, we set out our concerns about the shortcomings of the RIA.

418. The RIA as published with the draft Bill lacked detail. Estimates of resource implications were presented, but associated assumptions were not always made clear. For example, the RIA claimed that the number of tribunal hearings under the Bill would be 84 per cent higher than the current figure, but made no mention of the length-of-stay estimates used to calculate the number of people who would receive a hearing. As a result, we heard from witnesses who were suspicious of the estimates but frustrated by their inability to check the validity of the claims. It was only after requesting further detail from the Department that we were able to undertake a fuller analysis.

419. We recommend that, when presenting draft bills, the Government attach as annexes any models underpinning the Regulatory Impact Assessment (RIA) in order to allow interested parties more fully to examine the appraisals behind the figures in the RIA.

420. It is Government policy that all departments and agencies, where they exercise statutory powers and make rules with general effect on others, must produce an RIA. The Government’s guidance on RIAs advises policy-makers to: “Ensure that you have evidence supporting your assessment of the costs and benefits”. The estimates in the RIA were based on assumptions which were, however, frequently challenged in evidence we received. The Leeds Mental Health Trust told us, for instance, that:

“It is noted that work has been done to assess the possible workforce and resource requirements stemming from the Draft Bill. From the available documentation,
however, that assessment appears to lack rigour and to be based on potentially flawed assumptions.”  

421. Central to the implementation of the draft Bill will be the effect of the Government’s proposals on the number of compulsory detentions. We have therefore looked at the data on compulsory detentions and the Government’s appraisal of the effect on the numbers of detentions in detail. Figure 1 below shows two clear trends: (i) detentions under the Mental Health Act in England generally rose to 1998/99; and (ii) since then they have levelled off. The 2003/04 total of 45,629 detentions represents a 52 per cent increase on the 1990/91 level of 29,973, although it is slightly down from the peak of 47,035 in 2001/02.

Figure 1: Comparison of number of detentions under 1983 Act in England and number of Mental Health Review Tribunal hearings in England & Wales

Number of detentions under 1983 Act (000s)

Sources: Department of Health: In patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1992-93 to 2003-04, December 2004 (and previous editions)

422. We received some evidence throwing light on the trends. The Minister of State at the Department of Health, Ms Rosie Winterton MP, told us that the Government expects improvements under the NSF to increase the number of people treated early enough to prevent them becoming so ill as to warrant use of the Act. Some witnesses were prepared to make a similar link between community services and compulsion. NACRO told us that:

“If the resources were provided to give a comprehensive structure of assertive outreach services, crisis teams and so on we think that it is far more likely that it would be possible to engage with service users on a voluntary basis so that they could be helped to maintain their lives in the community without the use of compulsion and you would only then be talking about a smaller number of people whose illness
might deteriorate to the point where compulsory treatment in hospital became necessary.\textsuperscript{502}

423. We received evidence about the developing provision of assertive outreach treatment for patients. This is an intensive form of team-based care provided in the community. Assertive outreach teams, working with relatively small caseloads, are proving successful.\textsuperscript{503} However, it is remains an open question whether such approaches have a significant impact in terms of reducing the number of detentions.

424. Speculation about the trends in compulsory detentions would be just that, and therefore of little utility. The steep increase during the 1990s could, for example, have been caused by the psychotic effects of increased substance abuse, public and government pressure on psychiatrists to play safe and detain to avoid any risk to the public, or changes in modern patterns of practice which have led to shorter admissions and therefore more readmissions of patients who frequently relapse.\textsuperscript{504} Nevertheless it would have been helpful for the Government, which has access to the fullest range of data, to have produced a thorough analysis which examined the effects and more fully appraised the consequences of the changes proposed in the draft Bill. The RIA does no such thing. It asserts, however, that there will be no significant increase in the number of persons subjected to compulsory powers, as shown in Table 7.

Table 7: Activity under the 1983 Act and draft Bill

<table>
<thead>
<tr>
<th>Annual activity</th>
<th>1983 Act</th>
<th>Draft Bill</th>
<th>Additional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detentions</td>
<td>44,400</td>
<td>44,800</td>
<td>+400</td>
</tr>
</tbody>
</table>

Source: Mental Health Bill Team, Meeting the Workforce Requirements of the Mental Health Bill, November 2004

425. The Department admitted that there is limited empirical evidence to corroborate this assertion,\textsuperscript{505} and we have repeatedly heard the argument, from the Royal College of Psychiatrists among others, that the proposals in the Bill to widen the definition of mental disorder, remove exemptions and lower the bar for the use of compulsory orders, coupled with the introduction of community treatment orders, will lead to an inevitable increase in the number of detentions.\textsuperscript{506} King’s College London provided details of research from Australia showing increases in community treatment orders and involuntary admissions in Victoria between 1993 and 2000, and concluded that the figures suggested there would be a “significant increase in the use of compulsion in this country”.\textsuperscript{507}

426. We have been hampered by the limited information provided to us. The lack of empirical evidence and analysis underpinning the assumptions adopted in the Regulatory Impact Assessment has caused concern. It is not acceptable to issue an RIA which fails to analyse the key factors which will determine the outcome and efficacy of the Bill. Nor is it acceptable for the Department to indicate that it has commissioned a variety of studies

\textsuperscript{502} Q510 (Ms Smith, Nacro)
\textsuperscript{503} Q 1086, (Mike Firn, National Forum for Assertive Outreach)
\textsuperscript{504} Sometimes called “revolving door patients”
\textsuperscript{505} Mental Health Bill Team, Meeting the Workforce Requirements of the Mental Health Bill, November 2004, Appendix 2
\textsuperscript{506} Ev 50 (Royal College of Psychiatrists), question 2
\textsuperscript{507} Ev 779 (King’s College, London), para 10.1
which are ongoing and that it is committed to updating its estimates in the light of new evidence.\textsuperscript{508} We are disappointed that they failed to enter into comprehensive and exhaustive research before framing the draft Bill. This failure is all the more surprising given that the Department had two years from publication of the draft Bill in 2002 to collect and prepare the data. A review of the information in the whole area of mental health might be helpful.

427. There was no obvious involvement of mental health professionals in the drafting of the RIA. While the evidence we received questioning the Government’s assumptions suffered from a similar lack of empirical evidence and detail as the RIA, it made it obvious that the figures simply did not “look right” to experienced practitioners.

428. We recommend that the Government, as a matter of urgency, complete its studies into the potential impact of widening the definition of mental disorder, removing exclusions and introducing non-resident orders, and that in doing so it takes account of the opinions of practitioners. In the light of these studies, we expect the Government to re-examine the assumptions used in the Regulatory Impact Assessment and to produce a much more comprehensive RIA when it introduces the Bill.

429. Finally, overhanging all our concerns is lack of good data. Poor information and general data inadequacies in mental health services mean that, in determining workforce requirements under the current Act, the RIA used a series of estimated data inputs, including the annual number of hospital managers’ hearings and the length of time taken for various activities.\textsuperscript{509} We recommend that the Government re-examine the accuracy and strength of data used in the Regulatory Impact Assessment prior to the presentation of any associated Bill and ensures that the figures used are the result of direct measurement or improved sampling.

**Consequences of getting it wrong**

430. In determining the consequences of the Government being wrong in its assumptions and calculations, we have not been helped by the Department’s failure to include a full sensitivity analysis in the RIA. The Government’s guidance on RIAs states that:

“It may be that a single factor is crucial to the decision of whether or not an option is worth implementing. In such cases a useful form of sensitivity analysis is to see how much the value of this factor would have to fall (if it is a benefit) or rise (if it is a cost) to make it not worth undertaking the option.”\textsuperscript{510}

431. We believe that the assumptions underlying, for example, the key issue of the number of compulsory detentions under the Bill should have been the subject of a sensitivity analysis. We asked the Department of Health at what percentage increase in the number of

\textsuperscript{508} Ev 473 (Department of Health), questions 16 and 32

\textsuperscript{509} Mental Health Bill Team, *Meeting the Workforce Requirements of the Mental Health Bill*, November 2004, Appendix 1

compulsory patients it felt the Bill would become unworkable. In its response, however, the department was unable to tell us.\textsuperscript{511} We regret this.

432. The RIA includes three limited considerations of changes in assumptions. The first calculates that a 10 per cent increase in detentions would lead to a 20 per cent increase in additional staffing requirements.\textsuperscript{512} As a result, the estimated workforce requirements for the Bill, reproduced in Table 8, would increase from 830 whole time equivalents (WTE) to approximately 1,000 WTE.

\textbf{Table 8: Workforce requirements under the 1983 Act and draft Bill}

<table>
<thead>
<tr>
<th>Whole Time Equivalents</th>
<th>1983 Act</th>
<th>Draft Bill</th>
<th>Additional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>260</td>
<td>390</td>
<td>+130</td>
</tr>
<tr>
<td>Other medical staff</td>
<td>60</td>
<td>80</td>
<td>+20</td>
</tr>
<tr>
<td>Qualified nurse</td>
<td>20</td>
<td>110</td>
<td>+90</td>
</tr>
<tr>
<td>Other nurse</td>
<td>20</td>
<td>40</td>
<td>+20</td>
</tr>
<tr>
<td>Other clinical disciplines</td>
<td>0</td>
<td>80</td>
<td>+80</td>
</tr>
<tr>
<td>Social worker/AMHP</td>
<td>430</td>
<td>480</td>
<td>+50</td>
</tr>
<tr>
<td>Advocates</td>
<td>0</td>
<td>140</td>
<td>+140</td>
</tr>
<tr>
<td>Administrative/clerical</td>
<td>320</td>
<td>510</td>
<td>+190</td>
</tr>
<tr>
<td>Legal members</td>
<td>30</td>
<td>110</td>
<td>+80</td>
</tr>
<tr>
<td>Lay members</td>
<td>80</td>
<td>110</td>
<td>+30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,220</td>
<td>2,050</td>
<td>+830</td>
</tr>
</tbody>
</table>

\textit{Source: DH, Draft Mental Health Bill Explanatory Notes, Table 4}

433. We are concerned about the implications of this finding. The King’s Fund concluded in 2003 that there was “evidence to suggest that the crisis in recruitment and retention of mental health professionals persists, and that it threatens to undermine the Government’s plans for service reform”.\textsuperscript{513} Ms Angela Greatley, chief executive of the Sainsbury Centre for Mental Health, told us:

“We are seriously concerned about the implications for staffing with the new legislation. That, I think, is both in terms of implementing this Bill if it becomes an Act but also the effect on other services, because, of course, where compulsion is involved it may mean that the staff who are available will be drawn into that area of work and clearly will be less able to undertake the kind of work we all want to see in implementing the rest of the national service framework, for example”.\textsuperscript{514}

The Committee of Leeds Consultant Psychiatrists told us that:

“We feel that the figures for extra workforce quoted are a serious underestimate of the numbers required, and secondly that the necessary expansion, even to the numbers predicted in the draft Bill, is unachievable. This alone might render the new Act unworkable”.\textsuperscript{515}

\textsuperscript{511} Ev 473 (Department of Health), question 18
\textsuperscript{512} Mental Health Bill Team, \textit{Meeting the Workforce Requirements of the Mental Health Bill}, November 2004, para 10
\textsuperscript{513} King’s Fund, \textit{London’s Mental Health Workforce: A Review of Recent Developments}, 2003, p. 4
\textsuperscript{514} Q286 (Ms Greatley, Sainsbury Centre for Mental Health)
\textsuperscript{515} Ev 882 (Committee of Leeds Consultant Psychiatrists (CLCP))
434. The Department of Health told us of a number of initiatives and studies relating to these issues of recruitment and retention that it has put in place or commissioned, and the National Workforce Strategy details a variety of targets for the period 2003-2006. As yet, it is too early to determine whether these targets will be met or whether the announced initiatives are sufficient to remedy current shortages and meet future demands. In our view, there needs to be greater certainty in the ability of the Government to recruit a body of staff large enough to cover the requirements of the draft Bill and other mental health service priorities. The consequence of failure is likely to be a vicious cycle in which poor services and inadequate staffing levels lead to more people reaching a critical and “sectionable” stage of mental disorder, and in turn, a further decline in staff morale. Introducing a new Act in this climate would be hazardous. **We recommend that no new Act be introduced without assurances that the increased workforce requirements in the legislation will be met and, moreover, that the additional requirements will not be met at the expense of other parts of the mental health service, in particular the non-compulsory services.** We believe that this recommendation can be achieved in part by implementation of the Act being phased in several steps.

435. Our concern regarding the possibility of the draft Bill leading to a transfer of resources from non-compulsory services is heightened by the fact that the Government does not have full knowledge of the destination of mental health expenditure. Under the Government’s *Shifting the Balance of Power* initiative, it is for locally based Primary Care Trusts (PCTs), in conjunction with Strategic Health Authorities (SHAs), to plan and develop health services according to the needs of their local communities. As such, non-ring-fenced allocations are made to PCTs, which then commission services from hospitals, GPs and others. Similarly, on the social care side of mental health, it is for local authorities to identify local priorities and allocate spending from their PSS (Personal Social Services) total as appropriate. We heard that the arrangements described above make it difficult to assess where recent increases in spending have been directed. Rethink told us that it believed there should be “greater transparency in the allocation and tracking of resources”.

436. It is the Government’s choice to devolve decision making to local and regional levels, but this must be accompanied by an accurate monitoring system. **We recommend that the Government speed up efforts to develop appropriate systems for the effective monitoring of mental health funding streams.**

437. The Department of Health provides PCTs with targets and guidance. We are concerned, however, that this is not a sufficiently stringent means of ensuring that government priorities in relation to mental health are communicated. In 2003, the King’s Fund analysed expenditure at the mental health trust level and mapped this to London boroughs. They concluded that spending was far higher or lower than expected in certain London boroughs when compared with modelled predictions of the need for services.

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516 Ev 473 (Department of Health), question 13 and annex E
517 Department of Health: Mental Health Care Group Workforce Team, National Mental Health Workforce Strategy, August 2004; see http://www.nimhe.org.uk
518 Department of Health: *Shifting the Balance of Power: The Next Steps*, January 2002
519 Ev 230 (Rethink), para 6.1
520 Ev 473 (Department of Health), question 10
Among the reasons for this, they cited differences across PCTs and local authorities in the priority attached to mental health services.  

438. Even where funds are specially allocated there is some difficulty in determining Trusts’ uses of monies. The Audit Commission concluded in 2003 that, across the NHS as a whole, it was difficult to trace specially allocated funds because: “the [Department of Health] does not require trusts to record in a standard way how the money was spent”. As a result, the Commission thought: “funding may not have been applied to the intended priority area”. The Commission believed that, in some cases, trusts were using the special allocations to address underlying financial difficulties. The implementation of a proper system for monitoring funding streams will allow the Government to establish whether mental health funding is leaking into other priority areas at the clinical level.

Conclusions

439. Unfortunately, we have been unable to reach a firm view on the costs of implementing the draft Bill because of the inadequacies of the RIA, the absence of a sensitivity analysis and uncertainties attaching to the Department’s assumptions. There is a realistic possibility that the costs of implementing the Bill will be significantly greater than those estimated by the Government in the RIA. Moreover, we are able to point to a number of areas where there could be serious problems, such as the diversion of resources from “voluntary” services to compulsory detentions, and the inadequacies of capacity in the monitoring systems to alert the Government to growing problems.

Professional Roles

440. The draft Bill aims to underpin multidisciplinary team approaches in mental health care by providing a legal framework that allows the professional boundaries that currently exist to be relaxed. The intention is to allow “staff who have the right skills and experience to carry out key roles instead of restricting roles automatically to particular professional groups”. The Bill would spell changes in two key areas. First, the current role of Approved Social Worker (ASW) would be replaced by the Approved Mental Health Professional (AMHP), who may be drawn from a broader professional background. Secondly, the Bill provides for the creation of the role of the “Approved Clinician” who would be someone with “special experience in the diagnosis or treatment of mental disorder”. The clinical supervisor appointed to coordinate and manage care and treatment for each patient will be drawn from among Approved Clinicians. The key change here is to broaden the range of clinicians available to become clinical supervisors.

The Approved Mental Health Professional (AMHP)

441. Under the current Act, the Approved Social Worker (ASW) is meant to act as an independent non-medical safeguard for patients. The ASW is employed by a local...
authority, and is therefore independent of the hospital Trust or other institution and its medical staff. The British Association of Social Workers described the current position and role of the Approved Social Worker:

“There are currently around 4,500 ASWs, and they make virtually all the applications for compulsory admission to hospital under the civil procedures and are therefore the main ‘gatekeepers’, ensuring that the legal requirements are met and that a proper balance is struck between the interests of the patient and other parties. They are in practice the primary interpreters of the ‘conditions for compulsion’ at the point of a patient’s first entry into the mental health service […] Since they view the situation from a social care perspective, they provide a counterbalance to any tendency to over-medicalise what are often multi-dimensional problems. They have to be experienced social workers with an additional specialist qualification, and, uniquely in local government law, they act in a personal capacity when making decisions under the Act, and can therefore be sued as individuals”.

442. The draft Bill proposes to replace the role of the ASW with the Approved Mental Health Professional. This could be a social worker, mental health nurse or occupational therapist who has undertaken special training in the competencies required. The role of the AMHP is broadly the same as the current ASW, the only key change being that it would be carried out by people with professional backgrounds other than social work. The Government has described the proposed AMHP role as follows:

“The AMHP is responsible for co-ordinating the preliminary examination process and for providing a non-medical view when considering, with her/his medical colleagues, whether a patient meets the conditions for treatment under the Bill. Other duties of the AMHP include: registering patients, appointing nominated persons, notifying patients, those with parental responsibility for a patient under 16 and nominated persons of certain determinations and the availability of advocacy services, taking patients to hospital, and taking patients who abscond or who are absent without leave into custody”.

443. There was some apprehension among nurses and social workers alike about nurses and other health care professionals taking on this traditional social work role. The Royal College of Nursing and the Welsh Nursing and Midwifery Committee were both concerned whether performing the AMHP role could jeopardize the therapeutic relationship between nurses and patients. The Approved Social Work Interest Group (ASWIG), on the other hand, were concerned that professional groups other than social workers might be less effective in ensuring that social factors and perspectives are considered along with medical concerns. However, Mr Owen Davies, Senior National Officer, Local Government, Unison admitted the key factor is training:

“neither Unison or [the British Association of Social Workers] is saying only social workers can do this but what we are saying I think is there will need to be training of

525 Ev 575 (British Association of Social Workers), para 2
526 Department of Health: Draft Mental Health Bill (2004): Explanatory Notes, para 35
527 Ev 579 (Royal College of Nursing), executive summary para 5; Ev 798 (Welsh Nursing and Midwifery Committee), section 4; see also Ev 582 (Unison), para 8.4
528 Ev 860, (Approved Social Work Interest Group (ASWIG))
a sort which will give colleagues from other professions [...] confidence to be able to do their job. [...] The patient deserves to have the additional perspective of someone with a social work model or a non-medical model. As long as that is available through the training of the AMHP we do not see it as a fundamental barrier”

444. The key concern relating to this change from ASWs to AMHPs centred on the loss of independence inherent in the current social worker role, and thereby the perceived loss of an important safeguard for patients. One social worker explained that:

“The ASW is independent and is able to present these options to clinicians, patients and families. It is very unlikely that an AMHP who might be a community nurse or occupational therapist, for example, employed by the health service, would have the knowledge of community provision or would go against the views of a consultant employed in the same service”.

445. The British Association of Social Workers argued that the “independence of the ASWs has [...] already been seriously eroded by their secondment to joint mental health services and in some places by actual transfer to the NHS Trust as their primary employer.” The independent safeguarding function of the current ASW is assumed by the tribunal under the proposals of the Bill, and therefore we do not see the strict preservation of the independence of the ASW as a valid argument for the preservation of the status quo. We conclude that provisions for the move from Approved Social Workers to Approved Mental Health Professionals are satisfactory provided that national training standards are created which ensure that AMHPs:

a) bring a separate professional perspective and model of mental disorder;

b) are trained to assess social factors, and have experience in social care and community resources;

c) are equipped to provide comprehensive risk assessments;

d) are trained to explore the least restrictive alternatives to hospital admission; and

e) are trained to manage the practical tasks involved in the assessments and admissions to hospital.

**The role of the clinical supervisor**

446. The current role of the Responsible Medical Officer (RMO) will be assumed by the clinical supervisor under the draft Bill. This new category will be drawn from a wider range of professional qualifications than is the case for RMOs. The new category of professionals named “approved clinicians” is not fully defined in the draft Bill, since regulations will determine what will be required for a person to become an approved clinician, and thereby a clinical supervisor for a patient. The clear indication of the draft Bill, however, is that

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529 Q967 (Mr Davies, Unison)

530 DMH 39

531 Ev 575 (British Association of Social Workers), para 16

532 Draft Mental Health Bill (2004), cl. 3(1)
professionals such as clinical psychologists would be eligible to become approved clinicians and clinical supervisors. We learned that there is some difference of opinion between psychiatrists and psychologists as to the ability for people with a non-medical background to perform the clinical supervisor role. However, the difference of opinion arose not so much from the general competencies of non-medical clinicians such as psychologists, as from the Royal College of Psychiatrists’ view that there are two key inconsistencies in the draft Bill. First,

“We are sure that clinical psychologists are well able and have the skills necessary - or will have with appropriate training – to fulfil the general functions of a clinical supervisor. We raise just two issues. The first is that whilst we do not really understand why it is clear from the Bill that only registered medical practitioners are deemed […] to be qualified to assess whether a person meets the definition of mental disorder and the conditions required to make them subject to compulsion. If only a doctor can do that in the first instance and given that one of the obligations of a clinical supervisor is to keep under constant review whether a patient continues to meet the criteria, we are not quite sure how somebody who is not deemed competent to assess if somebody meets the criteria can decide that they continue to meet them”.

447. The second perceived inconsistency arises from the fact that one of the roles of the clinical supervisor is to prescribe ECT but not medication. The prescription of medication is governed by the Medicines Act whilst the prescription of ECT is not, and therefore, a clinical supervisor who is not a medical practitioner would not be able to prescribe medication, but would be able to prescribe ECT, subject either to the consent of the patient or the approval of the Tribunal.

448. We believe that within a modern multi-disciplinary team approach to mental health care and treatment there is scope for broadening professional roles such as that of clinical supervisor to encompass suitable professionals with non-medical qualifications. We agree with the British Psychological Society that the fundamental role of the clinical supervisor is to assess and coordinate the patient’s care and treatment needs rather than the prescription of medication. Psychologists possess the competencies and it is true to say that “the clinical actions of psychologists cover the breadth of mental health problems, and certainly all of the so-called categories of people that fall under the Mental Health Act”. Therefore, in appropriate cases, professionals other than psychiatrists should be able to act as clinical supervisors provided that they meet appropriate standards. We recommend that regulations stipulate the appropriate standards and competencies to be demonstrated following training.

449. We acknowledge the inconsistency in the Bill with regard to the prescription of ECT, and we urge the Government to re-consider the issue of whether clinical supervisors with non-medical backgrounds should be able to prescribe ECT, even with the safeguards provided by the tribunal.

533 Q 106 (Dr Zigmond, Royal College of Psychiatrists)
534 Ev 50 (Royal College of Psychiatrists) question 4, para 4
535 Q998 (Professor Kinderman, British Psychological Society)
11 The application of the Bill in Wales and devolved issues

Application of the Bill in Wales

450. The draft Bill applies to England and Wales. Where appropriate the National Assembly for Wales will be responsible for implementation and operational issues in Wales. Mental health services in Wales are significantly less developed than those in England. The fact that Wales is a sparsely populated and bilingual country brings further challenges to the delivery of mental health services. These factors complicate the implementation of the draft Bill in Wales.

451. Many witnesses were concerned that NHS Wales does not currently have the capacity to deliver what is envisaged in the draft Bill.\(^{536}\) The Royal College of Psychiatrists provided a summary of the features of Welsh mental health services which, they argued, would make the implementation of the Bill particularly difficult:

“Local Health Boards cover smaller areas and populations and command smaller budgets compared with Primary Care Trusts in England. They may be less able with regard to commissioning of new services;"

“...The Care Programme Approach, policy in England since the early 1990s, is just being introduced in Wales;"

“...There has been no substantial increase in funding for mental health services in Wales;"

“...There is a higher reliance on unsuitable traditional institutional bases. Community services are less developed and there are few facilities and staff who are available for, and trained to, deliver assertive outreach and home treatment services particularly for people who have a serious mental illness;"

“...The specialist forensic mental health services in Wales are poorly placed to respond to present challenges and current legislation. In particular, there are few low secure services and limited relationships between them and medium secure units. As a consequence the forensic services may be poorly placed to take on the challenges of this Bill;"

“...In 2002 there were 43 vacancies for all consultant psychiatrists in Wales (28% of the established workforce) and vacancies in general adult psychiatry posts of 34%”.\(^{537}\)

452. Much of Wales is rural. The delivery of mental health services in rural areas presents distinct challenges and these have contributed to the problems in establishing a robust infrastructure for mental health services. Rural populations are widely distributed, specialist services tend to concentrate on the urban areas and there is difficulty with the

\(^{536}\) Ev 798 (Welsh Nursing & Midwifery Committee), section 3; Ev 244 (Hafal), section 3; Ev 895 (Depression Alliance Cymru)

\(^{537}\) Ev 50 (Royal College of Psychiatrists), additional information section
recruitment and retention of staff because the opportunities for wider practice and promotion can be more limited. Ms Roberts from Hafal told us that “There are large proportions of places like Ceredigion and Powys, Pembrokeshire and Gwynedd that are not adequately served. We are seeing an increase of mental illness in the farming community, following all the stresses and strains of the last couple of years; and the infrastructure is simply not there”. These factors are likely to make the implementation of Community Treatment Orders particularly challenging in rural areas.

453. The development and provision of mental health services in Wales is in need of attention. Work is now being carried out to address the quality of the services. However, any diversion of resources will have a serious impact. Mr David Melding AM, Chairman of Health and Social Services Committee of the National Assembly for Wales, told us:

“[…] we are in a position of seeing a major change in legislation at a time when we are trying to develop the basic care model for mental health. It is difficult to think how the legislation might affect that in a very constructive way, it would seem to be better to implement these important changes and then have a stable situation in terms of the care model and then review the legislation, but we are in a position where we legislate for England and Wales and that is where we are at the moment”.

We agree with Mr Melding. It seems very unlikely that Wales could successfully implement the provisions of the draft Bill with the resources currently available. If it tried it would divert resources from important tasks like implementing their National Service Frameworks and the Care Programme Approach.

454. **We conclude that the standard of mental health services in Wales must be at least as good as it is now in England before the provisions in the draft Bill can be implemented. Resources should be allocated in order to enable the service to be brought up to the English standard.**

455. Wales is a bilingual country. The Welsh Language Act 1993 provides that the Welsh and English language should be treated equally. The Welsh Language Board referred to a report by the Welsh Consumer Council, which concluded:

“[…] in the case of Welsh-speaking patients, there are instances where they cannot be treated effectively except in their first language or in both their languages. This is especially true in the case of those receiving speech and language therapy, and for the following key groups: people with mental health problems; people with learning disabilities and other special needs; older people and young children”.

The Board submitted evidence to us, asserting that:

“[…] the Bill would benefit from the insertion of a clause, or numerous clauses, which state that those bodies with a remit in Wales, including the National Assembly

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538 Q 566 (Ms Williams AM, Liberal Democrat Health Spokesperson, National Assembly for Wales)
539 Q 267 (Ms Roberts, Hafal)
540 Ev 389 (Powys Agency for Mental Health), paras 6 and 8
541 Q 571 (Mr Melding AM, Chairman of the Welsh Assembly Health and Social Services Committee; Conservative Health Spokesperson, National Assembly for Wales)
542 Welsh Consumer Council quoted in: Ev 395 (Welsh Language Board), para 2
for Wales as the Responsible Authority, the Mental Health Tribunal for Wales and CHAI, should treat Welsh and English on a basis of equality, in accordance with the Welsh Language Act 1993”.  

Ms Jane Hutt AM, the then Minister for Health and Social Services in the Welsh Assembly Government, told us that the Welsh Assembly Government believes that in order to deliver quality services it needs to encourage as many Welsh speakers as possible to work within the mental health professions. Ms Hutt also indicated that it is the intention of the Welsh Assembly Government that the Welsh code of practice will contain a right for patients to have an assessment in Welsh if they so wish.

456. Given the need for investment in Welsh mental health services a clear decision needs to be made regarding whether delivery of those services in Welsh should be a priority at the moment. However, health is a devolved issue and this is a decision for the Welsh Assembly to make. Upon the Welsh Assembly Government introducing a requirement that mental health services in Wales be available in both English and Welsh, the Welsh code of practice can be tailored accordingly. We emphasise that the Committee is concerned about the patchy level of mental health service provision in Wales, irrespective of language.

MPs and Members of devolved legislatures who become mentally-ill

457. Clauses 294 to 297 and Schedule 12 to the draft Mental Health Bill deal with MPs and members of legislatures who become mentally-ill. The provisions in the draft Bill, if enacted, would replace (and make changes to) the arrangements which are set out at, section 141 of the Mental Health Act 1983. We drew the provisions to the attention of the Chief Whips of the Parties at Westminster as well as of the Presiding Officers of the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly, and invited their views. We received substantive replies from the Clerk/Chief Executive of the Scottish Parliament, the Presiding Officer of the National Assembly for Wales and Clerk to the Northern Ireland Assembly as well as the Clerk of the House of Commons. While the authorities at Westminster were largely content with the proposals, the main thrust of the representations from the devolved legislatures was that the provisions at clauses 294 to 297 and Schedule 12 to the draft Bill need to be adapted before they can be applied to members of the devolved legislatures.

458. Detailed scrutiny of the points raised by the devolved legislatures is outside the main areas which we have considered since October and it appears to us that the best course for resolving the issues raised would be direct contact between the Department of Health and the devolved legislatures. We bring the representations from the devolved legislatures about legislators who become mentally-ill to the attention of the Department and

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543 Ev 395 (Welsh Language Board), para 7
544 Q 551 (Ms Hutt AM, then Welsh Assembly Minister for Health and Social Services)
545 Q556, (Ms Hutt AM, then Welsh Assembly Minister for Health and Social Services)
546 Ev 1166 (Clerk/Chief Executive of the Scottish Parliament)
547 Ev 1167 (Presiding Officer, National Assembly for Wales)
548 Ev 1167 (Clerk to the Northern Ireland Assembly)
549 Ev 1168 (Clerk of the House of Commons)
suggest that discussions between the Department and the devolved legislatures take place to ensure that these issues can be resolved before the Bill proper is presented to Parliament.
Conclusions and recommendations

Background

1. We consider that the case for reform of the Mental Health Act is cogent but is by no means overwhelming. On balance, we accept that it is desirable for thorough legislative reform to be implemented and we believe it is appropriate that Parliament take the opportunity offered by the draft Bill to set important aspects of mental health policy on a new course for the next 20 years or so. (Paragraph 32)

2. We fully accept the need to incorporate effective risk management and public protection into mental health policy and a new Mental Health Act. However, this objective must never be allowed to predominate as the primary objective of reform. (Paragraph 33)

3. We hope that any Bill the Government presents to Parliament will be clearer and easier to read and follow than the current draft Bill. (Paragraph 35)

Principles and Codes of Practice

4. We believe that it is essential that fundamental principles be set out on the face of the Bill. It is not appropriate to leave fundamental guiding principles to the codes of practice. (Paragraph 64)

5. We conclude that the Mental Health (Care and Treatment) (Scotland) Act 2003 serves as an excellent model for the range and specificity of principles that must be set out on the face of a new Mental Health Act for England and Wales. We recommend that the Government use this model as a starting point for creating a set of explicit guiding principles to be set out in clause 1 of the Bill when re-drafted. It follows that the provisions of the Bill proper must reflect and support the principles included. (Paragraph 66)

6. We propose that for the principle listed in the Scottish Act of “minimum restriction of the freedom of the patient necessary in the circumstances” there be substituted in the Bill proper a principle based on the wording of the draft Bill, namely interference with, and restrictions imposed on, patients must be kept to the minimum necessary to protect their health or safety or the health or safety of other persons. (Paragraph 67)

7. We recommend that the Bill include a concept of capacity as one of its principles in the form of “significantly impaired decision-making”. The concept would be most directly expressed as one of the conditions for the use of compulsion. However, this will also need to be reflected in the principles and other provisions of the Bill. It should also be an explicit principle that practitioners must have regard to the past and present wishes of the patient. (Paragraph 71)

8. We conclude that a provision on the face of the Bill that anyone operating the legislation “must have regard to” a range of principles would provide a reasonable
balance between flexibility, on the one hand, and transparency and confidence on the other. (Paragraph 72)

9. We recommend the removal from the Bill of the provision for the possible disapplication of any principles when the Bill proper is brought forward. (Paragraph 75)

10. We consider that in cases where draft Bills leave significant provisions to be contained only in secondary legislation or codes of practice, it is not feasible to conduct completely effective pre-legislative scrutiny of the draft Bill without access to draft codes as well. We believe that in cases such as the draft Mental Health Bill, the best option is to publish skeleton codes and, if necessary, regulations, at the same time as the draft Bill, and undertake a full consultation on the codes and regulations in tandem with pre-legislative scrutiny of the draft Bill. We urge the Government to consider this option for future pre-legislative scrutiny wherever possible. We note, in the present instance, that several years have passed since the draft legislation was first mooted. We are disappointed that some of that time was not used to produce draft codes of practice. (Paragraph 79)

Definitions and conditions

11. Although we conclude that the Government should retain the definition of mental disorder contained in the current draft Bill, we believe the scope should be narrowed by means of specific exemptions and by the conditions for the use of compulsory powers. (Paragraph 95)

12. We conclude that a broad definition of mental disorder in the draft Bill must be accompanied by explicit and specific exclusions which safeguard against the legislation being used inappropriately as a means of social control. (Paragraph 100)

13. We recommend that a specific exclusion on the grounds of substance misuse alone (including dependence on alcohol or drugs) be inserted into the Bill. (Paragraph 104)

14. We recommend that a specific exclusion on the grounds of sexual orientation be inserted into the Bill. We do not agree that any exclusion should extend to sexual deviance. (Paragraph 106)

15. We recommend that the Government include in the Bill proper an extra condition to be met in the case of people with learning disabilities or communicative disorders such as autistic spectrum disorders. The provision in the 1983 Act which limits the range of circumstances in which people with a mental impairment can be detained for the purposes of treatment under the Act should be retained and adapted under the new Bill. A provision should be inserted whereby people with the aforementioned disorders are liable for compulsory treatment under the Bill only if they display seriously aggressive or severely irresponsible behaviour as a result of their condition and if such treatment as is properly and reasonably required can only be provided to such patients under conditions of compulsion. Furthermore, in our view, any reference to learning disability or autistic spectrum disorders on the face of the Bill, in Explanatory Notes or the “Easy Read” version should contain this caveat or a cross-reference to it. (Paragraph 111)
16. We recommend too that the codes provide illustrative examples of the full range of developmental conditions, including Asperger’s Syndrome. (Paragraph 112)

17. We recommend that the Bill be amended to contain a specific exclusion for the use of compulsory powers on the grounds of cultural or political beliefs or behaviours alone. (Paragraph 114)

18. We recommend that the second condition for the use of compulsion at clause 9(3) of the draft Bill be amended so as to read the “mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him under compulsory powers”. (Paragraph 118)

19. We recommend that the Government tighten criterion (a) at clause 9(4) in the draft Bill to prevent compulsory powers from being used on a permanent basis in respect of patients who either have a diagnosis associated with a constant risk of suicide or serious self-harm or who engage in chronic risk behaviours. (Paragraph 121)

20. We recommend that the criterion at clause 9(4)(b) of the draft Bill be changed to read “for the protection of other persons from significant risk of serious harm”. (Paragraph 128)

21. We recommend that the Government amend the fifth condition at clause 9(6) of the draft Bill so as to include a test of therapeutic benefit as used in the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003. (Paragraph 141)

22. We conclude that people with serious mental disorders who cannot benefit from treatment pose a very challenging problem, but recommend they be dealt with under separate legislation. (Paragraph 142)

23. We recommend that the codes of practice provide extensive guidance, with examples, assisting practitioners and tribunals in interpreting the notion of appropriate treatment. The codes should also emphasise the need for “appropriate treatment” to be understood as including culturally appropriate, and that services, as far as possible, should be provided in a culturally sensitive manner. (Paragraph 144)

24. We recommend that clause 9(7) be removed from the Bill. (Paragraph 149)

25. Given our recommendation to remove clause 9(7), clause 9(8) would become obsolete. (Paragraph 150)

26. We recommend that the Bill, as in the Mental Health (Care and Treatment) (Scotland) 2003 Act, include a condition at clause 9 that by reason of mental disorder the patient’s ability to make decisions about the provision of medical treatment is significantly impaired. (Paragraph 156)

Interface with Mental Capacity Bill

27. We recommend that, before Parliament is asked to assent to the Mental Health Bill, a clearer analysis of the interrelation between the two pieces of legislation be presented. The relationship between the Mental Capacity Bill and a future Mental Health Bill should be clarified primarily so that clinicians have a clear understanding of their
application in each particular case. This could conveniently be a common part of the respective codes of practice. (Paragraph 169)

28. We recommend that the Government bring forward legislation – either in the Mental Health Bill or separately – which would enable people to make advance statements and to record advance decisions, particularly if there is a treatment they would prefer not to receive. We also recommend that the arrangements provide for these statements (in relation to any future mental health treatment) to be taken into account by, but not become binding on, clinicians in determining the provision of medical treatment for mental disorder under the Act. (Paragraph 172)

29. We urge the Government to bring forward a comprehensive and universal set of proposals to deal with hospitalisation and treatment of patients affected by the Bournewood judgment, either as amendments to a Mental Capacity Bill (as it appears to be intending now), or, failing that, by introducing proposals in the Mental Health Bill, as soon as possible. (Paragraph 182)

Compulsory treatment in the community

30. We recommend that the use of non-residential treatment under compulsion be explicitly limited to a clearly defined and clinically identifiable group of patients. (Paragraph 192)

31. We therefore recommend the following series of amendments to the Bill which would focus the provisions of the Bill proper on a clearly defined and clinically identifiable group of patients - for example, patients who frequently relapse - and limit the scope and potential duration of non-residential compulsory treatment. (Paragraph 197)

32. The primary legislation and its regulations should provide a robust safeguard against the emergence of any two-tier threshold for imposition of formal powers. (Paragraph 198)

33. The following parameters for the use of non-residential compulsory powers should be included on the face of the Bill.

   a) A non-residential order should not normally be imposed without previous hospitalisation at least for the purposes of assessment.

   b) There exists evidence of previous responsiveness to, and co-operation with, proposed treatment before a non-residential order is imposed.

   c) Provisions for non-residential orders should be simple and be used to specify only:

      i. requirements or limitations on a person’s place of residence; and

      ii. medical treatment.

   d) There must be a maximum time limit for treatment under a non-residential order – certainly of not more than three years in any five year period.
e) The non-residential order must not authorise the use of force on the patient in the community (i.e. outside hospitals or clinics) beyond the powers currently available in the 1983 Act which provide for a patient to be conveyed to the place he is required to attend for treatment or to be conveyed to hospital. (Paragraph 199)

34. We recommend that the provisions for non-residential orders be accompanied by a requirement on health and local authorities to provide adequate care. Further, adequate care means care other than that provided by families and carers, and any provision for non-residential orders must ensure that burdens are not placed upon families and carers that would fall more properly on clinicians and the health and social services. (Paragraph 205)

Children and Adolescent Mental Health Services

35. We recommend that the Bill provide 16 and 17 year olds who are being treated under compulsion with the same safeguards as under 16 year olds in addition to the rights which they enjoy as adults. (Paragraph 215)

36. We therefore recommend that, if, notwithstanding our recommendation to remove clause 9(7) from the Bill, it were to be retained, the provision in clause 9(7) do not apply to 16 and 17 years olds but only to those who are 18 or older. (Paragraph 219)

37. We recommend that the Bill stipulate that under 18 year olds should be accommodated in age-appropriate facilities. This requirement could be modelled on section 23 of the Mental Health (Care and Treatment) (Scotland) Act 2003. If in exceptional circumstances under 18 year olds are treated on adult wards, the Bill should require the clinical supervisor to obtain advice from a Child and Adolescent Mental Health Services specialist during both the assessment and treatment of the patient in question. (Paragraph 229)

38. We recommend that there be a requirement that at least one medical assessment of a person under 18 years of age prior to the imposition of compulsory treatment should be by a clinician specialising in Child and Adolescent Mental Health Services. (Paragraph 230)

39. We recommend that the Bill require that, when a tribunal is hearing the case of a child or adolescent patient, it has to seek the advice of a medical member of the Expert Panel who is a doctor specialising in Child and Adolescent Mental Health Services. (Paragraph 231)

40. We recommend that, in order to give a consistency of experience for children dealt with by the law, child welfare principles also be included on the face of the Bill. (Paragraph 237)

41. We recommend that, where the predominant issue is the need for compulsory treatment for mental disorder, treatment of under 18 year olds be subject to the provisions in the draft Bill. (Paragraph 240)
42. We recommend, in respect of children and adolescents, that the care planning process reflect the process designed for a child subject to a Children Act 1989 order i.e. a multidisciplinary, regularly reviewed, advocacy-based way of working. (Paragraph 242)

43. We recommend that there be a duty, where the patient is 16 or 17 years of age, to ensure appropriate educational provision. Appropriate provision will usually mean specialised education to deal with adolescents who are being treated as in-patients for mental health problems and sufficient to meet their educational needs. (Paragraph 247)

44. We recommend that it only be possible to administer electroconvulsive therapy (ECT) to 16 and 17 year olds in line with the safeguards currently proposed in the draft Bill for those under 16. (Paragraph 252)

**Patients concerned in criminal proceedings, restricted patients and victims**

45. We recommend that the Government give serious consideration to ways of improving the drafting so that the provisions of the whole Bill, and particularly Part 3, can be more easily understood, and can be read easily in conjunction with the Criminal Justice Act 2003. (Paragraph 254)

46. We recommend that, where a court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contains a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute. (Paragraph 263)

47. We recommend that, where those exercising the functions of clinical supervisor form the view that a prisoner or person on remand meets the conditions at clause 137 and recommend that he is transferred to hospital, the Bill proper contain a duty requiring the Home Secretary to order his transfer to hospital. (Paragraph 264)

48. We recommend that when courts are considering whether to make a mental health order or hospital direction, there be a requirement that the mental disorder of the offender/patient should be of a nature or degree which makes treatment under compulsory powers appropriate. If the offender/patient is to be resident, then the disorder should be of a nature or degree warranting detention. (Paragraph 271)

49. We recommend, in the interests of non-discrimination, that the Bill proper and accompanying codes of practice be drafted in such a way as to make clear that courts, in making a mental health order or hospital direction, should base their assessment on whether the offender’s mental disorder renders him a risk to self or others, irrespective of whether that risk could be minimised by a prison sentence. (Paragraph 272)

50. We recommend that the Mental Health Tribunal be given the power to order the transfer and leave of absence of restricted patients. (Paragraph 277)
51. We recommend that there be a duty on judges to consult a member of the Expert Panel when considering a care plan. (Paragraph 281)

52. We recommend that, when drawing up care plans for patients involved in criminal proceedings, courts (directly or indirectly via the member of the Expert Panel) and clinical supervisors be subject to the same duties to consult as apply to non-offender patients. (Paragraph 286)

53. We recommend that, in cases where there is a victim of violence which has resulted in death or serious injury, the authorities be obliged to place a written victim impact statement before the court or tribunal so as to aid in the assessment of risk. (Paragraph 291)

54. We recommend that the Bill define the term “victim” in a way that covers people who are subject to threats or attacks from mentally disordered people, and the family of anyone who has been killed or seriously injured by a mentally disordered offender. (Paragraph 292)

Institutional safeguards

55. We recommend that the Government expedite the completion of its studies into the expected length of hearings under the Bill, taking into account the concerns we have raised regarding the extended remit of the tribunals and consulting the tribunals and representative user groups. Once these studies are complete, we expect the Government to recalculate and re-publish the workforce and funding implications of the new system in the Regulatory Impact Assessment when it presents the Bill proper to Parliament. (Paragraph 304)

56. We recommend that the opinions of medical practitioners on the best way forward be sought as a matter of urgency. Prior to the publication of any future Mental Health Bill and the introduction of the new Mental Health Tribunal system, we expect the Government to publish realistic plans detailing exactly from where the increased number of members of tribunals will be drawn, and explaining in detail how the new Mental Health Tribunal system will administer more than 40,000 hearings a year. (Paragraph 310)

57. We recommend that no new Act be brought into force until the Government can demonstrate that sufficient resources are available, both financial and human, to allow for the proposed extensions in hearing numbers and remit. (Paragraph 311)

58. We recommend that, in the interests of ensuring that hearings are both fair and seen to be fair, there be a clearer distinction between the roles of the tribunals as a detaining body and as a review tribunal. So, for example, a member of a tribunal that has imposed an order for assessment or treatment should never hear the review or appeal of that order. (Paragraph 314)

59. We recommend that the current discretion in section 72 of the 1983 Act, which permits the Mental Health Review Tribunal to discharge patients even where the detention criteria are met, be included in the Bill. (Paragraph 318)
60. We recommend that, in order to ensure a fair hearing, tribunals, when hearing substantive matters and sitting as a panel, sit only as a panel of three members. Furthermore, we consider it to be wholly inappropriate for a single member panel, consisting of a lawyer sitting in a judicial capacity, to decide substantive clinical issues. A panel only should be permitted to sit with fewer than three members at case management hearings. (Paragraph 322)

61. We recommend that clause 249 of the draft Bill also include provision for NHS Trusts to appeal to the MHAT on a point of law. (Paragraph 324)

62. We recommend that the Bill set out powers and duties that will ensure the preservation of a specialised system to monitor patients subject to compulsion. (Paragraph 330)

63. We recommend, too, that the body charged with monitoring patients subject to compulsion have a duty similar to the visiting duty already imposed on the Mental Health Act Commission. That role includes a duty to visit routinely mental health facilities to interview patients. (Paragraph 331)

64. We recommend that the responsibilities of the reformed Mental Health Act Commission include investigating and reporting on the Secretary of State's management of restricted patients. (Paragraph 331)

65. We recommend that the powers set out in paragraphs 329 and 330 above be given to a reformed Mental Health Act Commission. In order to take on the new powers, the new Commission will need more resources. (Paragraph 335)

Other rights and safeguards for patients, carers and relatives

66. We recommend that the widening of the number of people who can request an examination be tempered by a test or safeguards in the Bill to prevent vexatious, malicious or frivolous requests. (Paragraph 337)

67. We recommend that where the outcome of the examination is that the conditions for compulsion are not met but that the person appears mentally-ill, the examiners have discretion to refer for a mental health assessment. (Paragraph 339)

68. The evidence presented to us of people seeking help voluntarily, only to be turned away and then committing an offence and ending up detained under the Mental Health Act leads us to recommend that service users have the right to ask for an assessment of their need for mental health care as a resident or non-resident patient, and that the authorities be required to justify in writing any decision to decline such voluntary assessment. (Paragraph 342)

69. We recommend that the Bill should include a duty on public services to assess and to seek to meet the mental health need of people with mental health problems. (Paragraph 343)

70. We recommend that there be a duty on health and local authorities in each case to draw up a discharge plan and to provide the care in the plan, and that the provisions
of section 117 of the Mental Health Act 1983, relating to free aftercare based on need, be included in the Bill proper when introduced. (Paragraph 346)

71. We recommend that the Bill include a requirement on tribunals, when they are examining care plans, to consider wider concerns and considerations than purely medical matters - for example social and housing needs. (Paragraph 351)

72. We recommend that the codes of practice contain guiding principles for drawing up care plans which will govern the treatment and, for example, the privacy, safety and dignity of the patient. (Paragraph 352)

73. We recommend that, in the interests of safeguarding patients’ rights and involving the patient in his own treatment, the care plan be discussed with him. Except in those cases where the patient does not have capacity, the patient should be asked to sign the plan to prove that he has seen and discussed it, indicating whether he agrees with it. If the patient disagrees with specific aspects of the plan, this should be indicated on the plan either by the patient or the clinical supervisor prior to the patient signing the plan. (Paragraph 353)

74. We recommend that the Bill as introduced place an obligation on health authorities and local authorities to provide the care specified in a patient’s care plan, provided that it is in line with normally accepted national standards. (Paragraph 355)

75. We recommend that Type A treatments at clauses 191 to 195 of the draft Bill be under no circumstances used for patients lacking capacity, not even with the consent of the High Court. Where the patient has capacity we recommend that Type A treatment only be given with the patient’s informed consent and furthermore that, given the nature of these procedures, Type A treatments be subject to the ratification of a tribunal, even if the patient is able to give informed consent. (Paragraph 360)

76. We recommend that the main safeguards which will apply to Type B treatments at clauses 196 and 197 of the draft Bill be listed in the Bill. The safeguards should follow the model of the safeguards for ECT and thus should introduce a requirement to establish whether or not the patient has capacity and can give consent. (Paragraph 363)

77. Where a course of electroconvulsive therapy is prescribed under the emergency procedure, we recommend that the Bill specify the maximum number of treatments which can be given, to prevent emergency treatments becoming a route to a full course of treatment and bypassing the general requirements on ECT. We recommend that the maximum number of treatments under emergency procedures be limited to two. (Paragraph 368)

78. We recommend that the Bill transfer to the new Expert Panel the safeguarding function of the current second-opinion doctor (SOAD) system, which includes the power to veto proposed treatment. (Paragraph 370)

79. We recommend that the Bill make provision for the recording of details of the treatment being given under consent during the assessment period and of the details of the consent itself. We believe that treatment should be audited under all
circumstances, and we believe this to be particularly important in relation to treatment under the proposed new system of non-residential orders. (Paragraph 371)

80. We recommend that doses of medical treatment above the British National Formulary levels only be allowed in exceptional circumstances. Medication dosage above BNF levels should be authorised by the tribunals only when all other options have been exhausted. (Paragraph 372)

81. We recommend that the Bill regulate the use of seclusion and mechanical restraint by requiring the same kind of safeguards provided in the current Code of Practice to ensure that decisions to seclude or restrain are only made when absolutely necessary, are subject to regular monitoring and review and that the seclusion or restraint is brought to an end immediately the intervention is no longer needed for the protection of others. There should be a requirement to report such interventions to the Mental Health Act Commission and, if seclusion or restraint is prolonged, a member of the Expert Panel should visit the patient. (Paragraph 373)

82. We recommend that the Bill provide a framework for the review of the emergency administration of medication for mental disorder. In our view the review should be carried out by tribunals, although we accept that such reviews may be carried out retrospectively after emergency treatment has been administered. (Paragraph 374)

83. We recommend that, before the Government introduces the Bill proper to Parliament, it review the costs of setting up a discrete mental health advocacy service, as distinct from the new advocacy function to be introduced under the Mental Capacity Bill 2004. This review should be undertaken in consultation with those providing advocacy services and the Regulatory Impact Assessment should be expanded to ensure that it reflects detailed and robust costings, and a sensitivity analysis taking account of, for example, possible variations in the number of persons detained and the provision of advocacy services at examination stage, to “voluntary” patients and to those under compulsion in the community. (Paragraph 378)

84. We recommend that local authorities and health authorities be placed under a statutory obligation to produce local advocacy plans for the development and funding of independent health advocacy services to meet the needs of all service users, including mental health service users. (Paragraph 379)

85. We recommend that the Bill charge the Mental Health Act Commission with duties to set national standards for mental health advocates, provide accreditation and to investigate complaints. (Paragraph 383)

86. We recommend that there be a duty in the Bill on the appropriate authority to provide independent mental health advocates to meet the reasonable requirements of patients as soon as any statutory procedure with regard to the potential exercise of formal powers in their case is commenced. (Paragraph 387)

87. We recommend that there be a duty in the Bill on the appropriate authority to ensure that independent advocacy is available to all people with a mental disorder and that they have an opportunity to use the service. (Paragraph 388)
88. We recommend that patients have the right to an independent mental health advocate from the start of the initial examination stage or upon arrival at a place of safety and that the Bill place a duty on the authorities to remind patients of the availability of the advocacy service at key stages. (Paragraph 388)

89. We recommend that the right of patients to meet their advocates in private, unless it is unsafe to do so, be reinstated in the Bill. (Paragraph 390)

90. We recommend that the independent mental health advocate have no access to patient records without the patient’s informed consent and, for people whose decision-making is impaired, the nominated person be asked to make the decision for the patient. (Paragraph 395)

91. We recommend that the nominated person have broadly the same rights and powers currently exercised by the nearest relative under the 1983 Act. In particular, the nominated person should be able to:

   a) make an order for the discharge in respect of a patient where the patient is liable to be detained in a hospital in pursuance of an application for admission to hospital, and

   b) make an order for the discharge of a patient who is detained in a hospital, subject to 72 hours notice. The clinical supervisor would then be able to block discharge by certifying that, if discharged, the patient would be likely to act in a manner dangerous to himself or to others. If that happens, the patient, carer or nominated person should have a right to appeal to the Mental Health Tribunal for discharge on the same basis as patients detained for assessment. (Paragraph 399)

92. We recommend that patients be able to appoint an enduring nominated person. This could be done through an advance statement, as explained in chapter 4, if the Government brings forward proposals for advance statements or, if it does not, through a simple process and free-standing instrument. (Paragraph 402)

93. We recommend that a nominated person be able to exercise his powers from the start of the examination stage and be entitled to participate at the time of the examination. (Paragraph 403)

94. We recommend that, where the patient lacks capacity to appoint a nominated person and has not nominated someone previously, there be a default provision along the lines of the Scottish Act whereby the carer is the default first choice with the nearest relative as the default second choice. (Paragraph 404)

95. We recommend that, to safeguard the interests and autonomy of the person under compulsion, the Approved Mental Health Professional be able to disqualify a person’s choice of nominated person only if the nominated person is exploitative or lacks capacity. (Paragraph 405)

96. Clause 12(2) provides that carers cannot be consulted without first ascertaining the patient’s wishes and feelings, unless it is inappropriate or impractical to do so. We recommend this be strengthened so as to contain a presumption to consult a
patient’s carer when examinations and assessments are carried out, unless the patient is expressly opposed to it. (Paragraph 410)

Resources and professional roles

97. We recommend that, when presenting draft bills, the Government attach as annexes any models underpinning the Regulatory Impact Assessment (RIA) in order to allow interested parties more fully to examine the appraisals behind the figures in the RIA. (Paragraph 419)

98. We recommend that the Government, as a matter of urgency, complete its studies into the potential impact of widening the definition of mental disorder, removing exclusions and introducing non-resident orders, and that in doing so it takes account of the opinions of practitioners. In the light of these studies, we expect the Government to reconsider and re-analyse the assumptions used in the Regulatory Impact Assessment and to produce a much more comprehensive RIA when it introduces the Bill. (Paragraph 428)

99. We recommend that the Government re-examine the accuracy and strength of data used in the Regulatory Impact Assessment prior to the presentation of any associated Bill and ensures that the figures used are the result of direct measurement or improved sampling. (Paragraph 429)

100. We recommend that no new Act be introduced without assurances that the increased workforce requirements in the legislation will be met and, moreover, that the additional requirements will not be met at the expense of other parts of the mental health service, in particular the non-compulsory services. We believe that this recommendation can be achieved in part by implementation of the Act being phased in several steps. (Paragraph 434)

101. We recommend that the Government speed up efforts to develop appropriate systems for the effective monitoring of mental health funding streams. (Paragraph 436)

102. We conclude that provisions for the move from Approved Social Workers to Approved Mental Health Professionals are satisfactory provided that national training standards are created which ensure that AMHPs:

a) bring a separate professional perspective and model of mental disorder;

b) are trained to assess social factors, and have experience in social care and community resources;

c) are equipped to provide comprehensive risk assessments;

d) are trained to explore the least restrictive alternatives to hospital admission; and

e) are trained to manage the practical tasks involved in the assessments and admissions to hospital. (Paragraph 445)
103. In appropriate cases, professionals other than psychiatrists should be able to act as clinical supervisors provided that they meet appropriate standards. We recommend that regulations stipulate the appropriate standards and competencies to be demonstrated following training. (Paragraph 448)

104. We urge the Government to re-consider the issue of whether clinical supervisors with non-medical backgrounds should be able to prescribe ECT, even with the safeguards provided by the tribunal. (Paragraph 449)

The Application of the Bill in Wales and Devolved Issues

105. We conclude that the standard of mental health services in Wales must be at least as good as it is now in England before the provisions in the draft Bill can be implemented. Resources should be allocated in order to enable the service to be brought up to the English standard. (Paragraph 454)

106. Upon the Welsh Assembly Government introducing a requirement that mental health services in Wales be available in both English and Welsh, the Welsh code of practice can be tailored accordingly. We emphasise that the Committee is concerned about the patchy level of mental health service provision in Wales, irrespective of language. (Paragraph 456)

107. We bring the representations from the devolved legislatures about legislators who become mentally-ill to the attention of the Department and suggest that discussions between the Department and the devolved legislatures take place to ensure that these issues can be resolved before the Bill proper is presented to Parliament. (Paragraph 458)
Annex 1: Extract from Press Notice No. 1 issued 16 September 2004: JOINT COMMITTEE SEEKS EVIDENCE ON DRAFT MENTAL HEALTH BILL

Call for evidence

The Joint Committee invites interested organisations and individuals to submit written evidence as part of its inquiry into the Draft Mental Health Bill. Submissions, reflecting the guidance on written evidence given in this press notice, should reach the Committee as soon as possible and no later than Monday, 1 November 2004.

Scope of the Committee's inquiry

In particular, the Committee invites evidence on the following themes:

- Is the draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?
- Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent? Are the provisions for assessment and treatment in the community adequate and sufficient?
- Does the draft bill achieve the right balance between protecting the personal and human rights of the mentally ill on one hand, and concerns for public and personal safety on the other?
- Are the proposals contained in the draft Mental Health Bill necessary, workable, efficient and clear? Are there any important omissions in the Bill?
- Is the proposed institutional framework appropriate and sufficient for the enforcement of measures contained in the draft Bill?
- Are the safeguards against abuse adequate? Are the safeguards in respect of particularly vulnerable groups, for example children, sufficient? Are there enough safeguards against misuse of aggressive procedures such as ECT and psychosurgery?
- Is the balance struck between what has been included on the face of the draft bill, and what goes into Regulations and the Code of Practices right?
- Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced in the House of Commons on 17 July 2004)?
- Is the draft Mental Health Bill in full compliance with the Human Rights Act?
- What are likely to be the human and financial resource implications of the draft Bill? What will be the effect on the roles of professionals? Has the Government analysed the effects of the Bill adequately, and will sufficient resources be available to cover any costs arising from implementation of the Bill?
Annex 2: Programme of visits undertaken by the Joint Committee on the draft Mental Health Bill during the course of its inquiry

Details of informal meetings and visits

Visit to South London and Maudsley NHS Trust, which included visits to mental health facilities and meetings with patients and service users at the Bethlem Royal Hospital and in Lambeth, Southwark, Croydon, Kennington, Clapham, Deptford, Lewisham and Stockwell as well as the Maudsley Hospital, 24 November 2004

Visit to the Whitchurch Hospital, Cardiff, 15 December 2004

Visit to Broadmoor Hospital, Berkshire, 9 February 2005
### Annex 3: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>AMHP</td>
<td>Approved Mental Health Professional</td>
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<td>ASW</td>
<td>Approved Social Worker</td>
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<td>BNF</td>
<td>British National Formulary</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<tr>
<td>CHAI</td>
<td>Commission for Health Audit and Improvement (also known as the Healthcare Commission)</td>
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<tr>
<td>Clinical</td>
<td>An approved clinician appointed to be in charge of the assessment of the patient and any treatment provided. (1)</td>
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<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
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<tr>
<td>Compulsory</td>
<td>The legal powers of compulsion which empower the clinical supervisor to provide care and treatment for a mental disorder in the absence of a patient’s consent. (1)</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>DSPD</td>
<td>Dangerous and Severe Personality Disorder</td>
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<tr>
<td>ECHR</td>
<td>European Convention on Human Rights</td>
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<tr>
<td>ECT</td>
<td>Electroconvulsive therapy</td>
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<td>Expert Panel</td>
<td>Mental Health Tribunals will be advised by an independent medical expert drawn from the Panel. (1)</td>
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<tr>
<td>Formal powers</td>
<td>Being under the formal powers of the Bill means either that someone is detained in hospital as a resident patient or is subject to conditions as a non-resident patient. (1)</td>
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<tr>
<td>Healthcare</td>
<td>Another name for CHAI, the Commission for Health Audit and Improvement</td>
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<td>Commission</td>
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<td>IMHA advocates</td>
<td>Independent Mental Health Act advocates</td>
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<td>MDO</td>
<td>Mentally Disordered Offender</td>
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<td>MHA</td>
<td>Mental Health Act 1983</td>
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<td>MHAC</td>
<td>Mental Health Act Commission. The statutory body currently charged with visiting detained patients and safeguarding their rights.</td>
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<td>MHAT</td>
<td>Mental Health Appeal Tribunal</td>
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<tr>
<td>MHRT</td>
<td>Mental Health Review Tribunal. The draft Bill will replace MHRTs with Mental Health Tribunals.</td>
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<tr>
<td>MHT</td>
<td>Mental Health Tribunals. These would be set up by the draft Bill, to replace the Mental Health Review Tribunals under the 1983 Act. Under the Bill, there will be a Tribunal for England and a Tribunal for Wales. (1)</td>
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NSF
National Service Framework for Mental Health.
Published in September 1999, the NSF has established national standards for the care and treatment of mental illness in England. An NSF for Wales is being developed in conjunction with the new All Wales Strategy for adult mental health services. (2)

PCT
Primary Care Trust

Personality disorder
A disorder of the development of personality. It includes a range of mood, feeling and behavioural disorders including anti-social behaviour. (2)

PSS
Personal Social Services

Relevant conditions
The conditions which must be met for a patient to be brought under the formal powers in Part 2 of the Bill. See clauses 9, 116, and 130. (1)

Restricted patient
A patient subject to a restriction order or restriction direction

RIA
Regulatory Impact Assessment

RMO
Responsible Medical Officer

Section
A section is the act of detaining a person under the formal powers of mental health legislation. The person is then being "sectioned".

SHA
Strategic Health Authority

SOAD
Second opinion approved doctor

The 1983 Act
The Mental Health Act 1983, which is the current legislation governing the compulsory treatment of people with a mental disorder.

WHO
World Health Organisation

Sources:
(1) Draft Mental Health Bill: Explanatory Notes, Cm 6305-Ii, September 2004
(2) Department of Health: Reforming the Mental Health Act Part 1: The new legal framework, Cm 5016-I, December 2000
<table>
<thead>
<tr>
<th>Clause</th>
<th>Original text</th>
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<th>Source</th>
<th>Comments by the Government</th>
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<tbody>
<tr>
<td>1</td>
<td>Code of practice: general principles and guidance</td>
<td>There are several areas of mental health practice in which staff are in need of clear, comprehensive guidance. One of those areas is seclusion. However, there is no indication that such guidance will be provided in the Code of Practice.</td>
<td>David Hewitt (DMH 21)</td>
<td>1(a): The Code of Practice will provide decision-makers with guidance about the use of seclusion.</td>
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<td>The Code of Practice should explain the principles of the Community Care (Delayed Discharges etc.) Act 2003 and the Carers (Equal Opportunities) Act 2004 fit in with this legislation.</td>
<td>Carers UK (DMH 193)</td>
<td>1(b): The Code of Practice will cover how the Bill relates to other relevant legislation, including, as appropriate, the Community Care (Delayed Discharges etc.) Act 2003 and the Carers (Equal Opportunities) Act 2004.</td>
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<td>Concerns have been raised in the past over the use of polypharmacy, and the administration of doses above those recommended in the British National Formulary (BNF). Guidance on their use should be given in the Code of Practice.</td>
<td>BMA (DMH 248)</td>
<td>1(c): The Government is working with stakeholders on the development of the guidance that will be included in the Code of Practice.</td>
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<td>Both the Bill and the Code of Practice should state that there is a need to administer both the Act and the Code in the knowledge of gender awareness within mental health services.</td>
<td>WISH [Women in Secure Hospitals] (DMH 265)</td>
<td>1(d): The Government does not believe that there is a need for the Bill to restate duties that already exist in primary legislation. However, the Code will need to explain the legislative context for the Mental Health Bill. For example, the Human Rights Act, the Disability Discrimination Act, the Sex Discrimination Act and the Race Relations Amendment Act all apply to people being treated under the Bill and practitioners must also abide by the principles enshrined in these Acts when exercising their duties. The Code will also set out the general principles that decision makers must have regard to, and these will include principles relating to equality.</td>
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<td></td>
<td>The Bill should contain explicit reference to the effects of racism and the need for anti-discriminatory practice. While the Code of Practice will make reference to diversity, reference to the race equality and disability legislation within the Bill would highlight the importance of this area.</td>
<td>Commission for Social Care Inspection (DMH 346)</td>
<td>1(e): See response 1(d).</td>
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<td>Clause</td>
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</table>
| (2)    | The code must set out general principles to which a person must have regard whenever coming to a decision under or in pursuance of this Act in respect of a patient. | The principles should be listed on the face of the Bill. | British Psychological Society (DMH 19) King's College London (DMH 81) Law Society (DMH 111) Council on Tribunals (DMH 305) | 1(f): The Government believes that it is important for mental health legislation to have underlying principles that provide a framework for balanced decision making that will improve outcomes for patients and society. We are not fundamentally opposed, therefore, to the principles being on the face of the legislation, but we believe that the appropriate place for them is in the Code of Practice. There are two reasons for this:  
• The purpose of the law is to enable treatment to be provided to people with a mental disorder without their consent to prevent them harming themselves or others. To achieve this, we must ensure practitioners are able to balance the autonomy of the individual with the need to protect that individual or others from harm. If we were to have principles on the face of the Bill, they must reflect that balance. Our approach to achieving this balance is to allow principles to be disapplied in relation to some patients in circumstances where they may pose a risk to others (see also 1(i)).  
• The purpose of principles is to guide practitioners in how they apply the law, reflecting such balance. The Code of Practice is an appropriate place for such guidance and allows principles to retain a currency that would not be possible on the face of the Bill. Changes to the Code are themselves subject to Parliamentary scrutiny. |
|        |                |                |        | 1(g): The Bill requires that people coming to a decision or working under the aegis of the legislation "must have regard to" the general principles that will be set out in the Code of Practice and, similarly, that they "must have regard to" the further guidance that it will also contain. This formulation is consistent with Cabinet Office guidance on Codes of Practice which explains that "the requirement that a public authority or officer must have regard to the Code means that the authority or officer must consider the provisions of the Code and give them due weight in coming to their decision. They are not bound to follow the Code if they properly conclude that the recommendations of the Code are, in a particular case, either not relevant or are outweighed by other considerations. The legal significance of failure to give proper weight to the provisions of a code depends on the relevance and importance of those provisions in the context of the particular decision".¹ |

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<td>Clause</td>
<td>The Code’s authority could be strengthened without making its guidance legally binding. This should be done by the creation of a statutory duty to record and provide reasons for departures from such guidance in patients’ clinical records.</td>
<td>It is unacceptable for the Bill to allow that principles will have no universal application, but will be conditional in that they can be disapplied, wherever ‘inappropriate’ or impractical’.</td>
<td>Mental Health Act Commission (DMH 20) MIND (DMH 210)</td>
<td>1(h): See response 1(g).</td>
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<td>Clause</td>
<td>(4) The code may provide that one or more of the general principles is not to apply – (a) in circumstances in which its application would be inappropriate or impracticable, (b) in relation to the decisions or persons specified in the code.</td>
<td></td>
<td>No Force (DMH 44) IMHAP (DMH 50) Law Society (DMH 111) MHA (DMH 105)</td>
<td>1(i): Disapplication of the three objectives that the general principles must be designed to secure is necessary for the following reasons:</td>
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<td>Patients involved in decision making &amp; fair and open decision making. The Government must have in mind the need to control information for the minimisation of harm, and patient involvement being proportionate to the needs of clinical discretion and risk management. It is sometimes necessary to withhold from patients the evidence given by members of their care team for the protection of those members. Similarly, vulnerable relatives or neighbours of mentally disordered people must be able to give information without fear of its being relayed back to the patient to the detriment of relationships and rehabilitation.</td>
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<td>Clause</td>
<td>(10) The requirement imposed by subsection (b) does not apply if (a) it appears to the appropriate authority that by reason of the urgency of the matter it is not expedient for consultation to be undertaken, or (b) the persons in question have agreed that consultation should not be undertaken.</td>
<td>The requirement to consult over the code of practice should not be overturned.</td>
<td>Depression Alliance Cymru (DMH 195)</td>
<td>1(j): Ordinarily, the appropriate authority will consult before publishing the Code and it is certainly the Government’s intention to do so before the Code of Practice is published. This provision is included in the Bill so that the appropriate authority is able to publish the Code of Practice without consulting when it appears to him that by reason of the urgency of the matter it is inexpedient to do so or, when the parties who would ordinarily be consulted, have agreed that consultation should not be undertaken. This provision is more likely to be used if there is an urgent need to revise certain elements of the guidance included within the Code, possibly following a Court case or, if the revision required is trivial in nature and interested parties agree that consultation is not required before making the change).</td>
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<td>(11)</td>
<td>Before publishing the code, the appropriate authority must- (a) in the case of the Secretary of State, lay a draft of it before both Houses or Parliament, and (b) bring it into operation by an order</td>
<td>Parliament should have the opportunity to reject the Code. Contrasting the wording of clause 1(11) with clause 118(4) suggests that Parliament will not have such a power.</td>
<td>Bar Council (DMH 191)</td>
<td>1(k): The Secretary of State will lay a draft of the Code of Practice before both Houses of Parliament and bring it into operation by an Order. Clause 300(1) and (2) shows that the Code of Practice can be subject to annulment in pursuance of a resolution of either House of Parliament. This means that although there will be no automatic debate about the Code, a member of either House can request a debate within 40 sitting days of the Order being laid. The debate could lead to a rejection (‘annulment’) of the Order and therefore the Code.</td>
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<td>2</td>
<td>Basic definitions etc for purposes of Act</td>
<td>The definition of mental disorder is too broad. It would include all mental disorders listed in the commonly used classifications of diseases (including, for example, the addictions), as well as neurological disorders affecting the brain (for example, multiple sclerosis). Other diseases indirectly affecting the brain through, for example, metabolic or toxic effects would also be included. Physical conditions that lead to a temporary impairment or disturbance in the functioning of the mind or brain (e.g. diabetes) could also be included. We do not believe this is the intention. The definition of mental disorder should be linked to internationally accepted guidelines such as ICD or DSM.</td>
<td>British Psychological Society (DMH 19), IMHAP (DMH 50), King’s College London (DMH 81), Maca (DMH 296), Law Society (DMH 111), Lucy Scott-Moncrieff (DMH 304)</td>
<td>2(a): The definition and conditions have been drafted to enable those people for whom treatment is necessary to receive it. A broad definition is needed to ensure that no particular individual is excluded where that would run the risk of them not receiving treatment which is necessary. But the definition of mental disorder is only the starting point. Compulsion can only be used where all the relevant conditions are met. 2(b): The definition of mental disorder in The Mental Health (Care and Treatment) (Scotland) Act 2003 is “any mental illness, personality disorder or learning disability however caused or manifested”. The Government believes the definition in the draft Mental Health Bill is clear and has the advantage of not referring to specific categories of disorder, the understanding of which is apt to change over time, and may lead to inadvertent exclusions. The Government is satisfied that the definition of mental disorder in the Draft Mental Health Bill meets its policy aims. Also see response 2(a). 2(c): International guidance is likely to develop during the life of the Bill. The definition leaves scope for that development without the need to update the legislation.</td>
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<td>2(d)</td>
<td>The definition of mental disorder is flawed because it is tautological.</td>
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<td>Mental Health Foundation (DMH 229)</td>
<td>2(d): The Government does not believe the definition is tautological. The definition ensures that it is the effects – not the cause – which will determine whether a person is to be treated as having a mental disorder for the purposes of this Bill.</td>
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<td>C Godfrey (DMH 49)</td>
<td>This definition appears to create a paradox between a disturbance (which may be a temporary state which includes all people under the influence of drink/drugs) and a disability or disorder which is defined by the Disability Discrimination Act 1985 as being a condition that has lasted or is likely to last at least 12 months.</td>
<td>2(e): See response 2(a). The definition is not intended to diagnose but to identify whether a mental dysfunction exists at the time of a decision on compulsion. The Disability Discrimination Act 1995 (DDA) on the other hand is intended to protect people with a disability from discrimination in certain circumstances, and its definition of “disability” is specific to that context. It is acceptable to have different definitions in different legislation.</td>
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<td>Prof Pilgrim (DMH 77)</td>
<td>The interdependent constituent parts of ‘impairment’, ‘disturbance’, ‘disability’ and ‘disorder’ should be explained.</td>
<td>2(f): The definition is clear as it stands. Guidance on the application of the definition and the conditions for compulsion will be given in the Code of Practice.</td>
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<td>IMHAP (DMH 50)</td>
<td>(7) References to medical treatment are references to treatment for mental disorder provided under the supervision of an approved clinician; and for this purpose “treatment” includes- (a) nursing, (b) care, (c) cognitive therapy, behaviour therapy, counselling or other psychological intervention, (d) habilitation (including education, and training in work, social and independent living skills), and (e) rehabilitation (read in accordance with paragraph (d)).</td>
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<td>The definition of ‘medical treatment’, which includes education and work training, is too broad ‘Medical treatment’ should be defined narrowly, possibly limited to physical interventions (with drugs and ECT) and nursing care.</td>
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<td>Transcultural Psychiatry Society (DMH 219)</td>
<td>(7) References to medical treatment are references to treatment for mental disorder provided under the supervision of an approved clinician; and for this purpose “treatment” includes- (a) nursing, (b) care, (c) cognitive therapy, behaviour therapy, counselling or other psychological intervention, (d) habilitation (including education, and training in work, social and independent living skills), and (e) rehabilitation (read in accordance with paragraph (d)).</td>
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<td>The definition of medical treatment under the Bill is based on the current definition in the 1983 Act, amended in three ways - (i) in place of the current requirement for nursing care or other treatment under the supervision of any doctor, the definition under the Bill requires all treatment for the purposes of the compulsory powers of the Bill, including nursing, to be provided under the supervision of an approved clinician. It is intended that approved clinicians will be specialist doctors or senior mental health practitioners in mental health services; (ii) the existing references to habilitation and rehabilitation have been more fully defined in order to make clear that they include training in work, social and independent living skills; (iii) given the growing importance of new interventions being developed in the field of psychological interventions, their inclusion has been placed beyond any doubt by an express provision. The courts have accepted that the existing definition in the Mental Health Act 1983 comprises a broad range of treatments. The Government continues to believe that it is important to have available a wide range of therapeutic approaches to treating mental disorder so that care and treatment plans can be tailored to the individual needs of each patient. The Government consider it important that all treatment, including basic care and nursing, should be under the supervision of a senior practitioner with experience in the diagnosis and treatment of mental disorder. It is also considered helpful to place beyond doubt the broad scope of the definition includes important areas such as social and independent living skills and psychotherapy.</td>
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<td>Because what constitutes 'medical treatment' may be extended by making regulations that extend who is an 'approved clinician' under the draft Bill, so the relevant conditions for compulsion may be extended by regulations. This leaves too much undefined.</td>
<td><strong>2(h):</strong> There is no regulation-making power by which the definition of medical treatment or the conditions for compulsion may be extended. The new requirement for medical treatment to be under the supervision of an approved clinician provides a greater safeguard than the definition of medical treatment under the current Act. Under clause 3 the appropriate authority may only approve clinicians for the purposes of the Bill if they demonstrate that they have special experience in the diagnosis or treatment of mental disorder. As stated above, it is intended that approved clinicians will be confined to specialist doctors or senior mental health practitioners in mental health services. The Government is considering the best method of ensuring that this policy intention is achieved.</td>
<td>IMHAP (DMH 50) King’s College London (DMH 81)</td>
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<td>The inclusion of therapies listed under (c) are not justified. These therapies cannot be on a compulsory basis.</td>
<td><strong>2(i):</strong> Psychological interventions have been expressly covered to reflect the growing importance of new interventions being developed in this field, particularly for treating personality disorder. While the success of certain therapies do depend on patient co-operation, it is important that the Bill provides powers to ensure that, in the first instance, patients attend the required sessions. This will ensure the opportunity to engage with patients and build a therapeutic relationship. It will be a matter of professional clinical judgment as to whether, in relation to any individual patient, it is necessary for compulsory powers to be used in accordance with the relevant conditions, or whether it is appropriate for treatment to be provided voluntarily.</td>
<td>Social Workers of Hammersmith and Fulham (DMH 238) M MacAttram (DMH 118) T Lewis (DMH 135)</td>
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<td>Wherever treatment is mentioned, the need for it to be 'culturally appropriate' should be inserted into this Bill.</td>
<td><strong>2(j):</strong> The Code of Practice must describe how general principles will apply to treatment decisions under the Bill, including the need for awareness of patients' different cultural backgrounds. It is, therefore, considered more appropriate to cover this issue in the Code of Practice than on the face of the Bill. Existing anti-discrimination legislation will apply to the Mental Health Bill without it being replicated in the Bill.</td>
<td>Transcultural Psychiatry Society (DMH 219) M MacAttram (DMH 118)</td>
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<td>3</td>
<td>Approved clinicians and mental health professionals</td>
<td>The Bill provides for the training and approval of AMHPs to be lodged with the local authorities but it is silent as to which body will be responsible for ensuring sufficient numbers, and for managing them and holding them accountable after approval.</td>
<td>British Association of Social Workers (DMH 60) Commission for Social Care Inspection (DMH 346)</td>
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<td><strong>3(a):</strong> As part of the implementation strategy the Government is working with organisations representing social workers and other professionals eligible to be AMHPs on a wide range of issues relating to the implementation of the AMHP role including their training, management, qualifications, accountability, approval, workforce planning and regulation of the profession. For example the Department of Health is working with the General Social Care Council to develop the accreditation, training criteria and procedures that will be needed, building on the strengths of the current ASW training, for the new AMHP role.</td>
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<td>The Bill should include a duty to provide sufficient numbers of AMHPs.</td>
<td>ASS &amp; LGAs (DMH 208)</td>
<td>3(b): The Government believes that the most effective way of assuring sufficient numbers of AMHPs is to open up of the role to other professionals who have relevant skills and experience. This will help to broaden the pool of people able to act in this role, thereby addressing recruitment difficulties, while allowing the standards and the independence of this role to be maintained.</td>
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<td>AMHPs should be legally accountable to an independent body for the performance of their role. This body should undertake approval, re-approval, supervision, provision of legal advice, training, law updates and scrutiny of AMHPs.</td>
<td>ASS &amp; LGAs (DMH 208)</td>
<td>3(c): See response 3(a).</td>
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<td>AMHPs need to be required (as are ASWs now) to exercise their own independent judgment and act in a personal capacity rather than at the behest of their employers or other persons who might be involved with the patient. They should have the power to make referrals for social care assessments.</td>
<td>MIND (DMH 210)</td>
<td>3(d): The Bill provides for the AMHP to exercise his or her professional judgment in the context of the examination to determine if the conditions for compulsion are satisfied. All the examiners must take into account the nature and degree of the patient’s mental disorder and all the circumstances of the case in reaching their decision, and for the patient to be brought under compulsion all the examiners must agree that all the relevant conditions are met. The standards that will be set for the qualifications, experience and training of AMHPs will ensure that individuals undertaking this role will be equipped to take an independent view based on their professional judgment rather than on the organisation they come from.</td>
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<td>AMHPs need to be independent of or, at least, independently managed from the clinical team responsible for the patient’s ongoing care.</td>
<td>MIND (DMH 210) A Aitkins (DMH 252)</td>
<td>3(e): See responses 3(a) and 3(d).</td>
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<td>One current safeguard of the independence of ASWs is their right to speak alone to Mental Health Act Commissioners - we would hope a similar provision would be in place to safeguard the independence of any successor.</td>
<td>Social Workers of Hammersmith and Fulham (DMH 238)</td>
<td>3(f): The current Act does not provide a right for ASWs to speak alone to Mental Health Act Commissioners. There is nothing in the Bill that will prevent this practice, if it is deemed necessary to a particular investigation carried out by CHAI.</td>
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<td>(4) A person is an approved mental health professional...</td>
<td>AMHPs will need to use knowledge of locally available services in deciding whether the use of formal powers is necessary. Hence if AMHPs are working outside of the local authority for which they are approved, they will need amongst other things, to be familiar with as far as possible the other area’s services and facilities.</td>
<td>Commission for Social Care Inspection (DMH 346) 3(h): See response 3(g).</td>
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<td>(ii) if he is approved by another local social services authority in England for those purposes and the relevant English authority gives to him an authorisation for the approval to be treated as having been given also in relation to its area,</td>
<td>The power for an AMHP to work out of Trust area on occasion could mean that there were numbers of non-locally approved AMHPs - possibly agency workers - who would have no local knowledge or understanding of local facilities and cultures.</td>
<td>No Force (DMH 44) Hampshire Partnership NHS Trust (DMH 319) 3(i): The Government does not agree with this position. Details of who can become an AMHP are most appropriately left to secondary legislation because these are detailed matters, which require consultation. Regulations can also be more easily changed if other professional groups become eligible to perform this role in the future. Non-statutory guidance may also be issued regarding the standards for AMHPs.</td>
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<td>(6) In approving a person for the purpose of subsection (4), a local social services authority must have regard to such matters as the appropriate authority may direct.</td>
<td>The Bill should ensure that the social care perspective presently provided by ASWs is safeguarded. This is why the development and implementation of the AMHP role will build on what is best in the existing training and expertise of ASWs. This will enable AMHPs to bring the wider social perspective to the examination process.</td>
<td>Lifecraft (DMH 220) ASWIG (DMH 153) Rethink (DMH 192)</td>
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<td>Also see response 3(d).</td>
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<td>AMHPs should not be permitted to come from a medically trained background.</td>
<td>National Voices Forum (DMH 240)</td>
<td>3(k): Local authorities will approve AMHPs and must be satisfied that individuals have appropriate competence in dealing with people suffering from mental disorder. If somebody has undertaken medical training, but has then changed career, to become a social worker for example, this should not disbar them from being considered for the role of an AMHP.</td>
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<td>Expert Panel</td>
<td>Black and Minority Ethnic Mental Health Network (DMH 241)</td>
<td>7(a): The membership of the Expert Panel will, where possible, reflect the communities it serves. As part of the implementation strategy, the Government is looking at capacity building, for example, part of the role of the newly established Community Development Workers will be to promote people from black and minority ethnic communities to undertake roles created by the Bill, such as Tribunal member, member of the Expert Panel or advocate.</td>
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<td>There should be adequate Welsh language representation amongst members of the Expert Panel. The Board believes that there is an opportunity for the Bill to make a specific reference to having adequate Welsh language representation on the panel.</td>
<td>Welsh Language Board (DMH 310)</td>
<td>7(b): The Welsh Language Act 1993 provides that Welsh and English are equal in Wales. It places an obligation on the public sector to treat the Welsh and English languages on the basis of equality in the provision of services to the public in Wales. In this respect putting specific provision in the Bill would duplicate legislative provision already in existence. Language choice when being examined or assessed is very important and this will be reflected, as is the case now, within the Code of Practice.</td>
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<td>8</td>
<td>Mental Health Appeal Tribunal</td>
<td>Royal College of Psychiatrists (DMH 24)</td>
<td>8(a): It is true that applications may be made to the new Mental Health Tribunal by both clinical supervisors seeking assessment or treatment orders, and patients (or their representatives) challenging the use of compulsory powers. Patient applications, however, are not appeals against earlier Tribunal decisions, they are applications for a review of the case. This is an important distinction because, in hearing patient applications, the new Tribunal will not revisit an earlier decision but will consider the patient’s case afresh and make a new decision according to the up-to-date facts and circumstances prevailing at the time. In the unlikely event that a patient application is heard by the same panel of Tribunal members as dealt with an earlier application, this would not give rise to a conflict of interests. The Bill establishes a separate Mental Health Appeal Tribunal to hear appeals on points of law which will consider whether an earlier decision was lawful.</td>
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<td><strong>Abolition of Approved Social Workers (ASWs)</strong></td>
<td>The replacement of the Approved Social Worker by the AMHP is a backward step. ASWs exercise an independent role in assessment for compulsory admission. Their knowledge of resources in the community can often prevent compulsory admission. The ASW is independent and is able to present these options to clinicians, patients and families. They can assess situations independently of the medical model. It is very unlikely that an AMHP who might be a community nurse or occupational therapist, for example, employed by the health service, would have the knowledge of community provision or would go against the views of a consultant employed in the same service.</td>
<td>NE London Mental Health NHS Trust (DMH 113) Gloucester Survivors Forum (DMH 160) ASWIG (DHM 153) SE Advocacy Projects (DMH 225) R Pratt (DMH 39) T Allen (DMH 30)</td>
<td>See responses 3(a), 3(d), 3(g), 3(j) and 3(k).</td>
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It will be important to maintain the number of ASWs in the interim and training of approved mental health practitioners should be considered at an early stage in preparation for the implementation of the legislation. | National Mental Health Partnership (DMH 157) | | As part of the implementation strategy the Government will be working with organisations representing social workers and other professional groups. This should help to reassure ASWs that they have a key part to play when the new legislation is implemented – it is hoped and expected that the majority of AMHPs will be former ASWs when the new Act comes into force. Also see responses 3(b) and 3(j). | |

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<td>9</td>
<td>The relevant conditions</td>
<td>The exclusions in the 1983 Act should be reinstated. If the current law is misunderstood, the problem should be addressed by information and training, and if necessary by a rewording of the 1983 Act.</td>
<td>Mental Health Alliance (DMH 105) Mental Health Act Commission (DMH 20) Sainsbury Centre for Mental Health (DMH 107) Law Society (DMH 111) Alcohol Concern (DMH 300)</td>
<td>9(a): The Government does not believe exclusions from the definition of mental disorder are necessary. The conditions have been drafted to enable those people for whom treatment is necessary to receive it. It would be counter productive to exclude any specific group of people from treatment which was otherwise appropriate and necessary to their needs.</td>
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<td>Learning disability, or intellectual impairment alone, should be excluded from the definition of mental disorder within the Bill and as a ground in itself for the application of the provisions of the Bill.</td>
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<td>Welsh Assembly (DMH 59)</td>
<td>9(b): See response 9(a). The majority of people with learning disability or intellectual impairment will not meet the five conditions; all of which must be met to justify compulsion. In particular, the third condition for compulsion is that a person must be at risk of suicide, serious harm or serious self neglect or a risk to other people and the fifth that treatment for mental disorder provided under the supervision of an approved clinician must be available and appropriate for that patient. However, there may be cases where the conditions are met, and it would be wrong to exclude such patients from compulsory treatment where that is necessary.</td>
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<td>The introduction of a test of “impaired decision making” into either the definition or the relevant conditions would refine the scope of the Bill to ensure it is consistent with its intended purpose.</td>
<td></td>
<td>No Force (DMH 44)</td>
<td>9(c): A capacity based system (even one based on the more limited test of “impaired decision making”) would be ineffective to prevent the harm to themselves or others which may result from their disorder. There would be a risk of people being able to refuse treatment until they were so seriously ill that they would then be covered by the incapacity/impaired judgment criterion and this would result in professionals feeling obliged to use a very wide interpretation of impaired judgment. A capacity based approach would also disadvantage people with fluctuating capacity as this could lead to inconsistent treatment with consequent relapses and recovery once compulsion was restored. A capacity based Bill would also have the effect of making it impossible to provide treatment under compulsion for many people with personality disorder who have capacity. However, a person’s capacity to make decisions about their treatment, may still inform the three examiners, the clinical supervisor or the Mental Health Tribunal, in making a determination about whether the conditions for compulsion are met.</td>
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<td>The conditions for compulsion should be amended further to reflect the principle that persons whose capacity to make decisions about their health care is unimpaired should retain their right to decide their own treatment. It is recommended that a further condition should be added - “that because of the mental disorder the patient’s ability to make decisions about the provision of such medical treatment is significantly impaired”.</td>
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<td>British Psychological Society (DMH 19)</td>
<td>9(d): See response 9(c).</td>
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<td>9(e)</td>
<td>The issue of function should be specifically addressed within the conditions.</td>
<td>The Government is satisfied that there is no need for a specific mention of social functioning. An individual's social functioning will inevitably be an important factor in determining whether the conditions are met. It will, for example, be relevant to the question of whether medical treatment is necessary (the 3rd condition) and whether appropriate treatment is available (the 5th condition.). However, it is important to remember that these conditions are not merely factors to take into account, they are tests which will determine whether compulsion will be used. It seems unlikely that the question of a patient's social functioning could, by itself, constitute such a test. A person may be able, for most purposes, to function quite adequately, yet still be at significant risk either to themselves or to others.</td>
<td>Sainsbury Centre for Mental Health (DMH 107)</td>
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<td>(4)</td>
<td>The third condition is that it is necessary— (a) for the protection of the patient from— (i) suicide or serious self-harm, or (ii) serious neglect by him of his health or safety, or (b) for the protection of other persons, that medical treatment be provided to the patient.</td>
<td>The 'protection of others' is not qualified by a phrase containing the word serious. A difference in threshold for compulsion is thus implied. The risk of harm to others is to be divided into two classes, the former (for the 'protection of others' in the third relevant condition) being less than 'substantial' and 'serious'. Thus the 'protection of others' applies to risk which may be substantial but not serious, or serious but not substantial, or neither serious nor substantial. It is thus very unclear what is meant by the 'protection of others' and what others are to be protected from.</td>
<td>King's College London (DMH 81) Dr Calvadino (DMH 7)</td>
<td>9(f): The threshold for intervention to prevent self harm/neglect was raised in response to concerns expressed during consultation. Where the risk of harm is to others, intervention will need to be applied proportionately, i.e., as under the Mental Health Act 1983. 9(g): The term &quot;for the protection of other persons&quot; appears in the current Mental Health Act. The reference to substantial risk of serious harm, dis-applies the fourth condition, i.e. if the risk to others is sufficiently high (much higher than in the third condition) practitioners do not have to demonstrate that treatment cannot otherwise lawfully be provided to apply compulsion. Guidance on the application of the conditions will be given in the Code of Practice.</td>
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<td>9(f)</td>
<td>If the wording were as in the 1983 Act &quot;In the interest of&quot; rather than &quot;for the protection of&quot; it would enable the clinician to weigh up relative risks.</td>
<td>If the wording were as in the 1983 Act “In the interest of” rather than “for the protection of” it would enable the clinician to weigh up relative risks.</td>
<td>Royal College of Psychiatrists (DMH 24)</td>
<td>9(h): The Government is satisfied that the draft Bill reflects its policy aim. In the light of consultation on the previous draft of the Bill, changes have been deliberately made to make the condition more focussed than in the 1983 Act, so that it focuses on the suicide, serious self-harm and serious self-neglect, rather than the more general notion of “health or safety”. Nonetheless, the condition does require practitioners to weigh up relative risks, since they must decide whether medical treatment is necessary (rather than, for example, simply desirable).</td>
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<td>9(i)</td>
<td>Sometimes involuntary detention is necessary to prevent further deterioration of health, even in the absence of a current risk to the patient or others. The new Bill should not force psychiatrists to wait until there is an actual risk.</td>
<td></td>
<td>Group of Psychiatrists (DMH 18)</td>
<td>9(i): A determination of risk must be a matter of professional judgment. There is clearly a balance to be struck. The condition requires practitioners to weigh the degree of risk against the seriousness of the harm that might result, in determining whether medical treatment is necessary.</td>
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<td>(5)</td>
<td>The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.</td>
<td></td>
<td>Royal College of Psychiatrists (DMH 24) King's College London (DMH 81)</td>
<td>9(j): Least restriction is a stated objective on the face of the Bill. The Bill must provide, however, that the degree of restriction applied in any case is proportional to the harm envisaged. Compulsion may only be used where appropriate medical treatment is both necessary and available. In making those determinations, practitioners will be required to have regard to the general principles in the Code of Practice.</td>
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<td>The principle of least restrictive alternative should apply to all categories of patient.</td>
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<td>The meaning of the word ‘lawfully’ needs to be clarified. Does it mean that the person cannot be ‘sectioned’ if s/he consents to informal treatment, or does it mean that an incapacitated person cannot be ‘sectioned’ if s/he can be treated instead under the Mental Capacity Bill or the common law doctrine of necessity?</td>
<td></td>
<td>No Force (DMH 44) IMHAP (DMH 50)</td>
<td>9(k): The condition requires decision-makers to consider whether there is another lawful way of providing the medical treatment which they have decided is necessary. If there is, the condition cannot be met. This might be because they are satisfied that the patient will consent to the treatment, or (in the case of a child under 16) a parent will consent. It could also be because the treatment could be provided under the Mental Capacity Bill (once in force). It is not, however, the Government’s intention fundamentally to change the current position whereby incapacitated patients who resist treatment for mental disorder are (if the other criteria are met) typically treated under mental health legislation, rather than the common law. Once the Mental Capacity Bill is enacted, we will therefore need to review how this condition (in particular) interacts with the provisions of the Mental Capacity Bill to be sure that the legislation delivers the policy intention set out above and does not unintentionally alter the likelihood of incapacitated patients being (or not being) subject to formal mental health powers. Guidance on the application of the conditions will be given in the Code of Practice.</td>
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| (6)    | The fifth condition is that medical treatment is available which is appropriate in the patient’s case, taking into account the nature or degree of his mental disorder and all other circumstances of his case. | There should be a test of therapeutic benefit for treatment imposed under the Act. This could be defined as ‘clinical and/or social interventions that are likely to be of therapeutic benefit to the individual concerned’. Such a provision would be in line with Article 17(1)(iii) of Recommendation No Rec(2004)10, (of the Committee of Ministers of the Council of Europe to member States concerning the protection of the human rights and dignity of persons with mental disorder). | Royal College of General Practitioners (DMH 222)  
Matrix Advocacy Services (DMH 169)  
Mental Health Act Commission (DMH 20)  
Church of England (DMH 298)  
Royal College of Psychiatrists (DMH 24)  
Bar Council (DMH 191) | 9(l): No one can be brought under compulsion under the Bill unless treatment is available which is appropriate to his/her personal needs. The Government believes that this condition is consistent with Article 17(1)(iii) of the Council of Europe Recommendation. |
|  | The provision should be strengthened to provide that the treatment is actually available i.e. realistically available to a particular patient. It is not clear whether geographical or financial limitations will apply so that it may be fairly judged that this condition is not met. | | NE London Mental Health Services (DMH 113)  
West London Mental Health NHS Trust (DMH 243) | 9(m): See response 9(l). The fifth condition requires that treatment must be available which is appropriate in the patient’s case, taking account of all the circumstances. Where relevant that would include questions of geography. But it is not sensible to lay down rules – what is appropriate for one patient may not be appropriate for another. |
<p>|  | Particularly problematic is the notion of ‘appropriate’ treatment as one of the relevant conditions for compulsory treatment (clause 9(6)). The idea of appropriateness is a wholly uncertain one and, therefore, not a suitable term to use in provisions governing the use of coercive powers overriding individual autonomy. | | Justice (DMH 272) | 9(n): The concept of “appropriateness” is already in use in mental health legislation, e.g. Section 37 and Section 72 of the Mental Health Act 1983, both the Courts and Tribunals are experienced in its effect. It is for the decision makers to determine on the basis of their professional judgment whether appropriate treatment is available for an individual patient. Legislation cannot and should not attempt to cater for all permutations of individual circumstances. The legislation gives effect to the ECHR requirement that deprivation of liberty on grounds of unsoundness of mind must rest on objective medical expertise. |</p>
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<td>‘Medical’ treatment may not be the most relevant term bearing in mind the definition in clause 3, ‘clinical’ treatment might be more appropriate.</td>
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<td>National Mental Health Partnership (DMH 157)</td>
<td>9(o): In legislation of this kind it is necessary sometimes to use phrases which are defined with the legislation itself. Provided the definition is given there should be no confusion. Any number of phrases could be used, but “Medical treatment” has the advantage of being the wording used in the Mental Health Act 1983 and as stated in clause 2 (7) references to medical treatment are references to treatment for mental disorder provided under the supervision of an approved clinician.</td>
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<td>Culturally appropriate treatment should form part of the definition of “appropriate”.</td>
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<td>Black and Minority Ethnic Mental Health Network (DMH 241)</td>
<td>9(p): See response 9(n). Guidance on the application of the conditions will be given in the Code of Practice.</td>
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<td>9(o)</td>
<td>It should be made clear preferably on the face of the Bill that offering treatment or services in Welsh falls within the definition of appropriateness.</td>
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<td>Welsh Language Board (DMH 310)</td>
<td>9(q): Guidance on the application of the conditions will be given in the Code of Practice.</td>
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<td>(7) The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.</td>
<td>Case law makes clear that practitioners can impose compulsion on patients whose fluctuating or perhaps self-serving consent (as shown by past history) makes it unreliable. No extension to this should be permitted. It is also unnecessary since professionals can always use compulsory powers if cooperation changes to resistance.</td>
<td></td>
<td>MHA (DMH 105)</td>
<td>9(r): It may be necessary to take a cautious view of the likelihood of the mentally disordered person delivering the compliance he has expressed. Also see the response to 9(o). The case law reflected uncertainty about the effects of the 1983 provisions which we seek to avoid in the new legislation.</td>
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<td>It should be made clear in primary legislation exactly where practitioners will stand in the situation where a patient who is deemed to be a risk to others consents to treatment.</td>
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<td>Mental Health Act Commission (DMH 20)</td>
<td>9(s): The Government believes that this is clear in the primary legislation. The decision makers must decide whether the conditions are met.</td>
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<td>As drafted, and in combination with the Mental Capacity Bill, the fourth condition would prevent most patients from coming under the Bill unless they had capacity. This anomaly needs to be addressed.</td>
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<td>MIND (DMH 210)</td>
<td>9(t): See response 9(k).</td>
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<td>(8)</td>
<td>For the purpose of this Part, a determination as to whether a patient is at substantial risk of causing harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.</td>
<td>Since the issue of dangerous/criminal behaviour is dealt with in (7) and in Part 3, (8) adds nothing to the process. It could be safely deleted without affecting the determination of the relevant conditions in any way and may go some way to restoring confidence by patients that they are being assessed for their mental disorder and not for their potential criminality.</td>
<td>A Craig (DMH 25) Bridgend Social Workers (DMH 35)</td>
<td>9(u): The test in 9(7) is about the risk of serious harm to other people. It is not a test of criminality. The behaviour which could give rise to serious harm may or may not constitute a criminal offence, and that question does not form part of the determination which decision-makers have to make. Clause 9(8) is intended to ensure that the reason for any dis-application of the fourth condition is part of the record of the examiners' determination.</td>
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<td>12</td>
<td>Carers: consultation requirements in Part 2</td>
<td>The draft Bill appears to be inconsistent in the times where carers are consulted. They are not informed by the hospital of the appointment of the Clinical Supervisor. They are consulted over the formulation of the care plan but not sent a copy (including after a Tribunal). They cannot apply to the Tribunal. These anomalies need rectifying or justifying.</td>
<td>A Craig (DMH 25)</td>
<td>12(a): The policy is that carers should be consulted about most decisions that are being taken in respect of the patient, including the formulation of the care plan. The policy on notification is that there is only a duty to notify a carer where they are directly affected by a decision that has been taken, such as if the patient is to be discharged. The appointment of the clinical supervisor does not directly affect the carer, so the duty of notification is to the patient and their nominated person. The Government is checking to confirm that the draft Bill accurately reflects our policy in this area. The Bill sets out the minimum mandatory requirements for consulting and notifying carers, but these requirements do not prevent the consultation and notification of carers at other times if the patient wishes. Guidance on this will be given in the code of practice.</td>
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<td>Most patients approaching crisis will not agree that someone who has been trying to persuade them to accept help should be consulted. The Bill should address the fact that a patient, when unwell, could veto consultation with the carer despite accepting the carers involvement when well.</td>
<td>Rethink (DMH 192)</td>
<td>12(b): The Bill does not give the patient a right to veto the consultation of the carer. For each decision, the decision maker must decide whether it would be appropriate to consult the carer about a particular decision, and must take into account the patient’s wishes and feelings when deciding whether or not to consult them.</td>
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<td>14</td>
<td>Duty to arrange examination etc</td>
<td>The central omission in the Bill is the lack of a duty to provide an assessment of an individual’s mental health needs if one is requested, and care and treatment when it is needed.</td>
<td>SANE (DMH 374)</td>
<td>14(a): The Bill is not about providing services. It is about providing the legal framework for when someone can be treated for a mental disorder without consent, and what a person’s rights are in such a case. The Bill makes it clear that anyone can request an examination, and the relevant NHS body will be under a duty to determine whether all the relevant conditions appear to be met in the case of the person in question. If it decides they do not appear to be met, or if the examiners subsequently decide the conditions are not met, any health or social care needs the person has will fall to be considered under the general duty of the NHS and Local Authorities to meet such needs (as would be the case for anyone else).</td>
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<td>Patients should have an enforceable right to IMHA advocacy during the examination process.</td>
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<td>Action for Advocacy (DMH 46) MHA (DMH 23) Camden and Islington AIM Advocacy (DMH 93) Sainsbury Centre for Mental Health (DMH 107) Royal College of General Practitioners (DMH 222) Citizens' Advice (DMH 125)</td>
<td>14(b): The Government does not agree that this is desirable. Evidence from advocates who have had experience of being present during an initial assessment under the 1983 MHA has shown that there are a number of reasons why advocacy involvement at this early stage may not be desirable. Such assessments are often undertaken in very difficult circumstances, and the person being assessed may be too ill to understand the role of the advocate. There is also a risk that association with the act of compulsion being imposed can damage the future relationship of the advocate and service user. The Bill will establish for the first time a duty on the appropriate authority to arrange to such extent as it considers necessary to meet all reasonable requirements to provide advocacy for patients subject to the legislation. Once someone is being treated under the formal powers in the Bill, they have a particular need both to understand the legal procedures and what rights they have and, most importantly, to be able to make the safeguards work for them by articulating their own views and engaging with the clinical team. This is where advocacy can help to ensure the patient’s voice is heard. This new duty does not preclude the provision of advocacy at other times.</td>
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<td>It should be possible to appoint a nominated person to represent the patient during the examination process. If there is time to consult the patient’s carer it should also be possible to appoint a nominated person. (see clause 15(2)(b)).</td>
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<td>MHA (DMH 105) MIND (DMH 210)</td>
<td>14(c): Appointing the nominated person may be a time consuming process, requiring the patient’s choice to be identified and contacted. That individual will then need to agree to act as the nominated person and to notify the AMHP of their agreement. In practice it is not appropriate to delay the initial examination until the appointment of the nominated person is complete. The appointer is, therefore, only required to appoint the nominated person as soon as possible after the patient has become liable to assessment under compulsion. If, however, it is clear at an early stage who the patient's choice is and they are willing to be appointed, it may well be appropriate for that person to be involved and consulted in the process of compulsion and this will be explained in the Code of Practice.</td>
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<td>(1)</td>
<td>The appropriate authority must, if requested to do so by any person, determine whether all of the relevant conditions appear to be met in a patient’s case.</td>
<td>Opening the possibility that any individual can make such an application could provide opportunity for members of the community to object to the presence of neighbours on prejudicial grounds. It could have massive resource implications and be contrary to Article 8(2).</td>
<td>Royal College of Psychiatrists (DMH 24) Justice (DMH 272) Welsh Assembly (DMH 59)</td>
<td>14(d): The duty on the appropriate authority to arrange an initial examination has effect only if the NHS body concerned considers that the conditions appear to be met. There has to be some reason, or evidence, to justify an examination. We are confident that this provision complies with Article 8(2). The Government will work with stakeholders to establish procedures for dealing with requests for examinations. The NHS body concerned will be responsible for satisfying itself that the conditions appear to be met and will appoint examiners only if there is evidence to support that decision. The resource implications of the Bill have been estimated and appropriate provision will be made.</td>
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<td>If it is decided that this provision should remain then consideration should be given to making it a criminal offence to require an assessment without due cause.</td>
<td>Royal College of Psychiatrists (DMH 24)</td>
<td>14(e): This is unnecessary and would be disproportionate, given the safeguards against malicious requests outlined above. There could be a risk that such a measure would deter genuine requests, and jeopardise people who make a request in good faith which is rejected by the NHS body concerned.</td>
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<td>The right to request a decision as to whether “examination” will take place is much weaker than the nearest relative’s right to require the local authority to direct an approved social worker to consider an application for admission. In particular the carer and the nominated person should both have the right to apply for assessment and the right to a justification if they are not successful.</td>
<td></td>
<td>MHA (DMH 105)</td>
<td>14(f): Under the Mental Health Act 1983 a nearest relative has the right to require an ASW to consider making an application for admission but an application will only be made if the ASW considers the criteria for admission are met and the application is supported by two doctors. Under the Bill anyone has the right to request an examination including relatives and carers, and there is a duty on the appropriate authority to arrange an examination if the relevant conditions appear to be met. As under the Act liability to assessment or treatment under compulsory powers will require the agreement of three examiners, an AMHP and two doctors. Rather than give rights to the nearest relative, who may not be involved with the patient, the Bill emphasises the role of carers and gives them statutory rights to be consulted at key stages. The appropriate authority must, where practicable, consult carers before deciding whether to arrange an examination. Where carers make the request for an examination, they must be told the outcome if the appropriate authority decides it is not necessary to carry out an examination because they have determined the conditions for compulsion do not appear to be met. As explained above, the nominated person is appointed when a patient becomes liable to assessment. It would not be feasible to do this sooner. Appointing the nominated person may be time-consuming as the patient’s choice has to be identified, then contacted. That individual will then need to agree to act as the nominated person and to notify the AMHP of their agreement. However, this does not preclude someone who has been/ might be a nominated person from requesting an examination in the same way that anyone else can.</td>
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<td>(3) If – (a) the appropriate authority determines that all the relevant conditions appear to be so met, or (b) it receives a request for it to arrange for a patient to be examined made in accordance with section 230 or Schedule 6, it must, as soon as practicable after making the determination or receiving the request, arrange for the patient to be examined by the persons specified in subsection (4) (subject to subsection (8)).</td>
<td>The section relating to the determination of whether all the relevant criteria for compulsion are met is confusing. It may be very difficult to determine whether all the criteria are met before an examination is carried out. It would be more appropriate to state that there should be reasonable grounds to believe that all the criteria are met before arrangements are made for a patient to be examined.</td>
<td>BMA (DMH 248)</td>
<td>14(g): The Government believes that clause 14 will have this effect. The appropriate authority will need to take into account a number of factors, including the views of carers, in forming a view whether the relevant conditions appear to be met. It is the purpose of the examination to establish whether the conditions are in fact met in the patient’s case. The Government will ensure that the Code of Practice provides clear guidance as to the circumstances in which examinations are to be carried out.</td>
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<td>(4) Those persons are – (a) two registered medical practitioners in respect of whom the conditions specified in subsection (5) are met, and (b) an approved mental health professional who does not fall within the description specified for the purposes of paragraph (b) of that subsection.</td>
<td>The possibility that under the draft Bill both the medical staff and the AMHP undertaking the initial assessment may be employed by the same organisation, is an erosion of the protections provided by the present Act.</td>
<td>Welsh Nursing &amp; Midwifery Committee (DMH 100)</td>
<td>14(h): It is axiomatic that the AMHP will be independent and empowered to bring a broad social care perspective to their role. The Government will ensure that the development of the AMHP’s remit builds on existing training and expertise of ASWs, and will be consulting with stakeholders on how best to achieve this. Clause 14 (5)(b) enables regulations to be made to describe persons subject to a potential conflict of interest and who cannot therefore be appointed as examiners. Examples of the circumstances which might be precluded include a situation where all three examiners are employed within the same NHS management unit. Also see responses in respect of clause 3.</td>
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<td>Determinations to be made on examination</td>
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<td>15(2)</td>
<td>If the patient falls within a description specified by the appropriate authority in regulations, each of the examiners must, in carrying out an examination, also determine whether it is appropriate for the patient to be detained in a hospital while an assessment of him is carried out.</td>
<td>The intention that “normally assessment or treatment in hospital will be needed before someone is judged suitable for treatment in the community” should be established and clarified on the face of the Bill.</td>
<td>Mental Health Act Commission (DMH 20)</td>
<td>15(a) The Bill enables regulations to be made to define the limited group of patients who will be eligible for assessment and treatment in the community as “non-resident” patients. The intention is that this group will primarily be patients who have previously been treated in hospital and who are well-known to services, and are prone to cycles of discharge, relapse and readmission. The precise detail of the regulations is to be developed in consultation with clinical practitioners to ensure the aim is achieved without creating an obstacle to sensible clinical decision-making. Dealing with this issue in regulations will provide flexibility to allow amendments to reflect developments in professional practice and service provision. These provisions will define (by default) who must be detained in hospital and, therefore, because of the significant implications for patients’ human rights, the Parliamentary procedure for this power is affirmative resolution, to ensure an appropriate level of Parliamentary scrutiny.</td>
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<td>Community Treatment Orders should be available for patients only on authorisation of the Tribunal after a period of in-patient assessment.</td>
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<td>MHA (DMH 105) Royal College of Psychiatrists (DMH 24) British Assoc of Social Workers (DMH 60)</td>
<td>15(b): The aim of the Bill is to ensure that all patients are properly assessed and for most patients it will still be appropriate for this to happen in hospital. Only those patients defined in regulations will be eligible to be non-resident from the outset. The introduction of this power is an important improvement in protecting the rights of patients in a way that is in keeping with new treatment and ways of service provision. Under the principles, to be set out in the Code of Practice, treatment should be provided in the least restrictive setting appropriate to the patient’s needs and consistent with the safety of the patient, carers and the public. To delay the option of possible treatment in the community could mean some patients are detained unnecessarily and be contrary to this important principle. Most patients will be initially assessed in hospital but we believe that it is right that the clinical supervisor should have a duty to keep the residency status of all patients admitted to hospital for assessment under review, and we do not see a role for the Tribunal at this initial stage. For patients not meeting the description to be specified in the regulations, this duty applies only once a care plan has been prepared, which must be done within five days.</td>
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<td>The criteria governing whether assessment and/or treatment is to be provided in the community should be included in the Bill.</td>
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<td>NACRO (DMH 156)</td>
<td>15(c): As stated above the Government believes that regulations are the appropriate vehicle to set out such criteria and intends to consult on regulations to achieve this in due course.</td>
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<td>15(3)</td>
<td>If an examiner determines that it is not appropriate for the patient to be so detained, the determination must specify the conditions to be imposed on the patient to- (a) secure that the assessment may be carried out, or (b) protect his health or safety or other persons against the risk by reference to which the examiner determined whether the third of the relevant conditions is met in his case.</td>
<td>There should be statutory provision or guidance directing clinical supervisors to have regard to an individual's rights to liberty and respect for private life when setting conditions for non-resident patients.</td>
<td>Justice (DMH 272)</td>
<td>15(d): All decisions under the Bill must, necessarily, be taken in accordance with the European Convention on Human Rights by virtue of the Human Rights Act 1998. Other pieces of primary legislation, such as the Race Relations (Amendment) Act 2000, Sex Discrimination Act 1975 and the Disability Discrimination Act 1995, will also need to be taken into account. Also, the Code of Practice will set out the general principles that will inform the way that practitioners exercise their functions within the framework of the legislation.</td>
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<td>15(3)(a)</td>
<td>should read: “secure that the assessment may be carried out, if further assessment is necessary, or”</td>
<td>Dr G Lodge (DMH 74)</td>
<td>15(e): The Government does not consider that this amendment is necessary. At this stage of the process, it will be envisaged that further assessment to some degree will be needed. It is very important to ensure that the patient is properly assessed and this may take some time. In practice a patient's case would be kept under regular review to assess their response to treatment.</td>
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<td>4</td>
<td>The conditions may include (a) …</td>
<td>The use of the word 'include' leaves open, and unclear, what other conditions may be lawfully imposed, and this is unsatisfactory.</td>
<td>Institute of Mental Health Act Practitioners, (DMH 50)</td>
<td>15(f): This paragraph is intended to illustrate the type of conditions that could be appropriate for patients in the community. It cannot be an exhaustive list as the precise conditions will depend on local circumstances, and the individual in question. This provision therefore allows flexibility and avoids undue imposition on the patient. The examiner must consult the patient and any carer before imposing any condition, and the Tribunal process provides a further safeguard to ensure conditions are reasonable.</td>
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<td>6(c)</td>
<td>any carer of the patient (unless he falls within paragraph (b)), subject to section 12 and if practicable.</td>
<td>A mechanism is needed to identify and limit to a single person, “any carer”, specified in this subsection.</td>
<td>Dr G Lodge (DMH 74)</td>
<td>15(f): The conditions which may be imposed on the patient must be designed to secure assessment or treatment can be carried out, or to protect the patient or others against the risk by which condition three is met. This paragraph is intended to illustrate the type of conditions that could be appropriate for patients in the community. It cannot be an exhaustive list as the precise conditions will depend on local circumstances, and the individual in question. The examiner must consult the patient and any carer before imposing any condition, and the Tribunal process provides a further safeguard to ensure conditions are reasonable.</td>
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<td>16</td>
<td><strong>Consequences of determinations</strong>&lt;br&gt;(5) In any other case, the patient is liable to assessment as a resident patient.</td>
<td>This provides that a person who meets the conditions for compulsion may be detained in hospital if an AMHP and one doctor consider it appropriate, notwithstanding the views of the other doctor. This could result in detention even when medical opinion is split with the expert against detention. This may not comply with the ECHR which requires that detention is founded on reliable evidence.</td>
<td>Institute of Mental Health Act Practitioners, DMH 50.</td>
<td>16(a): The provisions under clause 16 require a doctor's decision that detention is necessary. The provisions are therefore compliant with the requirement in the ECHR that detention be based on objective medical evidence. In addition the Bill recognises the importance in giving the non-medical social model of care due weight in considerations about whether a patient should be detained in hospital, or whether there is a less restrictive option. The effect of clause 16 is that, where a patient is eligible for assessment in the community but the opinion of the two examining doctors is divided, the AMHP's decision will determine whether the patient is detained in hospital or assessed in the community.</td>
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<td>17</td>
<td><strong>Emergency patients</strong>&lt;br&gt;It is constitutionally inappropriate that a single doctor (rather than both professionals as at present) may authorise a citizen's compulsory admission and detention if the approved mental health professional accompanying her/him is not also of the opinion that detention is appropriate or that there is any urgent necessity for this</td>
<td>If powers of compulsion are to be genuinely a measure of last resort - to be used where only strictly necessary - then it is antithetical to this approach to have a presumption in favour of detention.</td>
<td>Justice (DMH 272)</td>
<td>16(b): The principle that compulsory treatment should be the least restrictive and least invasive consistent with the need to protect patient and others, is an important underlying principle of the Bill. The implications of this for the everyday decisions of practitioners will be set out in the Code of Practice. However, it is also important that there is proper assessment of patients who are so ill as to satisfy the conditions for use of compulsory powers and this is usually most effectively carried out as a hospital in-patient. Clause 16 therefore provides that patients can only be assessed in the community where both medical and non-medical views consider this to be appropriate. However, the residential status of all patients liable to assessment must be kept under review and, once a care plan has been drawn up, all patients will be eligible to have their assessment continued in the community where, in all the circumstances, this is considered appropriate.</td>
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17(a): A single doctor can decide the patient is an emergency patient but can only do so where both the doctor and the AMHP have decided that the conditions for compulsion are satisfied. This determination will include whether the treatment available is appropriate in all the circumstances of the patient's case (the fifth condition) so that the place where treatment is to be given will be a relevant consideration. As explained above, the principle that compulsory treatment should be the least restrictive and least invasive consistent with the need to protect the patient and others, will apply to decisions made by practitioners under this clause.
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<td>22</td>
<td>Registration</td>
<td>Currently the ASW is entitled not to make an application for emergency admission if they consider it not justified “in all the circumstances”. Under the draft Bill the AMHP would have no choice but to admit the patient if the doctor (who may not know the patient) decided it was an emergency. This should be reconsidered.</td>
<td>British Assoc of Social Workers (DMH 60)</td>
<td>17(b): See response 17(a).</td>
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<td>There is an error in clause 22 and clause 23 which would have the effect that, having examined a patient at home and having completed all the paperwork for a compulsory admission, the AMHP would first have to travel to the hospital to register the patient, then return to transport him or her to the hospital, since the power to transport is conferred only by registration.</td>
<td>British Assoc of Social Workers (DMH 60)</td>
<td>22(a): Nothing in the Bill requires registration to be carried out in person at the hospital. The important effect of clauses 22 and 23 is to ensure that the patient is only conveyed once the hospital has accepted formal responsibility for the patient. Consideration of the fifth condition will, in any case, necessitate agreement with service providers. As in current practice, patients will only be transported to hospital if the hospital has agreed to accept them. The Government is working with stakeholders to ensure that the processes established are practical and further explanation and guidance will be included in the Code of Practice.</td>
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<td>At the point of assessment it is not clear that the hospital will be obliged to register a person presenting for registration. The lack of such provision will put additional strain on those carrying out the examination.</td>
<td>Social Workers of Hammersmith and Fulham (DMH 238)</td>
<td>22(b): As now, it will be for service commissioners and service providers to agree whether, when, and how, services should be made available for patients. Under the Bill, in order to be satisfied that the fifth condition is met (that appropriate treatment is available) it is likely that examiners will need to reach agreement with service providers. Therefore, there should be no reason for a hospital to refuse to register a patient that they have previously agreed to treat.</td>
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<td>24</td>
<td>Appointment of clinical supervisor</td>
<td>Both in the choice of most appropriate Clinical Supervisor and in the selection of an Expert Member of a Tribunal, there is ambiguity. To clarify this issue clause 24 should be amended so that it states that the managers, when appointing a Clinical Supervisor, should have regard to all relevant circumstances, including the nature of the mental disorder, the likely nature of the care plan to be developed, and the professional training and competencies of the clinician, before appointing the Clinical Supervisor.</td>
<td>British Psychological Society (DMH 19)</td>
<td>24(a): The Government agrees that these are relevant considerations and will address them in the Code of Practice.</td>
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<td>Clinical supervisors must be qualified to assess if a person meets the conditions for compulsion in order to be able to keep under review if the conditions continue to be met.</td>
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<td>No Force (DMH 44)</td>
<td>24(b): The Government agrees. It will be vital to ensure that the standards of competencies and training set for the approval of those eligible for the role of Clinical Supervisor properly equip clinicians to carry out all aspects of the duties effectively and with appropriate professional expertise. The Government will be working with stakeholders to ensure the right outcome. It is expected that, in the majority of cases where a patient is so seriously ill as to require treatment under compulsory powers, the Clinical Supervisor will be part of a multi-disciplinary team. Decisions about whether the patient continues to meet the relevant conditions, or whether they should be discharged, will often, therefore, be made in discussion with the other professionals in the team.</td>
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<td>25</td>
<td>Determinations to be made on assessment etc</td>
<td>There are also serious issues regarding non-medical Clinical Supervisors and prescribing of medication and ECT.</td>
<td>Leeds Consultant Psychiatrists (DMH 182)</td>
<td>24(c): There is no intention to change professional practice as to who may lawfully prescribe medication or ECT. Clinical supervisors will work as part of a multidisciplinary team. Where ECT is being considered, we agree that the clinical supervisor should normally be a doctor. If they were not a doctor, then the clinical supervisor would not be able to authorise ECT without the independent advice of a doctor that it was necessary. This will be dealt with in the Code of Practice.</td>
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The draft Bill should stipulate that where appropriate, practitioners engaged in assessing or treating adult patients should request assessments under section 17 of the Children Act 1989, or any other legislative provision linked to accessing support for vulnerable children and young people. |

Barnardo’s (DMH 315) | 25(a): The Government agrees that where a parent is subject to compulsory powers, there is a need to ensure that the needs of children and young people are considered while the parent is subject to formal powers and on discharge. The Bill is not the appropriate vehicle for achieving this. The Social Care Institute for Excellence (SCIE) launched a parental mental health and child welfare network in July 2004. The aim of the network is to join up work between adult mental health services and childcare services to see that parents and children get the support they need. In 2005, SCIE, with support from the Department of Health, will undertake a systematic review of evidence and existing practice by health and social care services in supporting parents with mental health needs, including meeting the needs of ethnic minorities. The review will draw out key messages for good practice and identify where more research is needed. It is proposed that SCIE will then draw up national practice guidelines. |
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<td>There should be a duty on local authorities to provide assessments of need, leading to statements of health and social service provision to meet that need, similar to the rights accorded in Part 2 for patients preparing for discharge or being discharged from compulsory treatment.</td>
<td>MHA (DMH 105)</td>
<td>25(b): The Government does not consider that there is a need to impose further duties on LAs. The Bill requires a care plan to be produced for each patient who is liable to assessment, which must include the medical treatment to be provided. “Medical treatment” is widely defined to include social care and support, so that a holistic approach is taken to meeting the person’s health and social care needs, and a multi-disciplinary team will need to be involved. Packages of aftercare will be prepared for patients on discharge from hospital, taking into account their ongoing health and social care needs. Six weeks’ free intermediate services will be provided, to support the patient’s transition from hospital to community. After this period services will be provided in accordance with the general duty on the NHS and LAs to meet the needs of their populations.</td>
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<td>The draft Bill should provide medical professional with the discretion provided in the 1983 Act not to take action even where the minimum conditions are satisfied.</td>
<td>British Assoc of Social Workers (DMH 60)</td>
<td>25(c): Except in an emergency, it is for 3 examiners to decide whether, in their professional judgment, all the conditions for compulsion are met. Each of those examiners has discretion to apply their professional opinion as to whether the conditions are met. If they do not all agree that in the circumstances compulsion is necessary, to protect that individual from serious harm or neglect or to protect others, compulsion cannot be applied.</td>
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<td>If the clinical supervisor determines under subsection (2)(a) that all of the relevant conditions are met in the patient’s case, he must keep under review the question of whether all of those conditions are met....</td>
<td>Royal College of Psychiatrists (DMH 24)</td>
<td>25(d): Two doctors are involved in the initial examination with the AMHP, rather than other professionals, because medically trained examiners are needed at that crucial stage, when it may be that little or nothing is known about the patient or he or she is in crisis. The examiners are able to consider and diagnose any underlying physical cause of the symptoms and behaviours that the patient is demonstrating and distinguish these from symptoms and behaviours arising from a clinically recognisable mental disorder. The duty on the clinical supervisor to keep the conditions under review arises at a later stage and in a different context. The clinical supervisor will usually be supported by a multi-disciplinary team, there will be a growing evidence base on which to reach decisions and he or she will have an increasing knowledge of the patient. As explained above, the Government recognises that it will be vital to ensure that the standards of competencies and training set for the approval of those eligible for the role of clinical supervisor properly equip clinicians to carry out the duties effectively, and will be working with stakeholders to ensure that this is achieved.</td>
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<td>26</td>
<td>Duty to keep status of resident patients under review</td>
<td>Clause 26 authorises the Clinical Supervisor to make a patient resident for assessment, non-resident. This appears to conflict with clause 15(2) which determines that additional conditions, required if assessment is to be carried out in the community, will be set out in regulations. Further it is difficult to understand the distinction between clause 26 and clause 30.</td>
<td>Royal College of Psychiatrists, (DMH 24)</td>
<td>26(a): The Government does not agree that these provisions appear to be conflicting. Clause 15 deals with determinations to be made at the initial stage once the examiners have agreed that the relevant conditions appear to be met. At this stage only those categories of patients to be set out in regulations (likely, for example, to be those who have previously been hospital inpatients) will be eligible for consideration for assessment in the community. Clause 26 sets out provisions to be followed at a later stage in respect of resident patients, once assessment in hospital has begun. This clause imposes a duty on the clinical supervisor to keep the residency status of all patients under review, though for patients who are not in the categories to be set out in regulations the period of this review will not start until their care plan has been prepared (within 5 days of admission). The effect of these provisions will be that the need for patients to be detained in hospital will be kept under ongoing review, to ensure that patients who do not need to be detained in hospital can be treated in the community where this is compatible with the need to protect themselves and others. Clause 30 gives the clinical supervisor the power to grant leave of absence to resident patients, or to suspend conditions in the case of non-resident patients, only on specified occasions or for a specified period, subject to conditions in the interests of patients or others. An example might be to allow a patient to attend a family funeral, where the patient might be required to be accompanied as a condition of attendance.</td>
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<td>It is difficult to understand the distinction between the powers set out in clause 26 (transfer to the community) and those clause 30 (power to give leave of absence).</td>
<td>Royal College of Psychiatrists, (DMH 24)</td>
<td>26(b): See response 26(a).</td>
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<td>Change in status of non-resident patient</td>
<td>This provides that a non-resident patient can be detained on a determination made by one clinician, this opinion made be in conflict with the determinations previously made by three practitioners. Re-examination by three examiners would be preferable.</td>
<td>Institute of Mental Health Act Practitioners, DMH 50. No Force (DMH 44)</td>
<td>28(a): Once a patient becomes liable to assessment, the clinical supervisor must keep two things under review: whether the conditions continue to be met (if any one of the conditions is not met the patient must be discharged) and the residency status of the patient. A clinical supervisor who determines that a non-resident patient needs to be detained in hospital for assessment would only do so where it was considered that the patient could no longer be safely managed in the community. The patient's condition may have deteriorated, or, for example, if one of the conditions of non-residency were not complied with the clinical supervisor may decide that the patient should be treated as a resident patient. In the latter case a simple breach of the requirements will not necessarily lead to a change of residential status and the clinical supervisor will need to consider the reasons for the breach and all the circumstances of the case. As explained in response 24(b) the duties on the clinical supervisor to keep the patient's case under review arises in a different context from the initial examination. The clinical supervisor will usually be supported by a multi-disciplinary team, there will be a growing evidence base on which to reach decisions and he or she will have an increasing knowledge of the patient. The Government recognises the need to properly equip clinicians to carry out the duties of the clinical supervisor effectively, and we will be working with stakeholders to ensure that this is achieved.</td>
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<td>28</td>
<td>(5)(b) Otherwise, the period of 5 days beginning with the day on which the determination referred to in that subsection was made.</td>
<td>It is not necessary to reduce the time limit for other compulsory admissions from 14 days in the 1983 Act to five days in this draft. The 14 day period can be helpful in the case of a patient who is difficult to track down.</td>
<td>Dr G Lodge (DMH 74)</td>
<td>28(b): The Government does not agree. It is clearly desirable that, when the clinical supervisor determines that a patient should be detained in hospital for assessment, the patient should be brought to hospital as soon as possible. A five day period, for non-emergency patients, is considered appropriate to allow this to happen. Where a patient cannot be contacted within this period they may be considered absent without leave and the provisions under clauses 81 – 85 may have been triggered authorising the patient to be brought to hospital and detained beyond the 5 day period.</td>
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<td>35</td>
<td>Application to Tribunal for discharge of liability to assessment etc</td>
<td>The loss of the right to request discharge by patients and their representatives takes away the right for people to be able to take decisions and influence their own care. If the Tribunal holds the decision making powers then this could lead to a delayed assessment as the Tribunal may take time to meet. The removal of the powers of the Hospital Managers and the 'nearest relative' to discharge a patient is an erosion of protections provided in the current Act. Retaining the right to appeal to Hospital Managers under the Bill would offer detained patients an additional right of appeal within 28 days without the risk of the imposition of a longer term of detention should that appeal fail.</td>
<td>Lifecraft (DMH 220) Hertfordshire Users group (DMH 236) Welsh Nursing and Midwifery Committee (DMH 100) NE London Mental Health NHS Trust (DMH 124)</td>
<td>35(a): The Government does not agree that the Bill takes away the right for people to be able to take decisions and influence their own care. The provisions of the Bill enhance, rather than erode, patients' rights. Under the Bill the current dual system, of patients' cases being heard by both hospital managers and Review Tribunals would be replaced by a single procedure under which patients, their nominated persons and parents of children under 16 have rights to apply to the Tribunal for discharge. As the legal authority for the use of formal powers will primarily rest with the Tribunal, it is appropriate for patients seeking discharge to apply to it, rather than to have alternative routes to pursue. This single procedure will be clearer and simpler to understand; will ensure that patients' applications are considered by an independent judicial body with specialist expertise and will avoid the duplication of the current system. Also, under the Bill, the clinical supervisor is under a duty to keep under review whether the conditions for compulsion continue to be satisfied and, if they are not satisfied, to discharge the patient from compulsion. Where a patient, their nominated person, or a parent, has any doubts about the continued use of compulsory powers, they would first raise this with the clinical team. See also response 35(b).</td>
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<td>A patient appealing to a Tribunal currently knows that their worst outcome is that the Tribunal will not support their appeal. In the draft Bill a patient appealing against a 28 day detention order is liable to find that their consultant is simultaneously petitioning the Tribunal with the request for a 6 months treatment order. Patients experiencing this situation are likely to be deterred in future from appealing to a Tribunal. They are likely to perceive the new Tribunal as judge, jury and executioner.</td>
<td>J Millington (DMH 270)</td>
<td>35(b): The Government does not agree that the right of access to the Tribunal will be of little value. It ensures that the patient has access to independent scrutiny of the decision to use compulsory powers. The Tribunal will not act on its own volition to impose a treatment order unless the clinical supervisor has made a suitable application. If a patient’s application is due to be heard early on during the initial 28 days, the clinical supervisor is unlikely to have been able to prepare an application for a Tribunal order and without such an application the Tribunal will only be able (provided it determines the conditions are satisfied) to confirm the original 28 day period of liability to assessment. Where a patient’s application is due to be heard close to the expiry of the 28 day period, it is likely that the clinical supervisor will be in a position to apply for an order for assessment or treatment as appropriate. The Tribunal would need to deal with the clinical supervisor’s application within a matter of days in any case. The power to deal with both applications at the same time will avoid the need to hold two tribunals within a short period. While a 6 month treatment order is in effect, patients, nominated persons, and parents (where the patient is a child aged under 16) have the right to return to the Tribunal for a review of the patient’s case because, for example, their condition has improved. On the question of the Tribunal’s dual role (as explained under clause 8 above), it is true that applications may be made to the new Mental Health Tribunal by both clinical supervisors seeking assessment or treatment orders, and patients (or their representatives) challenging the use of compulsory powers. Patient applications, however, are not appeals against earlier Tribunal decisions, they are applications for a review of the case. This is an important distinction because, in hearing patient applications, the new Tribunal will not revisit an earlier decision but will consider the patient’s case afresh and make a new decision according to the up-to-date facts and circumstances prevailing at the time. In the unlikely event that a patient application is heard by the same panel of Tribunal members as dealt with an earlier application, this would not give rise to a conflict of interests. The Bill establishes a separate Mental Health Appeal Tribunal to hear appeals on points of law which will consider whether an earlier decision was lawful.</td>
<td>NE London Mental Health NHS Trust (DMH 113) Royal College of Psychiatrists (DMH 24) IMHAP (DMH 50) MHA (DMH 105)</td>
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<td>35(b)</td>
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<td>A Tribunal should not be permitted to authorise a treatment order if it is hearing an appeal within the first 14 days of the period of assessment.</td>
<td>Royal College of Psychiatrists (DMH 24)</td>
<td>36(a): See responses 35(a) and 35(b).</td>
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<td>38</td>
<td><strong>Duty to apply to Tribunal for order</strong></td>
<td>The draft Bill does not address the difficulty that will arise if the Mental Health Tribunal and the approved clinician cannot agree on the care plan. The Tribunal will be left with the problem of how to decide, and this will require negotiation with the clinical supervisor. It is an inefficient system compared to the 'second opinion approved doctor' under the 1983 Act. The opportunities for disagreement will be considerable, not only between any particular Tribunal and the approved clinician, but also between one Tribunal and the next.</td>
<td>King's College, London (DMH 81) Council on Tribunals (DMH 305) Law Society (DMH 111)</td>
<td>38(a): The Government thinks that it is inappropriate for the Tribunal to be able to impose a care plan without the agreement of the practitioner responsible for the care and treatment of the patient. As with second opinion approved doctors (SOADs) under the current Act, this is because the Tribunal is not accountable for the use of resources and the provision of services. Under the current Act SOADs may effectively veto certain treatment proposed by the responsible medical officer (RMO) where that treatment may only be given without consent if the SOAD has signed the relevant form (except in cases of urgency). SOADs do not, however, have the power to require treatment to be provided and the Code of Practice emphasises that disagreement should not be allowed to prejudice the patient's interests and that every attempt should be made by the SOAD and RMO to reach agreement. Under the Bill, the Tribunal will provide an effective forum to resolve disputes, taking into account the views of the patient and other parties such as the patient's social worker. The Tribunal will weigh the evidence put before it and will need a good reason, such as the expert panellist or the patient expressing concern or doubt about the content of the care plan, in order to suggest amendments to the content of the care plan proposed by the clinical supervisor. In case of intractable disagreement, if the Tribunal is otherwise satisfied that the conditions for treatment under the Bill are met, it is intended that the Tribunal adjourn and direct the managers of the hospital with which the patient is registered to take all reasonable steps to reconsider and bring forward an amended care plan. As mentioned above, in dealing with new applications, whether by the clinical supervisor or the patient, the Tribunal will consider the patient's case afresh and make a new decision according to the up-to-date facts and circumstances prevailing at the time.</td>
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<td>41</td>
<td>Duty to apply to Tribunal for further order</td>
<td>Given the breadth of the criteria for compulsion, it may be difficult for a patient to oppose the renewal of an order successfully if the clinical view is that the medication is keeping the patient well.</td>
<td>MHA (DMH 105)</td>
<td>41(a): The burden of proof is not on the patient to prove that he can be discharged, rather the Tribunal must satisfy itself by weighing the evidence, that all the conditions are met. It will consider evidence not only from the clinical supervisor, but must have the independent medical expert’s report, must take into account any expert report obtained by the patient, and may also hear the patient’s own views and those of other parties such as social workers. As now, the Tribunal may disagree with the clinical supervisor as to whether compulsory treatment is necessary. Consideration of issues such as whether a patient whose condition is effectively controlled by medication needs to be treated under compulsion and whether there are alternative treatments, is integral to consideration of the relevant conditions, in particular the third and fourth conditions relating to the risk a patient may pose to themselves or others and whether they may be treated voluntarily.</td>
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<td>45</td>
<td>Powers of Tribunal: application under section 38 or 41</td>
<td>The mandatory referral to Tribunal and the fact that the Tribunal is obliged to make an order whenever the relevant conditions are met irrespective of whether compulsion is desirable or likely to be effective displays a public protection agenda to the detriment of the rights of the mentally ill.</td>
<td>Bar Council (DMH 191) Hampshire Partnership NHS trusts (DMH 319)</td>
<td>45(a): See response to 41(a). The Government disagrees that in weighing the evidence as to whether the conditions are met, the Tribunal’s considerations will be weighted in favour of public protection to the detriment of individual patients. In particular, there must be treatment available that is appropriate in all of the circumstances of the individual patient’s case and for the majority of patients (all but the small minority of patients posing a substantial risk of causing serious harm to others), the fourth condition ensures that compulsory powers cannot be used where a lawful alternative exists. Whenever the procedures of the Bill require consideration of the relevant conditions, decision-makers must exercise their professional judgment in deciding whether the conditions are satisfied. That is where discretion lies. The Tribunal may, for example, find that the patient is not disordered, is not sufficiently disordered, that compulsion is not necessary, or that available treatment is not appropriate in all the patient’s circumstances. Unless satisfied that compulsion is appropriate on all those counts, they must discharge the patient from compulsion.</td>
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<td>46</td>
<td>Order (for further order) authorising medical treatment</td>
<td>If the clinical supervisor is not a registered medical practitioner then the assessment of mental disorder and conditions necessary for continuing compulsion are made on the basis of only one medical recommendation. The Mental Health Tribunal should be permitted to authorise specified medical treatments only if they are agreed as necessary by both the clinical supervisor and medical expert panel member. The Tribunal has no power to order the clinical supervisor to change the proposed treatment plan; only such amendments as are 'agreed' with the clinical supervisor may be made. The Tribunal thus provides no guarantee of judicial oversight compatible with Article 6, ECHR.</td>
<td>Royal College of Psychiatrists (DMH 24) Bar Council (DMH 191)</td>
<td>46(a): The Government considers that the Tribunal procedures proposed are compatible with the right to a fair trial and requirements under Article 6 ECHR. As explained in the response to 38(a), the Government thinks that it is inappropriate for the Tribunal to be able to impose a care plan without the agreement of the practitioner responsible for the care and treatment of the patient because it is not accountable for the use of resources to provide local services. The Government does not, however, consider the agreement of other parties to be essential. The Tribunal is under a duty to give reasons for its decisions. The Tribunal will weigh the evidence put before it and will need a good reason, such as the expert panellist or the patient expressing concern or doubt about the content of the care plan, in order to suggest amendments to the content of the care plan proposed by the clinical supervisor. It is unlikely that the Tribunal would find justification to agree a change with the clinical supervisor that was not supported by evidence from other parties. As explained above, if the Tribunal is otherwise satisfied that the conditions for treatment under the Bill are met, it may adjourn and direct the managers of the hospital with which the patient is registered to take all reasonable steps to reconsider and bring forward an amended care plan. See also response to 24(b).</td>
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<td>(5) If the order states that the patient is to be provided with medical treatment as a resident patient for any period, the order must – (a) state whether – (i) the order may only be discharged by the Tribunal, or (ii) the clinical supervisor is authorised to discharge the order,</td>
<td>The granting of powers to Mental Health Tribunals to reserve to themselves the decision to grant leave to or to discharge a patient is a form of ‘restriction order’ like that used in the forensic arena. It means that the clinical supervisor’s decision that it is appropriate for the patient to now be treated informally can be overridden by the Tribunal. It will further reinforce patients’ perceptions of the services as coercive.</td>
<td>King’s College London (DMH 81) Nottingham Senior Medical Staff Committee (DMH 284) MHA (DMH 105)</td>
<td>46(b): The effect will be similar to that of restriction orders but the Government consider that these powers are necessary to help better manage the small minority of difficult cases involving patients who pose a significant risk of causing serious harm to others but who are civil patients. Decisions on the discharge of such patients would be made by an independent Tribunal, taking into account all the issues and circumstances of the case, rather than an individual clinical supervisor. In most cases, where the clinical supervisor has ensured that all the relevant agencies have been involved and have approved the application, the Tribunal would be unlikely to find grounds for rejecting the application and would order the patient’s discharge as requested. It is intended that the Tribunal will only have this discretionary power where the patient poses a significant risk of causing serious harm to others and this patient group will be defined in regulations. This will allow amendment should it be found, for example, that the threshold of risk has been set too high or too low. The Parliamentary procedure for this regulation making power is affirmative resolution to ensure the proper level of scrutiny for this serious matter. Given that the Tribunal’s power will be limited to cases where there is a high risk to others, the Government believes this provision is reasonable and proportionate and complies with ECHR.</td>
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<td>(7) The conditions may include – (a) a condition that the patient – (i) attends at a specified place at specified times, (ii) resides at a specified place, (iii) makes himself available for treatment during specified periods, (b) a condition that the patient does not engage in specified conduct.</td>
<td>The breadth of the power contained in, for example, clause 46(7), enabling the Tribunal to attach a condition to an order relating to a non-resident patient requiring the patient not to “engage in specified conduct” provides cause for concern.</td>
<td>Council on Tribunals (DMH 305)</td>
<td>46(c): The conditions which may be imposed on the patient must be designed to secure that assessment or treatment can be carried out, or to protect the patient or others against the risk by which condition three is met. An application by the Clinical Supervisor seeking to impose conditions on the patient would need to be considered by the Tribunal according to the requirements of UK law. That is, taking into account the principles of natural justice; the underlying purpose of that legislation and the need to act in such a way that does not infringe a person’s human rights. As explained above, the Tribunal must give reasons for its decisions drawing on the evidence to provide reasonable justification. Guidance for practitioners on making applications to the Tribunal, including the conditions they might seek to impose, will be in the Code of Practice. The Tribunal will be able to take account of this guidance if it appears that a provision in the Code, or a failure to comply with the Code, is relevant to its consideration of a case, including the imposition of conditions on non-resident patients. It is envisaged that the provision will cover conduct such as drinking alcohol where the patient’s mental disorder is exacerbated by the consumption of alcohol.</td>
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<td>47</td>
<td>Order (or further order) authorising medical treatment: supplementary  (1) In the case of an order authorising the medical treatment of a patient, the period specified under subsection (8) of section 46 may not exceed 6 months.</td>
<td>The treatment order periods give concern: the first period should be for no more than three months - not six as suggested in the Bill.</td>
<td>Hertfordshire Users Group (DMH 236)</td>
<td>47(a): The Government disagrees that 3 months should be the maximum length of the first treatment order made by the Tribunal. There may be circumstances in which it would be appropriate to make an initial order for less than 6 months and the Bill provides the Tribunal with the flexibility to do so if that is appropriate. To make 3 months the maximum would put additional and unnecessary pressure on the Tribunal system. Where an order is for 3 months or more, the patient (or their representative) has a right to make a fresh application to the Tribunal for a review of their case.</td>
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<td>49</td>
<td>Order (or further order) authorising assessment  At the stage at which the Mental Health Tribunal determines whether to authorise an order for medical treatment (clause 46) or further assessment (clause 49), no additional threshold criteria is required in deciding whether the patient is to be a resident or non-resident patient. On the face of it that is incompatible with Article 5(1), ECHR. It is understood that the expert panel member will advise the Tribunal in relation both to grounds for compulsion and the care plan. However clause 47 and clause 49 suggest that the Tribunal can alter a care plan only with the agreement of the clinical supervisor.</td>
<td></td>
<td>Bar Council (DMH 191) Royal College of Psychiatrists (DMH 24)</td>
<td>49(a): The Government does not agree that the provision is incompatible with ECHR. The clinical supervisor’s application to the Tribunal will include the reasons for seeking an order on a resident or non-resident basis. In preparing a report, the medical expert must comment on every aspect of the application. Other parties to the case, including the patient, may also give their views on what is appropriate. The Tribunal will take into account and weigh all the evidence and representations made to it at the hearing from all parties, to decide whether the patient should be assessed or treated on a resident or non-resident basis. The Tribunal must reach its decisions according to the requirements of UK law. That is, taking into account the principles of natural justice; the underlying purpose of that legislation and the need to act in such a way that does not infringe a person’s human rights. The Tribunal must also give reasons for its decisions drawing on the evidence to provide reasonable justification. See response 46(a) regarding amendments to care plans.</td>
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<td>50</td>
<td><strong>Order (or further order) authorising assessment</strong> (4) No further order authorising the assessment of a patient may be made if the qualifying period in respect of him would exceed 3 months.</td>
<td>The potential length of the assessment period for both civil, and criminal justice patients seems to be as much as 4 months. The final care plan should be able to be drawn up within a much shorter period of time. For patients on 3 month orders not to have a right of appeal is a breach of human rights.</td>
<td>NE London Mental Health Trust (DMH 112)</td>
<td>50(a): Four months is the maximum period which may be necessary for some cases involving, for example, personality disorders. The Government anticipates that in the majority of cases, a treatment order will be made at an earlier stage. The clinical supervisor is under a duty to prepare an initial care plan within 5 days of the patient being admitted (or conditions being imposed on a non-resident patient). It may take some time for the clinical supervisor to complete his assessment and be in a position to apply for a treatment order, because, for example, medication can take time to have full effect. During the assessment period the patient’s case has to go before a Tribunal at least every 28 days (an assessment order can only be made for up to 28 days). The potential length of the assessment period for both civil, and criminal justice patients seems to be as much as 4 months. The final care plan should be able to be drawn up within a much shorter period of time. For patients on 3 month orders not to have a right of appeal is a breach of human rights.</td>
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| 53     | **Free care services etc before discharge** | | Bar Council (DMH 191) | **53(a):** The NHS and local authorities have responsibilities to meet the needs of their populations. The care plan will set out the services that a patient needs on discharge, and agreement will be reached with the relevant organisations about their provision.  
Local authorities have statutory responsibilities to meet the needs of their populations, and so it is not the case that the local authorities will have no statutory obligation to implement the care plan. A person who may need community care services has a right to be assessed by a local authority as to his needs (under section 47 of the NHS and Community Care Act 1990 ("the 1990 Act")). Community Care Services are defined in section 46(3) of the 1990 Act. They are—  
- residential accommodation for those who have a need for care and attention which is not otherwise available, under section 21 of the National Assistance Act 1948 ("the 1948 Act");  
- welfare arrangements for "blind, deaf, dumb and crippled persons, etc" under section 29 of the 1948 Act;  
- services promoting the welfare of the old people under section 45 of the Health Services and Public Health Act 1968;  
- services under section 21 of and Schedule 8 to the National Health Service Act 1977 (care of mothers and young children, prevention, care and aftercare; home help and laundry facilities).  
The way that these enactments take effect is that the Secretary of State either approves local authorities providing certain types of services or directs that they be provided. The relevant approvals and directions are in LAC (93) 10 and in circular 19/71. The Secretary of State has directed local authorities to make provision under section 21 of the 1948 Act (residential accommodation) for people who are ordinarily resident in their area or who are in urgent need (see LAC (93) 10, appendix 1). He has approved the making of arrangements under section 29 of the 1948 Act and directed that certain services be provided to those who are ordinarily resident in the local authority's area (see LAC (93) 10, appendix 2). He has approved the making of arrangements under Schedule 8 to the 1977 Act in relation to services for expectant and nursing mothers, services for the prevention of illness etc. and has directed that certain mental health services be provided (see LAC (93) 10, appendix 3). He has approved the provision of services under section 45 of the 1968 Act in relation to the needs of the elderly in circular 19/71.  
In addition, section 2 of the Local Government Act 2000 enables a local authority "to do anything which they consider is likely to achieve, […]  
(b) the promotion or improvement of the social well-being of their area."

This includes the power to incur expenditure, including giving financial assistance to any person or providing services or accommodation to any person. |
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<td>54</td>
<td><strong>Application to Tribunal for discharge of order (or further order) authorising medical treatment</strong>&lt;br&gt;(2) An order may be made to the Tribunal by –&lt;br&gt;  (a) the patient,&lt;br&gt;  (b) his nominated person, or&lt;br&gt;  (c) if the patient is aged under 16, any person with parental responsibility for him,&lt;br&gt;...for an order discharging the order (or further order) in question...</td>
<td>The managers of a hospital should retain the power to discharge a person detained by them if they are of the opinion that the statutory conditions which make detention lawful are no longer met.</td>
<td>IMHAP (DMH 50)</td>
<td>54(a): Hospital managers will continue to have duties under the Bill to ensure that the requirements are correctly followed and will play a vital role in implementing the new provisions effectively, but they will no longer have responsibility for hearing patient applications for discharge. Since the legal authority for the use of formal powers will primarily rest with the Tribunal, it will be appropriate for patients seeking discharge to apply to it, rather than to provide alternative procedures. This will ensure that patients’ applications are considered by an independent judicial body with specialist expertise and will also avoid the duplication in the current system of patients cases being heard by both managers and Tribunals.&lt;br&gt;See also response 35(a).</td>
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<td>55</td>
<td><strong>Application to Tribunal for change in status of resident patient</strong>&lt;br&gt;There is a power for a nominated person to request to the Tribunal that a resident patient become non-resident, but not the reverse. There is no power to challenge this. There is also a real danger that the facility to switch patients between resident and non-resident status could be led by bed shortages rather than patient needs.</td>
<td></td>
<td>MHA (DMH 105)</td>
<td>55(a): It is important that the Bill provides for patients to apply to the Tribunal, or for their nominated persons to apply on their behalf, where there is a change of status from non-resident to resident because the detention of a patient in hospital is, potentially, a serious infringement of the patient’s human rights. The same is not necessarily the case if a patient is being released from detention in hospital.&lt;br&gt;Clinical supervisors, advised in most cases by a multi-disciplinary team, are well placed to consider whether a patient should be assessed or treated on a resident or non-resident basis taking into account whether appropriate services are available to support the patient in the community. Clinical supervisors and Tribunals must be satisfied that all the relevant conditions continue to be met, including that, in all the circumstances, appropriate treatment is available for the patient.&lt;br&gt;If the nominated person is concerned that the decision to place the patient in the community has been made on the basis of a shortage of beds, rather than what is suitable for the patient, they may consider that the treatment of the patient is so inappropriate as to cast doubt on whether the fifth condition is satisfied. The nominated person may, therefore, consider that there are grounds for making an application for the patient to be discharged from compulsion. The Tribunal must be satisfied that all the relevant conditions are met, that non-residential status is appropriate, and must approve the care plan.</td>
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| 56     | Powers of Tribunal: applications under section 54 or 55  
(5) ... if the Tribunal determines that all of those [relevant] conditions are met in the patient’s case.  
(6) If the application is made under section 54, the Tribunals must make an order refusing the application. | The Tribunal has no discretion to discharge an individual if all the relevant conditions are met and therefore it may be extremely difficult for a patient to be discharged from the provisions of the Bill. | IMHAP (DMH 50)  
Law Society (DMH 111) | 56(a): The burden of proof is not on the patient to prove that he can be discharged, rather the Tribunal must satisfy itself by weighing the evidence, that all the conditions are met. As explained above, it will consider evidence not only from the clinical supervisor, it must also have the independent Medical Expert report, the patient’s own views and those of other parties such as social workers. As now, the Tribunal may disagree with the clinical supervisor as to whether compulsory treatment is necessary.  
As explained in the response to 45(a), whenever the procedures of the Bill require consideration of the relevant conditions, decision-makers must exercise their professional judgment in deciding whether the conditions are satisfied. That is where discretion lies. The Tribunal may, for example, find that the patient is not disordered, is not sufficiently disordered, that compulsion is not necessary, or that available treatment is not appropriate in all the patient’s circumstances. Unless satisfied that compulsion is appropriate on all those counts, they must discharge the patient from compulsion. |
<p>| 59     | Powers of Tribunal: application under section 58 | The Tribunal will have no power to amend or refuse aspects of the care plan without the agreement of the clinical supervisor. A clinical supervisor cannot be required to administer treatment which s/he thinks is not therapeutically appropriate. As a matter of principle the Tribunal should be able to block treatment which it is satisfied is not in the patient’s interests. Otherwise it is difficult to see that the role of the Expert Panel member is of great value. | MHA (DMH 105) | 59(a): See response 38(a). |
| 60     | Discharge by clinical supervisor of order (or further order) authorising medical treatment or assessment | There should be no limitation of the right to discharge by the clinical supervisor for those detained under civil sections. | Leeds Consultant Psychiatrists (DMH 182) | 60(a): See response 46(b). |</p>
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<td>63(a)</td>
<td>Duty to make a deferral order (2) The Tribunal must ... make a deferral order in relation to that person if it is satisfied that ... (a) no plan has been prepared by the managers of the relevant hospital and the relevant local authority containing a statement by each of them of the post-discharge services to be available to that person following the discharge and ... (b) all of the relevant conditions are likely to be met in his case within the 8 week period, if he is not provided with one or more post-discharge services after he ceases to be detained in hospital.</td>
<td>There is nothing in the Bill to require health and social services to work together to assess the person’s aftercare needs.</td>
<td>Mental Health Foundation (DMH 229)</td>
<td>63(a): The NHS and local authorities have existing general responsibilities to meet the needs of their populations. This is as true for people with mental health problems as it is for the rest of the population. Packages of aftercare should be put together for people before they are discharged from formal powers.</td>
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<td>63(b)</td>
<td>Keeping a person in hospital against their will due to insufficient community resources is capable of giving rise to a violation of Article 5(1) of the ECHR. If the conditions to make the order are no longer met then that order must be immediately discharged and the person free to leave. The point of discharge must be considered at the point of admission onwards to avoid any delays. Although the European Court of Human Rights has confirmed that discharge may be delayed for a reasonably time, a further 8 weeks of detention may not be considered reasonable in all circumstances. It would also be costly and might impose an unnecessary burden on inpatient services.</td>
<td></td>
<td>Citizens’ Advice (DMH 125) Birmingham MIND (DMH 155) Bar Council (DMH 191) Mental Health Foundation (DMH 229)</td>
<td>63(b): The Bill requires the Tribunal, when making a discharge order, to make a deferral order only in certain circumstances. These are: the patient has been in hospital for at least 28 days; no post-discharge care plan has been made; and, without such care, the patient is likely to meet all the relevant conditions for compulsion within 8 weeks. The deferral order gives the hospital managers the right to detain the patient for a maximum of a further eight weeks while the post-discharge care plan is prepared. The purpose of this provision is to minimise the likelihood that a person will be brought under formal powers again after being discharged. This aim is clearly in the patient’s interests, as it maximises their chances of longer term recovery. But the provision recognises that any such delay must be limited to a reasonable period defined on the face of the Bill and to apply only in those cases where the lack of a care plan is most likely to have serious consequences. The Government is confident that this provision is consistent with the findings of the European Court of Human Rights, which has observed that continued detention for a limited period is permissible even where the patient has ceased to be mentally disordered, if the purpose of the continued detention is consonant with the purpose of Article 5(1) and discharge is not be unreasonably delayed.</td>
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<td>64</td>
<td>Duties resulting from deferral order</td>
<td>In deciding to make a discharge order the Tribunal will have already satisfied itself that the conditions for compulsion are no longer met, yet the duty to defer discharge requires the Tribunal to predict whether the relevant conditions are likely to be met within 8 weeks if the patient is not provided with post-discharge services. This would seem an extremely difficult task.</td>
<td>Council of Tribunals (DMH 305)</td>
<td>63(c): The current Mental Health Act 1983 does not specify how the tribunal’s power to defer a patient’s discharge to a future date should be used, or how the tribunal should reach decisions about deferral. The Bill sets out clearly the limited circumstances in which the new tribunal can use this power. The new tribunal’s decisions must be a matter of judgment as to its view of what may be expected to be the outcome, taking into account current knowledge of the patient’s case and circumstances prevailing at the time.</td>
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64(b): This provision does not apply to restricted patients, so these concerns would not apply. |

64(a): See responses 68(a), 68(b) and 68(c). |

West London Mental Health NHS Trust (DMH 243) |

64(b): This provision does not apply to restricted patients, so these concerns would not apply. |

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<td>68</td>
<td><strong>Free care services, etc after discharge</strong>&lt;br&gt;<strong>(2) ...no charge may be recovered for any care service provided in respect of the discharged person during the initial 6 week period [after discharge]</strong></td>
<td>Six weeks is not a realistic time period for a patient to fully recover, and resources should be put into providing health and social care services that can span a reasonable amount.</td>
<td>R Pratt (DMH 39)</td>
<td>68(a): People are not expected to recover fully within a 6 week period. What the Bill proposes is that people who have been detained under the powers in the Bill will have rights to free support services (termed as intermediate care, because the services help provide a bridge between hospital and the community) for 6 weeks. After that, they will have access to support services in the same way as anyone else who needs them. The NHS and local authorities have responsibilities to meet the needs of their populations. This is as true for people with mental health problems as it is for the rest of the population. Packages of aftercare will be put together for people before they are discharged from hospital and discharged patients will get free intermediate care for the first 6 weeks. Some support services may have charges after that period, e.g. some day care services, but means-testing will mean that no-one will be deprived of services they need because they cannot afford to pay for them.</td>
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<td>It is unfair to require people to pay for treatment they are compelled to receive.</td>
<td>N Morris (DMH 47)</td>
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<td>It would be more appropriate if the free aftercare arrangements were driven by an agreed multi-agency discharge plan which reflected realistic timescales for the individual rather than an arbitrary and universal timescale.</td>
<td>Citizens’ Advice (DMH 125)</td>
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<td>Thought will have to be given to transitional arrangements for the group that is currently receiving free care under sec 117 of the 1983 Act particularly as some are only accepting the care as it is free and to start charging may put the care plan in jeopardy.</td>
<td>IMHAP (DMH 50)</td>
<td>68(b): The transitional provisions in Schedule 14 provide for people who currently receive free aftercare to continue to do so.</td>
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<td>The removal of the duty under section 117 of the 1983 Act places the burden for continuing care on the patient’s care plan, which authorities will have no statutory obligation to implement.</td>
<td></td>
<td>68(c): The NHS and local authorities have responsibilities to meet the needs of their populations. The care plan will set out the services that a patient needs on discharge, and agreement will be reached with the relevant organisations about their provision. Local authorities have statutory responsibilities to meet the needs of their populations, and so it is not the case that the local authorities will have no statutory obligation to implement the care plan. A person who may need</td>
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The consequences of excluding aftercare include (a) a multi-tiered system where those who can afford aftercare services stand a better chance of avoiding future mental disorder, and (b) inappropriate extension of non-resident orders in breach of Article 5(1) ECHR.

Community care services has a right to be assessed by a local authority as to his needs (under section 47 of the NHS and Community Care Act 1990 ("the 1990 Act"). Community Care Services are defined in section 46(3) of the 1990 Act. They are:

- residential accommodation for those who have a need for care and attention which is not otherwise available, under section 21 of the National Assistance Act 1948 ("the 1948 Act");
- welfare arrangements for "blind, deaf, dumb and crippled persons, etc" under section 29 of the 1948 Act;
- services promoting the welfare of the old people under section 45 of the Health Services and Public Health Act 1968;
- services under section 21 of and Schedule 8 to the National Health Service Act 1977 (care of mothers and young children; prevention, care and aftercare; home help and laundry facilities).

The way that these enactments take effect is that the Secretary of State either approves local authorities providing certain types of services or directs that they be provided. The relevant approvals and directions are in LAC (93) 10 and in circular 19/71. The Secretary of State has directed local authorities to make provision under section 21 of the 1948 Act (residential accommodation) for people who are ordinarily resident in their area or who are in urgent need (see LAC (93) 10, appendix 1). He has approved the making of arrangements under section 29 of the 1948 Act and directed that certain services be provided to those who are ordinarily resident in the local authority's area (see LAC (93) 10, appendix 2). He has approved the making of arrangements under Schedule 8 to the 1977 Act in relation to services for expectant and nursing mothers, services for the prevention of illness etc. and has directed that certain mental health services be provided (see LAC (93) 10, appendix 3). He has approved the provision of services under section 45 of the 1968 Act in relation to the needs of the elderly in circular 19/71.

In addition, section 2 of the Local Government Act 2000 enables a local authority "to do anything which they consider is likely to achieve, (b) the promotion or improvement of the social well-being of their area."

This includes the power to incur expenditure, including giving financial assistance to any person or providing services or accommodation to any person.

Where charging applies for NHS and local authority services, means-testing will mean that no-one is deprived of services on the basis that they cannot afford them. It will normally be easier for people who have been on non-resident orders – instead of in hospital – to make the switch from compulsion to being a voluntary patient, and so it will normally be easier to develop an appropriate aftercare package for them – we therefore believe that there will be no inappropriate extension of non-resident orders while aftercare is being sorted out.
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<td>76</td>
<td><strong>Transfer of responsibility for patients between hospitals</strong>&lt;br&gt;The proposal to require the clinical supervisor to give a minimum 7 days notice of transfer, other than in an emergency, is understandable but likely to have a significant adverse impact on patients, services and utilization of resources. It would be appropriate to waive the required notice if a patient is initially admitted for assessment or treatment outside their local catchment area, to avoid delays in returning them to their local mental health service where this is in their best interests.</td>
<td></td>
<td>Royal College of Psychiatrists (DMH 24) W London Mental Health Trust (DMH 243)</td>
<td>76(a): The minimum seven days notice of transfers will enable adequate time for patients and their nominated persons to object to the transfer. Whilst in some cases a delay may not be in a patient’s interests on balance it would not be appropriate to assume that the transfer would be welcomed by, or be in the interest of, the patient. However, where appropriate it will be possible to grant leave for the patient to reside at a different hospital whilst the transfer is processed.</td>
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<td>Other comments:</td>
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<td><strong>Burden of proof</strong></td>
<td>The burden of proof upon the detaining authority to establish the criteria for compulsion before the Mental Health Tribunal appears to have been eroded (clause 36(3), 45(2), 56(3)). It has been conclusively established that Articles 5(1) and 5(4) ECHR require the burden to be on the detaining authority (<em>R (H) v Mental Health Review Tribunal; Reid v United Kingdom</em> [2003]). The wording should be ‘If ... the Tribunal is not satisfied that all of the relevant conditions are met ...’ as in section 72(1) of the Mental Health Act 1983. There is no explanation why the latter wording appears in clause 59(1)(b) but not in the earlier provisions mentioned.</td>
<td></td>
<td>Bar Council (DMH 191)</td>
<td>The Government understand the point identified by the Bar Council and will ensure that the drafting of all the relevant provisions is correct and consistent prior to a Bill being formally laid before Parliament.</td>
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<td><strong>Expert Panel Conflicts of Interest</strong></td>
<td>The draft Bill’s failure to address the potential range of conflicts of interest facing Expert Panel members providing reports and evidence to Tribunals is a further serious failing, in the context of the proposed Tribunal.</td>
<td></td>
<td>MHRT Southern region (DMH 200)</td>
<td>Potential conflicts of issue for members of the Expert Panel will be covered in the Code of Practice and Tribunal rules. If a member of the Expert Panel has a personal connection with a patient or has recently treated a patient in a professional medical capacity then it would be inappropriate for that Expert to be selected to deal with that patient’s case. Where an Expert already called upon declares an interest, they would step down and the Tribunal would select a replacement from the panel.</td>
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<td><strong>Time limits</strong></td>
<td>There are also potential problems around time limits. Currently time limits apply to when a hearing has to be heard. There is no mention of this in the Bill, meaning that there will be possible delays in hearings and, ultimately, justice.</td>
<td>Black &amp; Minority Ethnic Mental Health Network (DMH 241)</td>
<td>Time limits will be dealt with in Tribunal Rules. The intention is that patient applications to the Tribunal challenging detention will be heard within 7 days.</td>
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<td><em>Saskatchewan</em> principles</td>
<td>The Saskatchewan principles as a possible model for the use of Community Treatment Orders should be explored.</td>
<td>BMA (DMH 248) Royal College of Psychiatrists (DMH 24)</td>
<td>The Government is aware of the Saskatchewan model and will take it into consideration in developing the provisions to be made in regulations. The prime group it is intended to describe would be patients whose conditions and treatment are already familiar to the clinical team and who have recently been assessed as a hospital inpatient. The regulations are likely to describe the minimum length of earlier hospital admission; confirm whether that period must have been under compulsory powers; and will also need to set the period within which that earlier hospital stay must have occurred. This is a similar approach to that taken in Saskatchewan but the precise detail is to be developed in consultation with clinical practitioners to ensure the aim is achieved without creating an obstacle to sensible clinical decision-making.</td>
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<td><strong>Part 3 Patients Concerned in Criminal Proceedings etc</strong></td>
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<td>87</td>
<td><strong>Remand to hospital for mental health report: preliminary</strong></td>
<td>When a court wishes to send a remand prisoner to hospital for assessment or treatment, there is no route by means of which disputes can be resolved. This can include disagreement between psychiatrists in medium and high secure settings about the required level of security. Where both doctors work under different Strategic Health Authorities, there is no managerial remedy. The court should be empowered to formally request a resolution.</td>
<td>West London Mental Health NHS Trust (DMH 243)</td>
<td>87(a): The Court takes the decision on the basis of the evidence before it of availability of appropriate facilities. In the event that there is a dispute between two facilities, the Court will be entitled to select the option best placed in its opinion to effect the remand and deliver the report to the Court.</td>
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<td>88</td>
<td><strong>Remand to hospital for mental health report</strong></td>
<td>Conditions should include that the court is satisfied that the patient can be admitted to the hospital within a reasonable time scale (e.g. 28 days) (see also clause 96).</td>
<td>Dr G Lodge (DMH 74)</td>
<td>88(a): This power replicates section 35 of the 1983 Act, including the time limits on admission to hospital. Clause 104 states that the court must be satisfied that arrangements have been made for admission to hospital within 7 days. (Subsections (3) and (13)).</td>
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<td>90</td>
<td>Duration of remand or further remand</td>
<td>There is no limit to the number of times a prisoner/patient can be further remanded or committed for reports or treatment. There should be a limit, after which the patient should be referred to a Mental Health Tribunal (see also clause 95).</td>
<td>Dr G Lodge (DMH 74)</td>
<td>Dr G Lodge (DMH 74) 90(a): An offender may not be remanded for report for a period exceeding 16 weeks in total (clause 90 (4)). The court is an independent judicial body and as such it is qualified to detain and to authorise medical treatment whilst an offender is on remand. The remand is subject to regular review by the Court (clause 93(5) and clauses 100 and 101). This enables the offender to receive treatment at the earliest opportunity, if they meet the conditions for compulsory treatment, and for that to continue for the entire period that they are remanded. However, this does not prevent the Court from disposing of the case when in a position to decide the appropriate disposal.</td>
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<td>93</td>
<td>Remand for medical treatment</td>
<td>A person can be remanded to hospital for medical treatment on the evidence of two registered medical practitioners, even if he has not been found guilty of any offence. We do not believe that the simple fact of being subject to criminal proceedings should make a person subject to broader conditions for compulsion than those in Part 2.</td>
<td>Maca (DMH 296) 93(a): Remands for treatment must be considered in the context of a person subject to the criminal justice process. Where a defendant has to be remanded in custody, it will often not be “necessary” to give him treatment for the protection of others. It is not in his interests to be excluded from treatment which he needs, and be remanded in prison, simply because he would comply with treatment. The ability to remand to hospital may be crucial to prompt determination of whether he should, if convicted, receive a mental health disposal rather than a prison sentence. A requirement that treatment be necessary in that context would impede the prompt delivery to the court of information in needs to determine whether diversion is appropriate.</td>
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<td>96</td>
<td>Conditions for medical treatment</td>
<td>The condition at clause 96(3) (appropriate treatment available) is drafted in the same words as for making a Mental Health Order at clause 116(3). If the Bill is passed with the proposed uniform wording, we can see lawyers arguing that it is wrong to detain somebody on the basis that appropriate treatment is available in order to then determine whether “appropriate treatment is available” for another section of the Bill. The Bill should make clear that “appropriate treatment” is interpreted differently in each clause.</td>
<td>Royal College of Psychiatrists (DMH 24) 96(a): “Appropriate medical treatment” has, and is meant to have, the same meaning under both clause 96 and 116. The intention is to enable an offender before the Court to receive treatment both on remand and/ or when the Court makes its final disposal in the form of a mental health order. This ensures that offenders can get treatment for a mental disorder at the earliest possible opportunity. In the event that the court process is incomplete after the maximum of sixteen weeks available for report, the court still needs the ability to order treatment during the remainder of the process; and that treatment must be appropriate. If there is no appropriate treatment, the resort must be to remand in custody.</td>
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<td>99</td>
<td>Care plans</td>
<td>Consideration should be given to requiring all care plans to be subject to Mental Health Tribunal scrutiny after a defined period.</td>
<td>Royal College of Psychiatrists (DMH 24) 99(a): This is primarily a criminal trial process. It is not a civil process of simply applying compulsion.. We believe the emphasis must be on completing the process of trial. The Court has been ordering treatment successfully since 1959, and there is no reason to complicate the process of trial in favour of an additional civil process. In the event that the Court makes a mental health disposal tribunal processes take over.</td>
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<td>There should be an opportunity for patient or advocacy input into the creation of the care plan that is necessitated by a Mental Health Order.</td>
<td>Mind National Organisation (DMH 210) 99(b): Whenever a Part 3 patient is subject to compulsory treatment they do have the right to an advocate whether that is on remand or when a mental health order has been made (see clause 248).</td>
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<td>114</td>
<td>Mental health order: preliminary</td>
<td>Under clause 114(2), to be eligible as the subject of a Mental Health Order, the court need only establish that the person did the &quot;act or omission constituting the offence&quot; and, therefore, the court does not establish whether the defendant had the mental element (mens rea) for the offence. With the exception of strict liability offences, not establishing the mental component of the offence prevents the founding of the defendant's guilt. Following Article 6(2), of the European Convention on Human Rights, the defendant is presumed innocent until proved guilty and, therefore, cannot be held to be criminally responsible for the offence.</td>
<td>Revolving Doors Agency (DMH 324)</td>
<td>114(a): Clause 114(2) replicates section 37 (3) of the 1983 Act. A Magistrates' Court may only use this power where it is satisfied that the person has committed the act with which they have been charged. It provides the flexibility to dispose of a case where, due to someone suffering from mental disorder, the case cannot be tried. This allows the Court to still make a mental health order to treat the disorder, if that is appropriate. A person who is dealt with by the Court in this way has the same right of appeal as any convicted offender. The process of finding unfitness and the trial of facts preserves the rights of the defendant because it does not infer guilt nor apply punishment. Under the current Act this power is rarely used but it ensures that the Magistrates’ Court is fully empowered to make the most appropriate disposal based on individual circumstances. We would wish to see this continue.</td>
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<td>115</td>
<td>Mental health order: care plans, etc</td>
<td>Clause 39(6) requires that the applying clinician must consult the patient (his parents, if under 16), his nominated person and carer. There are no comparable obligations under clause 115, providing a wholly unsatisfactory level of patient involvement in the process.</td>
<td>Revolving Doors Agency (DMH 324)</td>
<td>115(a): As above. See clause 99 answer 2.</td>
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<td>116</td>
<td>Power of court to make a mental health order</td>
<td>There should be greater congruence in the criteria for compulsory treatment for civil patients and those subject to criminal proceedings and under sentence. The Bill provides that any person charged with a criminal offence could be brought within the exercise of compulsory powers if he/she is suffering from a mental disorder of a nature or degree to warrant the provision of medical treatment and where appropriate medical treatment is available. This requires careful consideration, given the broad definition of disorder and treatment, and the number of people with personality or substance-dependency problems who appear in court.</td>
<td>Law Society (DMH 111) MHA (DMH 105) IMHAP, (DMH 50) JUSTICE (DMH 272)</td>
<td>116(a): A Part 3 disposal by the court substitutes compulsion not for liberty but for punishment. If the necessity condition applied to offenders it would mean that a compliant offender could not be diverted from the criminal justice system. The person's compliance with treatment would mean compulsion was unnecessary so he would have to receive a prison sentence. It would also be possible for manipulative offenders to frustrate the order of the court by withholding compliance until a health order was given; and then expressing compliance; requiring immediate discharge from compulsion. Any decision by the Court to divert an offender by way of mental health powers will be based on clinical evidence that there is mental disorder present for which there is appropriate treatment available. The intention, as now, is that if appropriate treatment is available for a defendant, and he meets the conditions, the court has the option of diverting him from punishment. That applies irrespective of the nature of the defendant’s condition. If he does not meet the conditions, he cannot be diverted.</td>
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<td>116(b)</td>
<td>Any difference in the criteria for compulsion between civil and criminal patients needs to be justified by reference to relevant distinctions in their situation. The threshold of risk should not be removed.</td>
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<td>MHA (DMH 105) Revolving Doors Agency (DMH 324)</td>
<td>116(b): As above.</td>
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<td>116(c)</td>
<td>It is possible that Mental Health Orders could be used to give compulsory treatment to people who could not otherwise be made subject to it, and whose mental disorder is not considered to have been a factor in their offending behaviour, nor likely to lead to future offending behaviour... we do not believe that a criminal conviction, or being placed on remand, should make people subject to compulsion by a 'back door'.</td>
<td></td>
<td>Maca (DMH 296)</td>
<td>116(c): Government policy since 1959 has been that mentally disordered offenders should be treated rather than punished wherever that can be achieved subject to the needs of public safety. Accordingly the offending behaviour does not have to be caused by the disorder. Indeed it is rare for that connection to be capable of objective proof. So this proposal would run contrary to established mental health policy for offenders and would mean they were treated less favourably than civil patients in terms of service provision.</td>
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<td>116(d)</td>
<td>The failure of the Bill to treat detained patients in the same way as non-detained patients by depriving them of the right of autonomy is discriminatory. It may violate Articles 3 and 8 of the ECHR.</td>
<td></td>
<td>The Bar Council (DMH 191) Mind National Organisation (DMH 210)</td>
<td>116(d): Under this clause the court may order that the medical treatment should be provided to the person either as a resident or non-resident patient. When a decision is taken under the Bill that a person should be treated under compulsion, any decision on whether to treat someone as resident or non-resident would be based on clinical evidence determining the appropriate setting for that person to receive treatment.</td>
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<td>117(a)</td>
<td>The court should be under a duty to appoint a member of the Expert Panel to assist in approving care plans.</td>
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<td>MHA (DMH 105) Law Society (DMH 111)</td>
<td>117(a): The Crown Court’s power to make a mental health order based on the care plan is based on a requirement to consider clinical evidence. The court will have to be satisfied that the treatment advocated is actually available and will be able to call on the expert panel if it needs further advice. The Crown Court has been making mental health disposals since 1959. Judges are therefore already experienced at considering mental health issues and the most appropriate disposal for an individual in such circumstances. It also considers fitness to plead under insanity legislation, which means it already has to consider complex medical evidence to make the most appropriate decision as to the disposal.</td>
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<td>117(b)</td>
<td>The court should be obliged to hear the evidence of a multi-agency panel of mental health experts.</td>
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<td>Revolving Doors (DMH 324)</td>
<td>117(b): The Court will consider evidence from the approved clinician about the mental disorder and the treatment that will be provided. It may also consult the Expert Panel should it wish to do so. In addition, the Court has access to a range of information as part of the normal court processes which will give a broader perspective on the issues before the Court and how best to dispose of the case.</td>
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<td>118</td>
<td>Mental health order: contents, etc.</td>
<td>In principle criminal courts should not be able to make care and treatment orders because they lack the benefit of the experience and expertise of the Mental Health Tribunal. These should, in all cases, be made by a Mental Health Tribunal.</td>
<td>MHA (DMH 105)</td>
<td>118(a): The Courts have considerable experience at considering mental health disposals as they have had to do so since 1959. Where they require further input they may consult the Expert Panel.</td>
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<td>Persons subject to Part 3 will lack the safeguards of civil patients. They should have the right to appeal to a Tribunal.</td>
<td>MHA (DMH 105)</td>
<td>118(b): Persons subject to Part 3 will be those subject to the criminal justice process. Any compulsion will be an alternative to punishment, not a primary infringement of their liberty. The Court, like the Tribunal, is an independent judicial body. It has the authority to make a mental health order. It would not be appropriate for the Tribunal, which has no criminal justice locus, to be an appellate tier for decisions of the Court. Restricted patients can apply to the Tribunal after six months of the order being given if they wish consideration to be given to the discharge or amendment of that order (clause 144). Unrestricted patients’ compulsion will end automatically after six months unless the tribunal makes a fresh order under Part 2 powers. In addition, offenders given a disposal under Part 3 have the same rights of appeal to a higher court as any other offender if they wish to appeal the decision of the Court.</td>
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<td>Courts could authorise care plans which include electro convulsive therapy and there is a clear danger that defendants could see such treatment as part of a punishment for an offence.</td>
<td>Bexley Mind (DMH 120)</td>
<td>118(c): The Government is aware of the serious implications of the use of electro convulsive therapy (ECT) and has therefore provided clear criteria within the Bill which state when it may be used. The ECT provisions and safeguards for civil patients apply in exactly the same way for offenders. This means that where someone has capacity they can refuse ECT, except in the case of an emergency. Where they do not have capacity there are procedural safeguards in place to scrutinise any proposed use of ECT. The court would have access to the advice of the Expert Panel in considering whether ECT should form part of a care plan.</td>
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<td>119</td>
<td>Mental health order: resident and non-resident patients</td>
<td>There is a risk that community teams will lack the skills to support people remanded in the community, or that doing this will divert resources from other groups of service users.</td>
<td>Royal College of General Practitioners (DMH 222)</td>
<td>119(a): Community teams already have experience of dealing with mentally disordered offenders in the community. Uniquely for patients subject to sanction under the 1983 Act conditionally discharged restricted patients have been managed successfully in the community since 1959. The Government does not accept arguments that mentally disordered people who have offended should fare worse in the allocation of services.</td>
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<td>127</td>
<td>Restriction orders: transfers and leave of absence</td>
<td>(4) The patient’s clinical supervisor may with the consent of the Secretary of State give the patient leave of absence from the hospital or hospital unit in which he is detained, subject to such conditions (if any) as the clinical supervisor thinks fit.</td>
<td>Bar Council (DMH 191) West London Mental Health NHS Trust (DMH 243) Lucy Scott Moncrieff (DMH 304) Dr Horne (DMH 308)</td>
<td>127(a): This overlooks the distinct roles of the Secretary of State and the tribunal. The tribunal is not constituted to perform risk assessments, but to protect the patient’s rights. It is only on the basis of independent risk management for restricted patients that they can be diverted from prison sentences. The current system works exceptionally well with low rates of recidivism, and effective protection for the rights of restricted patients. The Secretary of State does not intend to give up a system which works well.</td>
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<td>133</td>
<td>Transfer for mental health report of sentenced persons etc</td>
<td>If medical treatment is needed then it should be provided. The apparent discretion of the Secretary of State not to authorise the transfer of a prisoner to hospital should be replaced by a duty to authorise it.</td>
<td>Dr Horne (DMH 308)</td>
<td>133(a): Serving prisoners are offenders whom the Court has decided should receive a prison sentence. The Secretary of State’s primary responsibility is to protect the public from further harm. That is why he has a discretion and not a duty to transfer prisoners for treatment. In the event that he failed to direct the transfer of a prisoner to receive necessary medical treatment where the risk to others was appropriately addressed he would be liable to a challenge of unreasonableness.</td>
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<td>136</td>
<td>Termination of transfer for treatment</td>
<td>For prisoners who are compulsorily detained and treated in psychiatric hospital but who then return to prison, the Bill should specify a statutory requirement for care planning during the remainder of their sentence and after their release.</td>
<td>NACRO, (DMH 156)</td>
<td>136(a): The Government is sympathetic to the practical intent of this; which should be achieved as part of the NHS Prison In-reach programme. Practical implementation is however a matter for guidance rather than primary legislation.</td>
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<td>Other comments:</td>
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<td>Nominated Persons</td>
<td>The safeguards of a nominated person should apply to patients subject to the powers in Part 3 of the Bill.</td>
<td>MHA (DMH 105) MIND (DMH 210)</td>
<td>Restricted patients do not have a Nominated Person, just as they do not currently have a nearest relative. Restricted hospital orders are criminal disposals which follow the most serious offences. The court has concluded that protection of others has to prevail over other considerations and their management must be delivered on that basis. Unrestricted patients by contrast will have nominated persons.</td>
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<td>Advocates</td>
<td>It is recommended that advocates should be available to those people for whom a care plan is being drawn up; therefore before a Mental Health Order is made.</td>
<td>MHA (DMH 105)</td>
<td>As above. See clause 99(b).</td>
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<td>The right to a Mental Health Assessment</td>
<td>We believe that the right to a mental health assessment should be enshrined in the Bill and should also be extended to prisoners, whether sentenced or on remand.</td>
<td>NACRO (DMH 156)</td>
<td>Under the Bill anyone may request a mental health assessment, therefore including prisoners.</td>
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<td><strong>Identified mental health needs or prisoners not subject to compulsory treatment</strong></td>
<td>Where compulsory treatment is not needed but where there are identified mental health needs that would benefit from support and treatment in the widest sense, this should be provided by community based mental health services working alongside the relevant prison staff (again probably through prison in-reach, as currently being piloted in a number of prisons).</td>
<td>NACRO (DMH 156)</td>
<td>The Bill is about the use of compulsion, therefore where someone does not meet that threshold it is not an appropriate area to be dealt with in this legislation. The mental health needs of prisoners are a serious issue that the Department of Health and other bodies are taking steps to address through increased investment in mental health services and an increase in prison in-reach.</td>
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<td><strong>Part 4 Cross Border Provisions</strong></td>
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| **161** | **Transfer of patients from England and Wales**  
(10) The transfer of a patient to a relevant territory is subject to any provision having effect in that territory requiring that conditions are met before a person may be transferred to that territory. | Legislation in different parts of the United Kingdom should not have substantially different provisions. Should the current proposals be adopted in England and Wales a person who met the conditions for compulsion in England or Wales may not do so in Scotland or Northern Ireland. A person from Scotland, detained in England, may be unable to be transferred back to Scotland because he does not meet the conditions in that jurisdiction. | Royal College of Psychiatrists (DMH 24) | 161(a): It is an inevitable result of devolution that the conditions for compulsory treatment may differ in different parts of the UK, but this is a matter that will be taken into account when considering a transfer. Patients who are receiving compulsory treatment can be transferred from England and Wales to relevant territories if it is determined that the transfer would be in the patient's interest. Work by the Scottish Executive on the rules of cross border transfers is still ongoing, however the Government understands that all patients transferred into the country will be treated as meeting the conditions prior to a re-assessment. |

| **Part 5 Medical Treatment** | | | | |
| **177** | **ECT: general** | The nominated person should be notified and (if the patient wishes) an advocate involved if ECT is being considered. | MHA (DMH 105) | 177(a): It is expected that plans for ECT would normally be set out in a patient’s care plan and the Bill contains provisions for consulting the patient’s nominated person about the care plan. Regulations may also be made under clause 190 to allow notification to be given to the patient and other persons when a certificate authorising ECT has or has not been given. In developing those Regulations, the Government will consider the MHA view about notifying nominated persons. The patient will have access to the advocacy service under the general provisions of the Bill.  
177(b): The Government would expect advance statements to be taken into account when ECT is being considered for a person without capacity. However, the issue is complex and the right balance needs to be struck. We are currently considering the position of advance directives in relation to ECT. |

Advance directives should have legal force with regard to ECT treatment. | U Parker (DMH 231) | | |
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<td>It will be too easy in practice for consultants to by-pass the protective scheme set out for ECT.</td>
<td>No Force (DMH 44); IMHAP (DMH 50)</td>
<td>177(c): It would not be possible for a consultant to bypass the protective safeguards. Where a patient with capacity refused ECT, ethical standards, professional guidance and multi-disciplinary working would ensure that a consultant would not easily consider the patient to lack capacity. Where a patient lacks capacity, a tribunal has to decide whether the patient should receive ECT. The tribunal must be satisfied that the patient is not capable of understanding the nature, purpose or likely effects of the course of ECT. The tribunal is entirely independent, and so there would be an additional and independent assessment of capacity. In emergencies, for people without capacity, the clinical supervisor would need to certify that one or more of the emergency treatment conditions (clause 182) in respect of ECT is met; and there is a limit to the length of time the certificate permitting emergency ECT has effect (clause 184(3)). The draft Bill does not permit emergency ECT for people with capacity, although there is a regulation-making power – see below.</td>
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| 179    | **ECT: patient capable of consenting** | ECT should never be given to patients capable of consenting, without their consent. | E Stark (DMH 23)  
S Dawes (DMH 37)  
MHA (DMH 105)  
NACRO (DMH 156);  
British Psychological Society (DMH 19)  
ForUS & MIND  
Wales (DMH 36) | 179(a): The Bill seeks to strike a balance between maximising the autonomy of patients and ensuring that they get the treatment they need. In the current draft Bill, patients with capacity cannot be given ECT in any circumstances unless they consent. There is however a regulation-making power, in clause 183, to permit the provision of ECT in an emergency to a patient with capacity. An emergency would mean that treatment was needed immediately to save the patient’s life, or to prevent serious deterioration in their condition, or to alleviate serious suffering. The reason for this regulation-making power is that there is uncertainty about whether anyone who meets the criteria for emergency treatment would have capacity, and so there is uncertainty about whether any provision is needed for emergency treatment for people with capacity. The Government believes that provision needs to be made for emergency ECT for people with capacity to avoid the possibility that such patients might otherwise miss out on essential treatment. Further work is currently being carried out on this issue, including consultation with stakeholders and discussions with focus groups. |
<p>|        | | Treatments such as ECT should be subject to ratification by a tribunal even if patients are able to give informed consent. | | 179(b): The Government’s view is that a patient who has capacity should be allowed to determine whether or not they should have ECT, without ratification by a tribunal. The patient’s clinical supervisor will have to certify that the patient has had the nature, purpose and likely effects of ECT explained to them before they consented and that the patient was capable of understanding the nature, purpose and likely effects. |
|        | | The patient should be required to sign certificate indicating consent to ECT. | | 179(c): It would be normal practice for patients to give written consent to treatments such as ECT, and such consent being kept with the clinical notes. The need for provision on the face of the Bill is being considered. |</p>
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<td>180</td>
<td>ECT: patient not capable of consenting</td>
<td>The position with regard to incapable patients remains unclear in that it applies only to those patients who are registered under the Bill. It fails to address the question of whether a patient without capacity can be given ECT if they are not detained under the Bill. Can it be given under the general powers in the Mental Capacity Bill? Where patients lack capacity, ECT should only be given where it has been authorised by a Tribunal or the High Court, even in an emergency. ECT should be prohibited for persons not able to give informed consent.</td>
<td>W Leason (DMH 131), MDA (DMH 230), NACRO (DMH 156), British Psychological Society (DMH 19), MHA (DMH 105)</td>
<td>180(a): This issue is outside the scope of the draft Mental Health Bill. The provisions on ECT in Part 5 of the Mental Health Bill apply only to people under compulsion under the Bill. 180(b): The reason why there are separate provisions for ECT in an emergency is because, on occasion, in an emergency situation, there is not time to go to the tribunal or High Court. The clinical supervisor would need to certify that one or more of the emergency treatment conditions (clause 182) in respect of ECT is met. The regulation-making powers in relation to clause 184 will be used to ensure that the scope to use ECT in an emergency without tribunal authorisation is not abused. 180(c): ECT can be very helpful, and occasionally lifesaving, for some people and to deprive people without capacity to consent of those benefits is considered to be wrong. Evidence was presented to the Committee by the Royal College of Psychiatrists of extreme situations where a patient without capacity has benefited from ECT. Additionally, tribunal authorisation will ensure that there is independent authorisation of the use of ECT.</td>
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<td>181</td>
<td>Medical expert</td>
<td>The medical expert considering applications to use ECT without consent should be required to consult any advance statement and the nominated person and/or advocate.</td>
<td>ForUS &amp; MIND Wales (DMH 36)</td>
<td>181(a): The Government would expect advance statements to be taken into account when ECT is being considered for a person without capacity. However, the issue is complex and the right balance needs to be struck. We are currently considering the position of advance directives in relation to the use of ECT. The Bill provides for nominated persons to be consulted about a patient's treatment, including ECT, and the patient would have a right to an advocate if ECT was under consideration.</td>
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| 182    | Emergency ECT: conditions | The emergency criteria for ECT for those incapable of giving consent should be restricted to saving life. | MHA (DMH 105) National Voices Forum (DMH 240) Matrix Advocacy Service (DMH 169) | 182(a): The Bill seeks to strike a balance between maximising the autonomy of patients and ensuring that they get the medical treatment they need. The Government’s view is that the criteria for emergency treatment are sufficiently restrictive to ensure that a balance is achieved.  
182(b): The Government agrees that normally there would be no need for emergency ECT, as treatment decisions would usually be taken sufficiently in advance to avoid a crisis situation. There may, however, on rare occasions (as is the case under the 1983 Act – the last survey showed a rate of emergency ECT of about 10%) be the need for emergency ECT at short notice, and it is important to have the scope to provide this (with safeguards). There is evidence to suggest that some patients present symptoms late, and their “gradual decline” is over by the time services are involved. Monitoring of the use of the emergency ECT provisions will ensure that the provisions are not abused. The plans for implementation of the proposed legislation are designed to ensure that tribunal hearings will be held promptly, so that the need for emergency ECT will be avoided apart from in rare cases. |
| 183    | Emergency ECT: patient capable of consenting | (1) The appropriate authority may by regulations provide that, if a certificate [given by the patient’s clinical supervisor] to which subsection (2) applies is in force –  
(a) the prohibition in section 178(1) does not apply in relation to a course of ECT, and  
(b) the patient’s consent is not required for the provision to him of the course of ECT  
It is difficult to envisage circumstances where the emergency power will apply yet the patient would retain capacity. | IMHAP (DMH 50) Law Society (DMH 111) S Johnson (DMH 167) | 183(a): The arrangements will be set out in law. They will be set out in regulations which will be subject to affirmative resolution and, therefore, be subject to full debate in both Houses of Parliament.  
183(b): It is recognised that there are some professionals who consider that anyone who needs ECT in an emergency would not have capacity. There are, however, other professionals who believe that people needing emergency ECT might have capacity. The Government therefore considers that provision needs to be made for emergency ECT for people with capacity to avoid the possibility that people might otherwise miss out on essential treatment. |
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<td>185</td>
<td>ECT: patient aged under 16 (2) A relevant patient aged under 16 may not be given any ECT, except as provided in....</td>
<td>ECT should never be given to children or young people. The age limit over which ECT can be given is too low. Because of the seriousness of the procedure, and the greater vulnerability of young people to be damaged by it, the threshold for safeguards for young people should be 18 and not 16.</td>
<td>MIND (DMH 210) UKAN (DMH 2.27) MHA (DMH 105) Manic Depression Fellowship (DMH 290)</td>
<td>185(a): ECT is given exceedingly rarely to under 16s and, when it is given, it is almost always given to older children (over 13 years). The Government recognises that there are concerns about the use of ECT for children. It also recognises that in those few cases where it is used it can be for real benefit to child patients and may be lifesaving. The Royal College of Psychiatrists gave an example of its use in oral evidence to the Committee. We believe that the answer is not to have an outright ban of ECT for children but instead to have specialised safeguards that deal with the issues particular to children, as well as the concerns about ECT. The Bill provides that, except in an emergency, no child should be given ECT without the agreement of the tribunal or the High Court. The tribunal or Court must consider the views of professionals and of all with parental responsibility along with those of the child. 185(b): The Bill provides for 16 and 17 year olds to be treated as adults. The nature of any boundary or threshold is that it may not exactly reflect the point at which all young people meet maturity. It is thought appropriate that 16 and 17 year olds should be treated as adults in terms of mental health legislation.</td>
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<td>194</td>
<td>Type A medical treatment: patient not capable of consenting (2) This subsection applies to an authorisation of the course of type A medical treatment given by the High Court.</td>
<td>The provision for allowing psychosurgery by High Court order should be excluded from the Bill, and the current safeguards in the 1983 Act maintained. Because of its hazards and lack of clear evidence for the treatments benefit in general, or basis of predicting its success in the individual concerned, it should never be given to a person who does not have the capacity to consent to it.</td>
<td>MHA (DMH 105) MIND (DMH 210) National Voices Forum (DMH 240)</td>
<td>194(a): Psychosurgery is very rarely used. It is considered a treatment of last resort. There have, however, been very occasional cases where it has been considered that it would have been beneficial to people who lack capacity (as long as there were very strong safeguards). We therefore think it is wrong to deny them the possibility of such benefit, so long as there are adequate safeguards.</td>
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<td>196</td>
<td>Type B medical treatment (1)... “type B medical treatment” means such descriptions of medical treatment as may be specified as such in regulations made by the appropriate authority. (2) Regulations under subsection (1) may not specify – (a) ECT, or (b) any type A medical treatment.</td>
<td>Any other aggressive treatments are not defined in the Bill and are simply categorised as “type B” as may be specified as such in regulations.” Doses in excess of British National Formulary limits, and cocktails of medications (i.e. combinations of 4 or more medications) require additional safeguards before they can be used.</td>
<td>MIND (DMH 210), National Voices Forum (DMH 240), Manic Depression Fellowship (DMH 290)</td>
<td>196(a): The Bill provides a mechanism for introducing safeguards for what are currently designated as “type B” treatments. The category is not formally defined to allow for the inclusion of other treatments requiring safeguards in the future, should evidence suggest other treatments need such safeguards. There are, however, no plans at present to use this power. The Government believes that levels of prescribing, multi-drug prescribing/polypharmacy and the types of drugs prescribed are issues that are best dealt with as matters of best practice, rather than through legislation.</td>
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<td>197</td>
<td>Regulation of type B medical treatment (2)... regulations may include provision as to the cases in which the prohibition on type B medical treatment does not apply in relation to the giving of a course of such treatment to such a patient. (3) These cases may include cases in which – (a) a clinical supervisor has been appointed for the patient.</td>
<td>The fact that a clinical supervisor has been appointed should not, of itself, be sufficient authority to provide type B medical treatment.</td>
<td>For Us &amp; MIND Wales (DMH 36)</td>
<td>197(a): The appointment of a clinical supervisor does not, in itself, mean that there is authority to provide type B treatment. The provisions in clause 197(3) are designed to clarify the circumstances in which type B safeguards will be applied.</td>
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<td>199</td>
<td>Compulsory treatment of Part 2 patients</td>
<td>The consent of a compulsory patient ... is not required for the provision to him of any medical treatment to which this section applies...</td>
<td>David Hewitt (DMH 21), Tees &amp; NE Yorks NHS Trust (DMH 196), GMC (DMH 329)</td>
<td>199(a): The special safeguards provided for in Part 5 of the Bill relate to treatments which are particularly invasive and/or sensitive and are only given under strict controls. See above for why those safeguards are not considered appropriate for polypharmacy and dosages above recommended limits.</td>
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Other comments:
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<td>Omissions</td>
<td>The Bill abolishes the existing right of patients to an independent, binding, second-opinion concerning the appropriateness of the medication they are forced to take. This seems contrary both to common-sense and recent court decisions, so that we doubt whether it complies with the European Convention.</td>
<td>The Bill introduces different independent safeguards for patients to the 1983 Act, in particular independent authorisation by the tribunal of all cases within 28 days, with advice from an independent expert doctor. This authorisation includes approval (and therefore an independent opinion) of the patient's care plan.</td>
<td>IMHAP (DMH 50)</td>
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<td>There is nothing in the legislation to prevent treatment being given in unsafe conditions by inadequately trained staff - a real possibility as audits of ECT show. The law should require compliance with national standards.</td>
<td>The Bill concerns the circumstances in which people with mental health problems can be treated without consent, and sets out the processes for treating them, and safeguards for the patients. It does not cover treatment standards, which are ensured through other methods, eg accreditation of professionals' training, inspection of services by the Healthcare Commission, BMA and NICE guidelines.</td>
<td>MHA (DMH 105)</td>
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<td>The Bill should be amended to include provision for emergency administration of medication for mental disorder, modelled upon the clauses providing such powers in respect of ECT.</td>
<td>The Bill provides that no treatment, including medication, can be given until a care plan has been developed, except in an emergency – and the care plan must be authorised by the tribunal within 28 days. The special safeguards for ECT are not considered necessary for medication.</td>
<td>MIND (DMH 210)</td>
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<td>National guidance on drug treatments should be incorporated into a mandatory Code of Practice.</td>
<td>As above.</td>
<td>MIND (DMH 210)</td>
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<td>The hazardous nature of psychiatric drugs, and the bad experiences that some patients have had, justifies inclusion in the Bill of an offence of reckless prescribing, to afford some protection against the worst practices.</td>
<td>As above.</td>
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| Clinical supervisor | In an emergency the clinical supervisor can authorise ECT. Where the clinical supervisor is not a doctor this should be prohibited. | The clinical supervisor should seek to provide treatments that the patient is willing to accept, and should seek the informed consent for each treatment being proposed. People with capacity should be able to refuse any treatment, including drug treatment. | BMA (DMH 248)  
Bevan Brittan Solicitors DMH 297  
MIND (DMH 210) | Clinical supervisors will work as part of a multidisciplinary team. Where emergency ECT is being considered, we agree that the clinical supervisor should normally be a doctor. If they were not a doctor, then the clinical supervisor would not be able to authorise ECT without the independent advice of a doctor that it was necessary. This will be dealt with in the Code of Practice.  
The Government agrees that, wherever possible, treatment plans should be agreed with the patient. There are, however, occasions when patients refuse treatment, or refuse a particular treatment, which is considered essential for the patient. It is on those occasions that treatment may need to be carried out without consent. |
<p>| Part 6 Informal Treatment of Patients aged under 18 | Qualifying child patients | The proposal to create a ‘qualifying child’ status adds complexity to an already confused scenario. | National Children’s Bureaux &amp; Children’s Legal Centre (DMH 194) | 204(a): In treating children and young people for mental disorder, mental health practitioners have tended to apply the common law on consent and treatment. This means that where children are able to make decisions about their treatment they may consent to, but not refuse, treatment. Where children refuse treatment, it may go ahead without legal compulsion if a parent consents. This can lead to difficult situations where children who are able to make decisions have been treated against their will, without the protection of statutory procedures and few legal safeguards. The Bill makes specific provisions to address this; young persons of 16 or 17 are treated as adults for the purposes of treatment for a mental disorder. For children under 16 who resist treatment, there are special safeguards. The safeguards for a ‘qualifying child’ are targeted at a specific group of children, where the nature of child’s mental disorder is most likely to require invasive treatment and detention in hospital against the child’s own wishes. Children in these circumstances currently have few safeguards. |</p>
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<td>Statutory safeguards should be extended to all children and young people in inpatient settings.</td>
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<td>Barnardo's (DMH 315)</td>
<td>204(b): There is a need to ensure that any intervention into family life is proportionate to the problem it is intended to address. The safeguards are targeted at those children most in need of protection – where the nature of the child’s mental disorder will require intensive treatment in hospital against the child’s own wishes. The proposals are intended to strike a fair balance between the rights of the child and the parents' right. Where the child himself, those with parental responsibility and those with clinical responsibility all agree treatment is necessary the Government believe it would be unnecessarily intrusive to formalise the procedure. Given the demands on the CAMHS workforce, the Government believe it is right to concentrate resources on those cases where there is clearest evidence of need.</td>
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<td>207</td>
<td>Assessment for safeguards: child patients</td>
<td>The criteria for under 16s should be reconsidered. They combine with a widened definition of ‘mental disorder’ and will cover a large number of young people with behavioural problems (known as ‘conduct disorder’) whose behaviour would not meet the threshold for diagnosis (with ‘personality disorder’) in adults. The breadth of the definition coupled with the absence of exclusion will have a significant impact on Child and Adolescent Mental Health Services and services for children and young people with learning disabilities.</td>
<td>Young Minds (DMH 64) Royal College of Psychiatrists (DMH 24)</td>
<td>207(a): It is not the Government’s intention to increase the number of people subject to the compulsion. It is important to have a single broad definition and to avoid introducing specific criteria for different groups, whether that is based on a diagnosis e.g. personality disorder or other co-existing problems which may require specialist expertise in diagnosis. The conditions provide that compulsion can be applied where the professional decision-makers conclude it is necessary, proportionate and appropriate. The Government’s view is that the conditions as a whole would not cause anyone to be subject to compulsion inappropriately.</td>
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<td>At least one medical assessment prior to use of the powers in the Bill should be by a doctor specialising in the assessment and treatment of children and adolescents.</td>
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<td>Royal College of Psychiatrists (DMH 24) Barnardo’s (DMH 315)</td>
<td>207(b): There may be times of crisis where a child who has not previously received treatment for a mental disorder, becomes seriously ill quickly. Where there are no lawful alternatives the child may need to be treated under mental health legislation. In these circumstances, it may be of vital importance that the child receives appropriate treatment quickly. Restricting the need for assessment to a psychiatrist specialising in the assessment of children may lead to unnecessary and lengthy delay in accessing appropriate treatment. It is recognised that access to 24 hour cover by CAMHS specialists is not universal. This need for increase numbers of CAMHS specialists is highlighted in the Children’s NSF as an important area for improvement and development but this will take time to deliver.</td>
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(7) The sixth condition is that the treatment can lawfully be provided to the patient without him being subject to the provisions of Part 2.

A Gillick/Fraser ‘competent’ child should be empowered to make his or her own decisions to the same extent as an adult. Use of parental authority alone to give treatment to children under 16 is at odds with the increasingly early maturity of children and the concept of Gillick competency.

Consideration should be given to clarifying the issue of consent, in particular the setting of legislative criteria for consent given by children and when and in what circumstances consent by children, or lack of consent, can be overridden.

There seems to be no assistance in dealing with the difficult question of young patients with fluctuating competence, on which current common law is confusing and unhelpful.

The issue of consent can be complex and extends beyond mental health into other areas of life and as such the Mental Health Bill is not the appropriate vehicle for addressing the issue beyond the changes proposed for those suffering from a mental disorder. The Government believes that this is an area where those professionals treating children and young people are best placed to use their professional judgement about whether a child has capacity. Professionals will take into account a child’s capacity to consent to the proposed treatment, the nature, likely impact and duration of the treatment, as well as the view of those with parental responsibility and the professional opinion of colleagues. Professionals are best placed to judge the weight to be given to a child’s view, which may fluctuate. The Code of Practice will provide guidance on the issue of children’s consent to treatment in a mental health context.

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<td>209</td>
<td>Advocacy and appointment of nominated person: qualifying child patients</td>
<td>Where the patients is a child, the advocate should be a specialist in children.</td>
<td>Young Minds (DMH 64)</td>
<td>209(a): The Government agrees that those working with children should, wherever possible, be child specialists. However, the Government would not want to create an unintended barrier that might prevent a seriously ill child receiving the support and help they need. The Code will make clear that where possible advocates should be child specialists.</td>
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<td>210</td>
<td>Preparation of care plan for qualifying child patient</td>
<td>It should be provided on the face of the Bill that care plans should provide for the family, educational and after care needs of children.</td>
<td>Young Minds (DMH 64)</td>
<td>210(a): The care plan requirements are intended to ensure that there is a properly considered plan for the care and treatment of the child. The care plan must include a description of the medical treatment (as defined in the Bill) which is to be provided to the child and any other information relating to the care of the child. The Code of Practice will provide guidance on meeting the needs of the family, educational and after care needs of children.</td>
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<td>The care planning process should reflect best practice under the Children Act 1989 and meet the requirements of the Children Bill 2004, with children's views and wishes at its core.</td>
<td></td>
<td>Barnardo's (DMH 315)</td>
<td>210(b): The Government agrees that care plans should reflect existing best practice. In providing special safeguards to children who are refusing treatment but who are being treated by virtue of their parents’ consent the intention is to give the child a greater say and involvement in their treatment. Children should be kept as fully informed as possible about their care and treatment, and their views and wishes ascertained and taken into account, having regard to their age and understanding. The Bill makes clear that in drawing up the care plan the clinical supervisor must consult the child, unless it is inappropriate or impractical to do so. A copy of the care plan must be sent to the child along with a number of other people. The clinical supervisor is required to keep the care plan under review and consult with the child if changes are proposed.</td>
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<td>At the very least there should be a requirement that a child specialist should be consulted in relation to the care plan of a child.</td>
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<td>Mental Health Alliance (DMH 105)</td>
<td>210(c): The Government agree that where possible those involved in the care and treatment of children should be child specialists. Where this is not possible, it would be good practice for clinical staff caring for the child to have access to a CAMHS professional for advice and consultation.</td>
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<td>There should be a duty on hospital managers to ensure assessment of family needs, and to ensure that appropriate provision is included in the care plan.</td>
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<td>Young Minds (DMH 64)</td>
<td>210(d): Where a parent is subject to formal powers, it is important to ensure that the needs of children and young people are considered while the parent is under compulsion and on their discharge. The guidance on Fair Access to Care Services draws attention to the need to attend to any family needs arising from parental responsibilities. Under the Children Act 1989, the local authority social services have a duty to safeguard and promote the welfare of children in their area. The Social Care Institute for Excellence (SCIE) also launched a parental mental health and child welfare network in July 2004. The aim of the network is to join up work between adult mental health services and childcare services to see that parents and children get the support they need. In 2005, SCIE, with support from the Department of Health, will undertake a systematic review of evidence and existing practice by health and social care services in supporting parents with mental health needs, including meeting the needs of ethnic minorities. The review will draw out key messages for good practice and identify where more research is needed. It is proposed that SCIE will then draw up national practice guidelines.</td>
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<td>218</td>
<td>Application to Tribunal for discharge of qualifying child patient</td>
<td>Powers relating to discharge should also take account of the provisions for ‘qualifying children’ under the Leaving Care (Children) Act 2002.</td>
<td>National Children’s Bureaux &amp; Children’s Legal Centre (DMH 194)</td>
<td>218(a): The Government believes this is best dealt with in the Code of Practice, which will cross-refer to existing guidance on the Children Act 1989 (as amended by the Children (Leaving Care) Act 2000).</td>
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<td>219</td>
<td>Tribunal proceedings under Chapter 2</td>
<td>At least one member of the Mental Health Tribunal must have specialist knowledge in relation to the care and treatment of children and adolescents.</td>
<td>Royal College of Psychiatrists (DMH 24) Young Minds (DMH 64)</td>
<td>219(a): The aim is to ensure that the Tribunal does have access to specialist advice, whether through the Tribunal membership or the reports provided by the Expert Panel. The further investment in improving CAMHS will mean that the number of specialist professionals available to contribute to the work of Tribunals will increase over time.</td>
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<td>(3) .... the Tribunal in question – (a) must appoint a member of the Expert Panel who is a registered medical practitioner (the “medical expert”).</td>
<td>The medical member of the Expert Panel must be a doctor specialising in the assessment and treatment of children and adolescents.</td>
<td>Royal College of Psychiatrists (DMH 24)</td>
<td>219(b): See response 219(a).</td>
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<td>(4) On the making of an application to it under section 216 in respect of a patient the Tribunal in question – (a) may appoint one or more members of the Expert Panel...</td>
<td>Inclusion of expert panel members should not be at the discretion of the Tribunal, rather it should be a statutory requirement where the Tribunal is considering the care and treatment of a minor.</td>
<td>Barnardo’s (DMH 315)</td>
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<td>Other comments:</td>
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<td>Duty to provide age appropriate services</td>
<td>There should be a duty on health authorities to provide age-appropriate accommodation for under-18s subject to the Bill or needing in-patient treatment.</td>
<td>Royal College of Psychiatrists (DMH 24) MHA (DMH 105) Young Minds (DMH 64)</td>
<td></td>
<td>The Government agrees that, where possible children and young people should be accommodated with others of a similar age and in appropriate age-related accommodation, but it is important not to create a barrier that could result in a seriously ill young person or child not receiving the treatment they need. There may be situations where age appropriate accommodation does not always correlate with clinically appropriate accommodation. There needs to be sufficient flexibility for older adolescents to be treated within adult services where this is the safest, most protective and least restrictive option. The principle of flexibility (and choice) is enshrined in the Children’s NSF.</td>
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Wherever young people are admitted to adult wards the law should require the clinical supervisor to obtain advice from a children's clinical specialist.

The Government agrees that those working with children and young people should, where possible, be child and adolescent mental health specialists. There should be appropriate liaison in place with CAMHS and, when appropriate, either advice from CAMHS staff or their involvement in the care of a young patient. It would be inappropriate for such a requirement to be enshrined in law, when for instance it might not be required in the case of a 17 year old or when it would be impractical, for example, in the case of a brief and temporary short admission. The Code of Practice will set out the guiding principles for practitioners working with children with serious mental disorder.

There should be an obligation on commissioners to ensure sufficient numbers of doctors specialist in the assessment or treatment of Children and Adolescent are available to meet the provisions of this Bill.

Health and social services have responsibilities to meet the needs of people with mental health problems, and they have been funded to do so. Considerable additional funding has gone into mental health services in the last few years to make sure the services are there. The Government is making an additional investment of approximately £300 million for Child and Adolescent Mental Health Services (CAMHS) in the three years to 2005-06. This money will make it possible to build capacity, improve access and help deliver a comprehensive CAMH service across the country. It would be difficult to place commissioners under a legal obligation in situations where there may be recruitment difficulties over which they have no control. It is recognised that access to 24 hour cover by CAMHS specialists is not universal. This need for increase numbers of CAMHS specialists is highlighted in the Children's NSF as an important area for improvement and development but this will take time to deliver.

There has been a steady increase in the numbers of Consultant Child Psychiatry posts over the last decade and this increase is set to continue. However, there are still places in the country where recruitment into posts remains difficult. Local initiatives will be required, with attention being paid to new ways of working and service re-design, if these workforce shortages are to be addressed. The National CAMHS Support Service in conjunction with NIMHE are able to assist services at local level in this work.

Regulations should stipulate that only in exceptional circumstances would it be acceptable for a non-specialist to supervise a young person’s care.

The Government believes that this is best addressed in the Code of Practice, which will make clear that those involved in the care and treatment of children and adolescents should, wherever possible, be child specialists.
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<td>Educational Provision</td>
<td>There should be a duty on hospital managers, where the patient is a child, to ensure appropriate educational provision (unless the child is past school leaving age and has left education other than because of his / her mental illness).</td>
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<td>Young Minds (DMH 64) Hampshire Partnership NHS Trust (DMH 319)</td>
<td>There is duty of Local Educational Authorities to provide appropriate education. Section 19 of the Education Act 1996 provides that each local authority shall make arrangements for the provision of suitable education at school or otherwise than at school for children of compulsory school age who because of illness or exclusion may not receive suitable education unless special arrangements are made for them. The guidance “Access to Education for Children and Young People with Medical Needs” has been written for Local Education Authorities, schools, hospital and home teaching services, hospital and health trust managers, chief executives primary care trusts, and social service departments on how to meet this duty. The guidance sets out the minimum national standard for the education of children and young people who are unable to attend school because of medical needs. It provides advice to ensure all local education authorities have in place vital arrangements to enable continuance of the learning process, to keep education alive in the pupil’s life, and where possible maintain progress.</td>
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<td>Child Welfare Principles</td>
<td>The omission of child welfare principles is to be regretted.</td>
<td>National Children’s Bureaux &amp; Children’s Legal Centre (DMH 194) Barnardo’s (DMH 315)</td>
<td>The Code will set out the guiding principles for all decisions concerning the use of powers in the Bill and will set out guidance for practitioners about how they should proceed when undertaking duties in respect of the Act, including child welfare principles.</td>
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<td>The draft bill fails to reflect Clause 11 of the Children Bill 2004, which creates a new duty binding all NHS Trusts to co-operate in safeguarding and promoting the welfare of children.</td>
<td>Barnardo’s (DMH 315)</td>
<td>The duty of safeguard exists without the need to replicate section 11 of the Children Act 2004 in the draft Mental Health Bill. Section 11 of the Children Act 2004 places a duty on a wide range of bodies, including Primary Care Trusts, NHS Trusts and NHS Foundation Trusts to make arrangements for ensuring that their functions (and any services administered on their behalf) are discharged having regard to the need to safeguard and promote the welfare of children. In addition, section 13 of the Children Act places Trusts under a duty to co-operate with the local authority in establishing a Local Safeguarding Children’s Board, the statutory successor to the Area Child Protection Committee.</td>
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<td>Statutory Reviews for Children</td>
<td>Article 25, of the UN Convention on the Rights of the Child requires regular reviews for children placed in institutional care. The draft Bill should incorporate provision for statutory reviews for children receiving in-patient mental health care.</td>
<td>For children subject to formal powers, the care plan must set out the medical treatment the patient requires and provide the authority for the patient to be treated without consent. The clinical supervisor may review the care plan at any time and it must be reviewed each time a Tribunal considers the patient's case. For children not subject to formal powers but qualifying for special safeguards under Part 6, the care plan must be reviewed at least once every three months. In addition, a review may be requested by the patient, consenting parent, any person with parental responsibility or the patient's nominated person. The decision whether to carry out the review when requested will be a matter of professional judgement for the clinical supervisor to decide in each case. That decision may be looked at by a medical expert and ultimately the Tribunal. The Tribunal can order the clinical supervisor to carry out a review.</td>
<td>National Children's Bureaux &amp; Children's Legal Centre (DMH 194)</td>
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<td>Accountability</td>
<td>All health agencies should be accountable for the protection of children affected by the use of compulsory powers, as required by the Children Bill 2004.</td>
<td>The duty to safeguard exists without the need to replicate section 11 of the Children Act 2004 in the draft Mental Health Bill. Section 11 of the Children Act 2004 places a duty on a wide range of bodies, including Primary Care Trusts, NHS Trusts and NHS Foundation Trusts to make arrangements for ensuring that their functions (and any services administered on their behalf) are discharging having regard to the need to safeguard and promote the welfare of children. In addition, section 13 of the Children Act places Trusts under a duty to co-operate with the local authority in establishing a Local Safeguarding Children's Board, the statutory successor to the Area Child Protection Committee.</td>
<td>National Children's Bureaux &amp; Children's Legal Centre (DMH 194)</td>
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<td>SEN Assessments</td>
<td>NHS trusts should have the powers to request and obtain assessments of children either for SEN or for services under clause 17 Children Act 1989.</td>
<td>NHS Trusts have a duty to notify local authorities (LAs) about children whom they intend to accommodate for more than 3 months. On receipt of this notification LAs have a duty to consider whether they need to exercise any of their powers under Children Act 1989. So they already have a duty in respect of the long term patients. They also have duties in respect of child protection concerns which may arise. For all children, the SEN Code of Practice, which is statutory guidance, advises that designated medical officers for SEN should ensure that Health Authorities have arrangements for NHS Trusts and GPs to inform LEAs of children they think may have SEN.</td>
<td>National Children's Bureaux &amp; Children's Legal Centre (DMH 194)</td>
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<td>Children whose parents are being treated under the Bill</td>
<td>Barnardo’s would like the Bill to include a right to information for all children and young people whose parent or carer is subject to compulsory treatment.</td>
<td>Barnardo’s (DMH 315)</td>
<td>In setting out the requirement to consult and notify those involved in the patient’s care and treatment, we have had to balance carefully the interest of people to be informed about a patient's condition with the right of the patient to privacy. In the case of children and young people, there is the added need to ensure that any information given is appropriate to the age, understanding and circumstances of the child or young person, for example, where the young person is the main carer. Where health and social care professionals are required to consult a carer, they must have regard to the patient's wishes and feelings in deciding whether it is appropriate to do so. The Bill sets out the minimum consultation and notification requirements; fuller guidance will be set out in the Code of Practice.</td>
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<td>Part 7 Powers of Entry, Conveyance and Detention</td>
<td>Clause 225(5) changes the 1983 Act and allows the police to take a person without being accompanied by a mental health professional. This is a retrograde step as, while the police are experts at apprehending individuals, they are not so expert in dealing with mentally disordered people. The police should always be accompanied.</td>
<td>A Craig (DMH 25)</td>
<td>225(a): The powers contained in clause 225 are based on part of section 135 of the 1983 Act. Section 135 contains two distinct powers enabling the police to, when acting under a warrant, enter premises and take an individual. In the case of patients who are subject to the powers of the Act and are absent without leave section 135(2) enables the issuing of a warrant enabling the police to act without being accompanied by a mental health professional. Where an unknown individual is suspected of needing treatment under the Act the police must be accompanied a mental health professional, something which is reproduced in clause 227 of the draft Bill. Clause 225 only applies to persons who are already subject to the Bill and does not introduce any new powers compared to the 1983 Act. Wherever possible a mental health professional should accompany the police when taking a patient, however this may not always be possible and it is necessary to empower the police to be able to, acting under a warrant, retake a patient who is unlawfully at large.</td>
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| 226    | **Powers of entry and inspection**  
(1) An approved mental health professional may, at any reasonable time, enter and inspect any premises in which a person is living if he has reasonable grounds for believing that the person—  
(a) is suffering from mental disorder, and  
(b) is not under proper care. | It is unacceptable that an AMHP should have a power to enter and inspect a person’s home, just because they have grounds to believe the “person has a mental disorder and is not under proper care.” An AMHP should only be permitted to enter, accompanied by the police with a warrant, if they have grounds to believe there is a serious risk to the occupant’s health and safety. | National Voices Forum (DMH 240) | 226(a): This clause, which is based on section 115 of the current Act, enables an approved mental health professional at a reasonable time to enter and inspect premises and to form a view as to what further steps, if any, need to be taken under the Bill. It does not provide any authority to force entry or remove the person from the premises. |
| 227    | **Warrant to remove a person to a place of safety**  
(1) A justice of the peace may issue a warrant under this section if it appears to him, on information on oath laid by an approved mental health profession, that there are reasonable grounds for believing that a person believed to be suffering from mental disorder (“the patient”)—  
(a) has been, or is being ill-treated, neglected or kept otherwise than under proper control, in a place within the jurisdiction of the justice, or  
(b) is unable to care for himself, and is living alone in a place within that jurisdiction. | Clause 227(1) repeats the wording of the Mental Health Act 1959 which in turn was in the 1983 Act. The wording is old fashioned and could do with being reworked for the 21st century even if the eventual effect of the new words are the same as the old. Whether a person can care for themselves, or is being ill-treated or neglected, is not the same issue as whether the only way in which a statutory assessment can be undertaken is by forced entry and removal. Although this is the usual reason for using the power, it continues not to be a ground for issuing the warrant. | A Craig (DMH 25)  
IMHAP (DMH 50) | 227(a): The Government believes the current drafting achieves its policy intention. A justice of the peace may issue a warrant under this section where it appears that an individual is suffering from a mental disorder and that person is either unable to care for themselves or is being neglected. The Codes of Practice will emphasise that wherever possible efforts should be made to secure an informal assessment of a person. However, this will not always be possible and it is necessary to provide a power to act to remove to a place of safety a person who is believed to be in need of treatment under formal powers. |
<p>|        | (4) …this subsection does not authorise his detention beyond the end of 72 hours beginning with his arrival at the first place of safety to which he is removed. | A period of detention of 72 hours in a police station is wholly inappropriate for the purposes of the assessment needed. An assessment when a police station is used should be completed within a maximum period of 12 hours. | Independent Police Complaints Commission (DMH 206) | 227(b): The Government agrees that police stations are not the ideal place to detain a person awaiting assessment. The Codes of Practice will make it clear that assessments should be completed as soon as practicable which, along with the new power under the Bill enabling transfers between places of safety, should help limit the length of time a person is held within a police station awaiting assessment. |</p>
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<td>Where a person is brought to a police station and is thought to have a mental health problem and to be under the influence of alcohol or drugs, the person should continue to have his or her medical condition monitored closely until either being transferred to hospital or discharged, within a six-hour time limit.</td>
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<td>MIND (DMH 210)</td>
<td>227(c): See response 227(b).</td>
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<td>(5)... “place of safety” means – (c) a police station</td>
<td>There should be a prohibition on the use of police stations as places of safety other than in exceptional circumstances.</td>
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<td>H Armitt (DMH 98) ASS &amp; LGA (DMH 208) MIND (DMH 210) Independent Police Complaints Commission (DMH 206) MIND (DMH 210)</td>
<td>227(d): The Government agrees that police stations are not an ideal place to detain a person as a place of safety, but at times it may be the only appropriate place available when the person needs to be removed to a place of safety where they can be protected from harm. Under the Bill there is a new power to transfer a person between places of safety. This will mean that the person can be more easily moved to a hospital or other approved place. The Government believes that this is not an appropriate issue for legislation. Service improvements are being tackled and delivered through initiatives such as the National Service Framework for Mental Health.</td>
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<td>If it is necessary to use a police station as a place of safety, on rare occasions and as a last resort, then there should be a positive duty placed under the Bill upon the relevant health authority to assess need and provide/procure adequate facilities (for example, registered care provision), to act as intermediate care prior to assessment and to make a decision on residential detention, in a similar manner to which other intermediate care facilities are provided for other patients in need of healthcare.</td>
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| 228    | Urgent removal to a place of safety  
(1) This section applies where a constable, on information from an approved mental health professional, has reasonable grounds for believing that –  
(a) there is on any premises a person who is believed to be suffering from mental disorder (“the patient”),  
(b) the patient is in urgent need of care or control to prevent him causing serious harm to himself or others, and  
(c) the urgency makes the patient’s removal under a warrant impracticable. | The police power to detain a person without a warrant in an emergency should not be extended to private property since it would be open to abuse. The obtaining of a warrant is usually possible within hours rather than days. While this clause may not be a technical breach of Article 8 of the European Convention on Human Rights it will be an undue interference with family and private life. Furthermore, the power may be used simply to avoid the trouble of obtaining a warrant and may be open to challenge under Article 5. Section 17 of the Police and Criminal Evidence Act 1984 already gives police the power to enter premises for the purpose of saving life and limb or preventing serious damage to property. | Durham & Darlington NHS (DMH 101)  
MHA (DMH 105)  
Law Society (DMH 111)  
NACRO (DMH 156) | 228(a): This clause ensures that the police can intervene in an emergency to prevent a person from causing serious harm to himself or for the protection of others. A warrant is necessary to detain beyond six hours so the power will not generally enable avoidance of the need to obtain a warrant. This provision, unlike section 17 of the Police and Criminal Evidence Act 1984, provides both the safeguard of specified criteria for forced entry and for the removal of the person to a place of safety. |
| 229    | Removal to a place of safety from a public place | The Bill should provide the right of access to specialist mental health advocacy when the person arrives at the place of safety, whether it is a psychiatric hospital or police station. | Action for Advocacy (DMH 46)  
MHA (DMH 105)  
Sheffield Mental Health Advocacy Service (DMH 109) | 229(a): The Government does not agree that this is desirable. The Bill provides for all patients to be informed of the help available from the Independent Mental Health Act (IMHA) advocate by the approved mental health professional as soon as possible after they become liable to assessment under compulsion. Evidence from advocates has shown that there are a number of reasons why advocacy involvement at this early stage may be difficult. When an individual is removed to a place of safety it is often in very difficult circumstances, and the person may be too ill to understand the role of the advocate. There is also a risk that association with the act of compulsion being imposed can damage the future relationship of the advocate and service user. |

Other comments:
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<td>Clause 225 enables a constable to enter premises specified in the warrant issued under this clause, if need be by force, and remove the patient there and when they do so may be accompanied by any person who is a registered medical practitioner or an authorised person. Later in the Bill, under clause 227 the police presence and actions are part of a multi-disciplinary intervention, where a constable must be accompanied by at least one approved mental health professional and at least one registered medical practitioner and under clause 228 the constable must be accompanied by at least one approved mental health professional. There seems no evident logic to these variations. Although this multi-disciplinary approach is to be commended it must be applied consistently to all those interactions.</td>
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<td>Independent Police Complaints Commission (DMH 206)</td>
<td>The difference between clauses arises from the need to provide powers to respond to different circumstances. The police may be acting in respect of a known person already subject to powers under the legislation and who is absent without leave, or they may be acting on untested information interacting with an individual for the first time. There is also a need to recognise that it may not always be possible, due to the level of urgency, to be accompanied by an approved mental health professional and a registered medical practitioner.</td>
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<td>Any action under Part 7 of the Bill should be requested by a Mental Health Professional. If entry has to be made, the police should be accompanied by a Mental Health Professional. The Police should have extensive Mental Health Awareness Training under the Bill.</td>
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<td>Lifecraft (DMH 220) South Cambs User Forum (DMH 221)</td>
<td>It does not follow that the police should be automatically impeded from taking or retaking a person who is absent without leave or unlawfully at large by the non availability of a professional. Work is currently being undertaken to increase training for the police under the 1983 Act. Changes made under the Bill are being considered by relevant bodies in order to take them into account in future training.</td>
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<td>232 Introductory</td>
<td>(4) For the purpose of this Chapter a person is disqualified if… (b) he appears to the appointer to be incapable of being a nominated person because of illness or mental disorder.</td>
<td>A patient may wish to choose someone with a mental disorder - indeed, people who have direct experience of mental disorder and of the mental-health system might be particularly effective nominated persons. It needs to be clear that a person can only be incapable if s/he lacks capacity within the Mental Capacity Bill’s definition.</td>
<td>MHA (DMH 105) MIND (DMH 210)</td>
<td>232(a): The Mental Capacity Bill does not give a blanket definition of incapacity, so for example, someone who is not capable of managing their own finances under the Mental Capacity Bill may well be capable of acting as a nominated person under the Mental Health Bill. The Government agrees that just because a person has an illness or a mental disorder does not mean that they will be disqualified from acting as a nominated person – if someone appears capable of acting as a nominated person then they can if they are not disqualified for any other reason. The code of practice will give guidance for the appointer when deciding whether someone is incapable to act as the nominated person.</td>
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<td>232 Introductory</td>
<td>(5) References in this Chapter to a person who is “suitable” are to a person who appears to the appointer to be suitable to be the patient’s nominated person having regard to all the circumstances, and in particular to that person’s relationship to or connection with the patient…</td>
<td>We do not accept that there should be any other criterion for “suitability” than the relationship or connection with the patient - which is already within the Bill. Giving the appointer (a mental health professional) discretion over the “suitability” of the nominated person will reduce the likelihood that his/her choice is respected and considered independent.</td>
<td>MHA (DMH 105) MIND (DMH 210)</td>
<td>232(b): Whilst eligibility is a necessary criterion to act as a nominated person, it is not in itself sufficient. The suitability criterion requires the eligible person also is suitable to be the nominated person. Guidance on what is unsuitable will be given in the code of practice, and will include factors such as whether the eligible person is in fact involved in an abusive relationship with the patient, and whether the eligible person is physically contactable. The Government intends that in the most cases the patient’s choice of nominated person is to be respected, and guidance in the code of practice will make this clear. Where the patient wishes to appeal about the choice of nominated person where it is made on his behalf, clause 243 enables them to apply to the tribunal for it to review the decision. This will deter the appointer from going against the patient’s wishes.</td>
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<td>232 Introductory</td>
<td>We do not accept that there should be any other criterion for “suitability” than the relationship or connection with the patient - which is already within the Bill. Giving the appointer (a mental health professional) discretion over the “suitability” of the nominated person will reduce the likelihood that his/her choice is respected and considered independent.</td>
<td>The draft Bill does not suggest that the loaded word “suitable” will be explained, or that guidance as to ‘unsuitability’ will be given, in rules, regulations or the Code of Practice.</td>
<td>David Hewitt (DMH 21)</td>
<td>232(c): See response 232(b).</td>
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<td>233</td>
<td>Appointment: general</td>
<td>The nearest relative should be allowed to make decisions as to whether a patient needs to be detained until a nominated person is appointed.</td>
<td>T Lewis (DMH 135)</td>
<td>233(a): The Government does not agree. The Government believes that giving the nearest relative rights in relation to a patient would risk a violation of Article 8 of the European Convention of Human Rights (right to respect for private and family life) in certain circumstances, as the patient would not have any choice in the appointment of the nearest relative (see in particular the declaration of incompatibility made by the High Court in the case of <em>R (on the application of M) v Secretary of State for Health</em> [2003] EWHC 1094 (Admin)). In most cases, we envisage that the nominated person appointment will take place within a short period of time once the decision to treat under compulsory powers has been taken. If the appointer does not appoint a nominated person within a reasonable period of time, clause 243 allows the patient to apply to the tribunal for an order requiring the appointer to make an appointment. Furthermore, it is never appropriate for the decision to treat under compulsory powers to rest with one individual alone, particularly where that individual is a family member and may not be able to take an unbiased view of the patient’s needs. The Bill ensures that the decision to treat someone under compulsory powers does not rest with any one person, but will be taken by two registered medical practitioners and an approved mental health professional (except in emergencies where the decision is taken by the AMHP and one registered medical practitioner). Both before and during the initial examination, the examiners have a duty to consult any carer of the patient, to ensure that wherever possible all relevant factors can be taken into account when deciding whether to treat under compulsion.</td>
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<td>The identity of the nominated person should be allowed to be specified in an advance statement.</td>
<td>Rethink (DMH 192) LifeCraft (DMH 220)</td>
<td>233(b): The Bill provides that the appointer should ascertain the patient’s wishes and feelings about the appointment of a nominated person. Guidance in the code of practice will make clear that it is good practice for decision-makers to take into account previously expressed wishes and feelings of the patient to the extent that such an advance statement is pertinent to determining the patient’s current wishes and feelings about who should be appointed.</td>
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<td>If there is no advance statement, the nominated person role should default to the carer, using a default hierarchy as in the new Scottish legislation.</td>
<td>Rethink (DMH 192)</td>
<td>233(c): The Government does not agree. The absence of an advance statement does not mean that a patient should not have the opportunity to take part in choosing their nominated person to the extent that they are able. By default, if a patient is not capable of selecting a nominated person then the appointer must appoint the most suitable, eligible person. Individual circumstances vary considerably, and whilst the most suitable eligible person might be the patient's carer it cannot be assumed that this will always be the case. The provision as drafted allows the appointer to take into account all the relevant factors when making this decision. Where there is no suitable, eligible person, the local authority must be appointed.</td>
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<td>(2) If the patient is aged under 16 the appointer must appoint- (a) the most suitable eligible person, or (b) if there is no suitable eligible person, the appropriate local social services authority</td>
<td>The potential for conflict between those who have parental responsibility for a child patient needs to be addressed; particularly as the role of the nominated person cannot be shared.</td>
<td>Royal College of Psychiatrists (DMH 24)</td>
<td>233(d): The provisions for appointing nominated persons under the Bill ensure that the child's wishes and feelings and all of the other circumstances of the case will be taken into account. Inevitably, there is potential for conflict between those who have parental responsibility for a child patient, such as where parents are separated or divorced, or where they disagree about treatment proposed for the child. It is important that wherever possible clinicians seek to support the family to resolve their difficulties in the knowledge that stability within the parental relationship promotes child well-being. It is a matter of best practice for clinicians to avoid interventions that are likely to exacerbate conflict or that will undermine normal parental authority necessary to provide proper care for the child. In most cases it is envisaged that the nominated person will be someone with parental responsibility. However, in situations where the child and parent are in conflict, as may be the case for a qualifying child patient under Part 6 of the Bill, the appointer will take this into account when deciding who is suitable and eligible to be the nominated person. In any case, all people with parental responsibility as defined under the Children Act 1989 have rights under the Bill to be consulted and notified about the care and treatment of a child.</td>
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<td>238</td>
<td>Nominated person: general provisions</td>
<td>We wonder whether the nominated person is given sufficiently useful role to justify all of the consultation and notification requirements throughout the Bill.</td>
<td>IMHAP, DMH 50.</td>
<td>238(a): Clause 238 sets out that the role of the nominated person is to be consulted about the patient's wishes and feelings about a decision to be taken. In this way, the nominated person is a safeguard to ensure that patient's voice is heard whilst they are treated under formal powers. The consultation and notification rights throughout the Bill, alongside provisions such as in clause 35 where the nominated person can apply to the tribunal for the patient's discharge, ensure that the nominated person provides a meaningful safeguard.</td>
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<td>The 1983 Act gives several powers to the nearest relative which the draft Bill does not replicate for the nominated person. This includes the power to take steps to discharge a patient under compulsion. The nominated person should have the same powers as the nearest relative in the 1983 Act. The nominated person can apply to the Mental Health Tribunal for the patient's discharge. However, this is again an inadequate replacement of the nearest relative's right to ask the hospital managers to grant discharge under the 1983 Act.</td>
<td></td>
<td>Royal College of Psychiatrists (DMH 24) S Daves (DMH 37) Manic Depression Fellowship (DMH 290) The Law Society(DMH 111) Rethink (DMH 192)</td>
<td>238(b): The role of the nominated person and the nearest relative are deliberately different. The 1983 Act gives nearest relatives power in their own right, such as the right to discharge the patient from treatment under compulsion, whereas the nominated person is specifically there to represent the wishes and feelings of the patient. The Government believes that, taken alongside new safeguards such as the 28 day tribunal hearing introduced under the Bill, the rights of the nominated person to be consulted and notified about the patient’s treatment and to apply to the tribunal on the patient’s behalf amount to a comprehensive set of safeguards for the patient. The Government does not accept that the right to apply to the Mental Health Tribunal is an inadequate replacement for the nearest relative’s right to ask the hospital managers to grant discharge under the 1983 Act, given that the MHT is an independent judicial body.</td>
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<td>239</td>
<td>Restriction of role of nominated person</td>
<td>In addition to the much reduced rights of the nominated person compared to the nearest relative, clause 239 allows the functions of the nominated person to be further reduced to such an extent that there may seem little point in his/her continuing in the role.</td>
<td>V Yeates (DMH 302)</td>
<td>239(a): The role of the nominated person is deliberately different from that of the nearest relative, so it is difficult to make a straightforward comparison of their respective &quot;rights&quot;. Nonetheless, while nominated persons deliberately do not have a decision-making role under the Bill, they do have greater rights than nearest relatives to be consulted about aspects of the patient's treatment. This includes rights to be consulted and notified about the patient’s care plan. The nominated person is there to represent the wishes and feelings of the patient. The right for the patient to limit the role of the nominated person (clause 239) is an important safeguard of the patient’s rights. It is not appropriate, when taking into account the patient’s rights, to force the patient to allow the use all of the functions of the nominated person if they do not wish to. This provision allows for patients to limit the role of their nominated person in specific areas or for a limited time, without having to request a change in nominated person. This might be useful, for example, where the relationship between the patient and the nominated person is temporarily under strain.</td>
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<td>241</td>
<td>Revocation by appointer</td>
<td>The professional services should have a mechanism for setting aside the nominated person if they believe the nominated person is acting against the patient's best interests (i.e. something to replace the &quot;displacement of nearest relative&quot; procedures in the current Act).</td>
<td>A Craig (DMH 25)</td>
<td>241(a): The nominated person role does not include making a decision about ‘best interests’, rather it is about representing the patient’s wishes and feelings. The patient is able to veto the nominated person from undertaking specific functions if they choose (clause 239), or to request a revocation of the nominated person appointment. Furthermore, the appointer must revoke the NP appointment if the person is no longer suitable, eligible, or willing to be the NP, or if they think it appropriate having regard to the patient’s wishes (clause 241).</td>
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<td>241(b)</td>
<td>The patient must also have the power to revoke an appointment which s/he has made.</td>
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<td>MHA (DMH 105)</td>
<td>241(b): Clause 241 provides for the patient to request a revocation of the nominated person appointment, or they can apply to the tribunal if there has been a change in circumstances (Clause 244).</td>
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<td>242</td>
<td>Cessation of appointment</td>
<td>A nominated person should remain in post after discharge from an order subject to the agreement of the patient, though their powers would be held in abeyance. If s/he require a different nominated person next time s/he could be permitted to specify a person at the point of discharge. That person's name would be included in the patient's records.</td>
<td>MHA (DMH 105) MIND (DMH 210) Social Workers of Hammersmith and Fulham (DMH 238) National Voices Forum (DMH 240)</td>
<td>242(a): The Government does not agree. There are practical difficulties that arise if a nominated person remains in “post” beyond the immediate period of compulsion. It could be many months or even years before a patient is treated under formal powers again (if ever). Changing circumstances make it possible that the current nominated person will no longer be the patient's preferred choice in the future. Situations could also arise where the nominated person is no longer suitable or eligible. For these reasons it is considered appropriate that the nominated person needs to be reappointed at each episode of compulsion.</td>
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<td>247</td>
<td>IMHA advocates</td>
<td>The functions of advocates include explaining things to the patient. Who are they advocating for?</td>
<td>IMHAP, (DMH 50)</td>
<td>247(a): The IMHA advocate will advocate for the patient. One way they will safeguard the patient is by helping them (by way of representation or otherwise) to exercise their rights under the legislation. This will often require the advocate to explain the provision of the legislation and treatment provided under it as the basis for providing help to patients in exercising their rights.</td>
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<td>IMHAA will, as far as possible, be independent from the providers of treatment to ensure that there is no conflict of interests, whether perceived or actual.</td>
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<td>A statutory requirement should be introduced and placed on local and health authorities to produce local advocacy plans which will outline a plan for the development and funding of advocacy services to meet the needs of all mental health service users and other groups of people that can benefit from advocacy.</td>
<td>Action for Advocacy (DMH 46)</td>
<td>247(b): The Mental Health Bill will establish for the first time a duty on the appropriate authority to arrange advocacy to such extent as it considers necessary to meet all reasonable requirements for patients subject to the legislation. PCTs in England and LHBs in Wales will be funded through their allocations to commission statutory advocacy. Within this context, it is right that local bodies are responsible for planning and commissioning local advocacy services, enabling them to reflect local priorities and needs.</td>
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<td><strong>The Bill should state clearly and strongly that clinical/care staff should have a responsibility to tell patients about advocacy at key times:</strong>&lt;br&gt;- on admission to hospital.&lt;br&gt;- whenever special, particularly invasive treatments are concerned (ECT, psychosurgery, hormone implantation to reduce sex drive, etc).&lt;br&gt;- on review of care or treatment.&lt;br&gt;- at discharge or transfer from hospital or release from compulsion.&lt;br&gt;- when any other significant decisions are being made.</td>
<td>The following should be essential points at which advocates should be available for a patient who wishes their services:&lt;br&gt;- at the examination stage of civil patients;&lt;br&gt;- at the time of a mental health report in a criminal justice setting;&lt;br&gt;- when special treatments are being considered;&lt;br&gt;- when a person is in a place of safety;&lt;br&gt;- on review of care or treatment;&lt;br&gt;- at discharge or transfer from hospital or release from compulsion;&lt;br&gt;- when any other significant decision is being made.</td>
<td>Camden and Islington Aim Advocacy (DMH 93)</td>
<td>247(c): Clause 19(4c) requires that the AMHP notifies the patient of the help available from IMHA advocates as soon as possible after they are made liable to treatment under formal powers. A member of clinical/care staff may feel that it is appropriate to remind patients of the availability of advocacy at other times during their treatment. Guidance on this will be given in the code of practice. The Bill provides for IMHA advocacy to be available for patients who are being treated under compulsory powers. This new duty in no way interferes with the possibility of seeking help from non-statutory advocates at other times, and at times when the patient is not being treated under compulsory powers, such as if they are taken to a place of safety or are undergoing an initial examination. Once someone is being treated under the formal powers, they have a particular need to both understand the legal procedures and what rights they have and, most importantly, to be able to make the safeguards work for them by articulating their own views and engaging with the clinical team. This is where advocacy can help to ensure the patient's voice is heard. Whilst we note that for a patient being treated under compulsory powers the Bill does not specify particular times when an IMHA advocate should be involved, the IMHA advocate could be involved at any time during the patient's treatment. Clause 247(d) sets out that the type of help they provide must include help in obtaining and understanding information (e.g. about the medical treatment the patient is receiving, the authority under which it is being provided and the patient's rights under the Act) and help with exercising those rights. Depending on their circumstances, different patients may require this help at different points in their treatment.</td>
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<td><strong>The Bill should reflect the need for advocacy to be independent and the Government should ensure that advocacy services are supported to work towards independence.</strong></td>
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<td>Action for Advocacy (DMH 46)</td>
<td>247(d): The Government agrees. Clause 247(h) sets out that the provision of IMHAA should as far possible be independent of any person responsible for the patient's treatment. Department of Health has commissioned work from the University of Durham to identify and develop good practice in advocacy. This will include recommendations about the organisational arrangements for accreditation, commissioning and provision to ensure the high quality and independence of advocacy.</td>
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| (1)    | The appropriate authority must arrange, to such an extent as it considers necessary to meet all reasonable requirements, for help from persons, to be known as IMHA advocates,… to be available to qualifying patients and to their nominated persons. | Advocacy should not be restricted to those who have been sectioned, therefore denying those who are voluntary patients. | T Allen (DMH 30)  
Citizens Advice (DMH 125)  
Action for Advocacy (DMH 46) | 247(e): As stated above, the Mental Health Bill will establish for the first time a duty on the appropriate authority to arrange advocacy to such extent as it considers necessary to meet all reasonable requirements for patients subject to the legislation. Once someone is being treated under the formal powers in the Bill, they have a particular need to both understand the legal procedures and what rights they have and, most importantly, to be able to make the safeguards work for them by articulating their own views and engaging with the clinical team. This is where advocacy can help to ensure the patient’s voice is heard. This new duty in no way interferes with the provision of informal advocacy provision at other times. The provision of advocacy for voluntary patients is within the powers and responsibilities of local authority and health service bodies. |
|        | There should be clearer guidelines to ensure that the appropriate authority is not allowed to consider the availability of advocates to be unnecessary. Patients should have an enforceable right to advocacy. | | Maca (DMH 296)  
MIND (DMH 210)  
Action for Advocacy (DMH 46) | 247(f): As stated above, clause 247 sets out a duty for arrangements to make advocacy available to such an extent as it considers necessary to meet all reasonable requirements for patients being treated under formal powers. It will be for PCTs to commission sufficient advocacy to meet this requirement.  
The Scottish legislation provides a duty to ensure advocacy is available but this is a general requirement. In England and Wales emphasis has been placed on developing specialist Mental Health Act advocacy in order to ensure the advocacy service which detained patients can access is of an agreed standard working to a common code of practice and delivered by trained specialist advocates. This does not rule out the provision of alternative advocacy services for people with mental disorder who are not subject to the powers of the Act. |
<p>|        | Advocacy should and can only be a safeguard for the person subject to compulsion (not their nominated person) and this should be clearly stated in the Bill. | | Derbyshire Mind Advocacy Services (DMH 66) | 247(g): The nominated person is there to represent the wishes and feelings of the patient, and in most cases will have been appointed because the patient has requested them. For this reason, it may be appropriate (and the patient may wish) for the nominated person to have access to support from the advocate on behalf of the patient. Where the patient does not want this, clause 247(f) would allow the patient to veto the advocate from providing support to the nominated person. |</p>
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<td>The provision of advocacy by the same advocate to both patients and their nominated persons may cause conflicts of interest. This section should be redrafted to minimise such conflicts occurring, and ensuring the advocates role is not compromised.</td>
<td>Action for Advocacy (DMH 46)</td>
<td>247(h): See response 247(g).</td>
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<td>(3)</td>
<td>Responsibility for giving all information to the patient and explaining the treatment, including the patient's rights under the Bill must remain with the multi-disciplinary team and must not pass to the IMHA advocate.</td>
<td>247(i): Clause 284 sets out that the responsibility for providing patients with information and helping them understand it is part of the responsibilities of providers of mental health services. The role of the advocate is to help patients and their nominated persons obtain and understand information. It in no way substitutes for or reduces the duties on other professionals to provide information in the first place.</td>
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<td>(4)</td>
<td>An IMHA advocate authorised by a qualifying patient or his nominated person on his behalf may at a reasonable time, for the purpose of providing, in accordance with the arrangements, help requested by the patient or his nominated person-</td>
<td>Action for Advocacy (DMH 46)</td>
<td>247(j): The provision of private facilities for meetings between the patient and their advocate, nominated person or carer is a good practice issue, and will be included in the code of practice.</td>
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<td>(a) meet with the patient, and</td>
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<td>The removal of the right to meet in private, proposed in the 2002 Bill, is cause for concern.</td>
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<td>(b)</td>
<td>The IMHA advocate should not have the right of access to the patient's records without the patient’s express permission. Rather the Bill should read that the patient has ‘the right to instruct their advocate to apply to access his/her records on their behalf’.</td>
<td>247(k): The Government does not agree. The Government believes that in order to provide help to the patient the advocate should be able to ask the hospital managers for access to the patient's records. The hospital manager can refuse the advocate access if appropriate, and in deciding what is appropriate they must take into account the patient’s wishes and feelings.</td>
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<td>247(l)</td>
<td>The proposal to provide IMHA advocates with access to records without the patient's informed consent should be scrapped and, for people whose decision-making in this regard is impaired, the nominated person should be given this right.</td>
<td>Assoc. of Mental Health Advocates (DMH 267)</td>
<td>247(l): As stated in the response to 247(k), the Government believes it is important for the advocate to be able to request access to the patient's records in order to provide them with help. The nominated person is there to represent the wishes and feelings of the patient, and as such does not depend on them having access to the patient's records. The patient could request to see their records and share them with the nominated person should they wish to do so – details on the patient's right to access records will be given in the code of practice.</td>
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<td>247(m)</td>
<td>When a person's decision-making capacity is impaired and they cannot consent to information being shared on their behalf, information should be made available as needed to advocate effectively.</td>
<td>Sheffield Mental Health Advocacy Service (DMH 109)</td>
<td>247(m): The Government agrees, and the Bill provides for this by allowing the advocate to have access to the patient's medical records if the hospital manager thinks it is appropriate (clause 247(e)).</td>
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<td>(6)</td>
<td>The appropriate authority may by regulations provide that a person may act as an IMHA advocate- (a) only if requirements specified in regulations are met in respect of him... (b) only if requirements specified in regulations are met in respect of any person with whom arrangements are made for him to act as an IMHA advocate, (c) only in circumstances otherwise specified in regulations</td>
<td>Cymar (DMH 45)</td>
<td>247(n): Clause 247(g) gives a power for secondary legislation to be developed setting out requirements that must be met for a person to act as an IMHAA. It is intended that these regulations will include the professional qualifications, training and experience required. There will be public consultation on the contents of the regulations.</td>
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<td>(7)</td>
<td>Independence should mean independence and not independence 'so far as practicable'.</td>
<td>Sheffield Mental Health Advocacy (DMH 109)</td>
<td>247(o): The Government agrees that the advocate should be independent of anyone providing the patient's care, whilst acknowledging that in some small local health communities it may be difficult to ensure that there exist no formal or informal links between the advocacy service and the mental health service. The independence of advocacy services from providers of mental health services will be established through arrangements for the commissioning services. Recommendations about the best way of achieving this independence will be made by the project on IMHAA commissioned by Department of Health from the University of Durham. In addition, advocates will receive training to ensure that they behave completely impartially.</td>
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<td>247(6)</td>
<td>If a qualifying patient who has capacity to do so notifies the appointer… that he does not want help to be provided to his nominated person under arrangements under this section, while that notification has effect such help may not be provided to the nominated person.</td>
<td>IMHA advocates should only be able to work with nominated persons when this is a specific instruction of their client. The current wording however puts the emphasis on the patient to advise the advocate not to work with their nominated person if they feel it is not in their interests. This places an unnecessary burden on the patients to act assertively in a situation where there is potential for manipulation and where complex relationship dynamics may exist.</td>
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<td>247(7)</td>
<td>The appropriate authority may make payments to any person in pursuance of arrangements under this section.</td>
<td>It is not clear how IMHA advocates’ independence of the detaining authority (who may well be paying them) is to be guaranteed. This is not an adequate substitute for the protection presently afforded to citizens by co-opted independent managers.</td>
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<td>247(8)</td>
<td>The making of a mental health order by the court is conditional upon the preparation and submission of a ‘care plan’ by an approved clinician (clause 115(1)). However as clause 248(2)(f) states that a patient will only become a ‘qualifying patient’ for the purposes of clause 247 when a mental health order is ‘in force’, anyone for whom a mental health order is proposed will not have access to advocacy.</td>
<td>It is recommended that clause 248 be extended to those people for whom a ‘care plan’ under clause 115(1) is being drawn up, therefore before a mental health order is made.</td>
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<td>247(9)</td>
<td>A Court remanding under Mental Health Act powers is acting in pursuance of the criminal justice process. It would be inappropriate for advocacy processes, designed as a safeguard for patients under compulsory treatment, to cut across criminal justice processes for determining whether to direct from prison.</td>
<td>Action for Advocacy (DMH 46) MIND (DMH 210)</td>
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<td>Abolition of nearest relative</td>
<td>The abolition of the nearest relative undermines the family in favour of acquaintances who may not have the patient’s best interests at heart.</td>
<td>The Government does not agree. Nominated persons will, wherever possible, be selected by patients themselves. In most other cases, the appointer will be required to appoint the most suitable eligible person. Often this will be a close family member, but circumstances and families differ, and it would be inappropriate to assume that a family member is automatically a more suitable person than (for example) a friend. Moreover, as noted in the response to clause 233, the automatic appointment of a particular relative would risk a violation of the European Convention of Human Rights (right to respect for private and family life) in certain circumstances, as the patient would not have any choice in the appointment of the nearest relative (see in particular the declaration of incompatibility made by the High Court in the case of R (on the application of M) v Secretary of State for Health [2003] EWHC 1094 (Admin)).</td>
<td>NE London Mental Health Trust (DMH 112)</td>
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<td>A patient’s spouse or partner should retain their existing power to object reasonably to admission to hospital. Why get rid of the right to lodge a reasonable objection? That person should also retain the existing power to discharge from detention a patient who is not likely to act in a manner dangerous to her/himself or others.</td>
<td>As stated earlier, as part of the overall package of safeguards, the Bill ensures that the decision to detain someone should not rest with one person, but will be taken by two registered medical practitioners and an approved mental health professional (except in the case of emergencies). Both before and during the initial examination, the examiners have a duty to consult any carer of the patient, to ensure that wherever possible all relevant factors can be taken into account when deciding whether to detain that person. Chapter 7 of Part 2 provides that once a patient is being treated under formal powers, the nominated person can apply to the tribunal for the patient to be discharged, or for a change in status of the patient i.e. that they be made a resident or non-resident patient. The 1983 not only gives nearest relatives the right to object to admission for treatment (though not admission for assessment) and the power to order the discharge of the patient (subject to a veto where the patient is likely to act in a manner dangerous to himself or others), it also gives the nearest relative the right to apply for detention in the first place (subject to the normal two medical recommendations). The Government think it is anachronistic for one person to play such a direct decision making role in the care of another person simply by virtue of being the nearest relative.</td>
<td>No Force (DMH 44) IMHAP (DMH 50)</td>
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<td>Carers’ right to advocacy</td>
<td>Carers should have rights to IMHA advocacy. Under the draft Bill the carer has no access to IMHA advocacy unless she is also the nominated person. This is in spite of the rights identified under the Health and Social Care Act 2001 and the practice guidance of the Carers and Disabled Children Act 2000.</td>
<td>The patient and their nominated person can have access to IMHAA. In cases where the patient has chosen the carer to be their nominated person, then this will allow the carer access to IMHAA.</td>
<td>MHA (DMH 105) Rethink (DMH 192)</td>
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<td>Overseeing advocacy</td>
<td>An independent, separate agency should oversee the quality of IMHA advocates.</td>
<td>Arrangements for the assuring the quality and appropriateness of advocacy will depend on the arrangements for the commissioning of advocacy services which have still to be decided, and will be considered by the project on IMHAA commissioned by Department of Health from the University of Durham. They will reflect:</td>
<td>Sheffield Mental Health Advocacy Service (DMH 109)</td>
<td>This is an implementation issue and, as stated above, will be considered by the project on IMHAA commissioned by Department of Health from the University of Durham.</td>
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<td>• (i) The requirements for advocacy to be specified in regulations under clause 247(g);</td>
<td>Gloucester Survivors Forum (DMH 160)</td>
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<td>• (ii) The duty of the commissioners of advocacy services to ensure that advocacy services are delivered to the standards they have specified; and</td>
<td>Social Workers of Hammenmth and Fulham (DMH 238)</td>
<td>As above.</td>
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<td>• (iii) The responsibilities for the Healthcare Commission which will have specific responsibilities under the Mental Health Bill to audit and inspect all aspects of the services within their remits.</td>
<td>Herefordshire Users Group (DMH 236)</td>
<td>As above.</td>
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<td>To ensure independence the CPPI Patient &amp; Public Forums (with the help of their support organizations) should be tasked with the employment and management of independent advocacy services.</td>
<td>This is an implementation issue and, as stated above, will be considered by the project on IMHAA commissioned by Department of Health from the University of Durham.</td>
<td>T Allen (DMH 30) A Flores (DMH 31)</td>
<td>The Mental Health Bill will establish for the first time a duty on the Secretary of State to provide advocacy for patients subject to the legislation. PCTs will be funded through their allocations to commission statutory advocacy. Within this context it is right that local bodies are responsible for planning and commissioning local advocacy services, enabling them to reflect local priorities and needs.</td>
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<td>To ensure that advocacy takes its appropriate role we would wish to see it supported with clear standards of service provision and workforce.</td>
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<td>Encrypt (DMH 115)</td>
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<td>Training for advocates</td>
<td>A uniform national system of accredited training should be established.</td>
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<td>Encrypt (DMH 115)</td>
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<td>Funding for advocacy</td>
<td>If funding for advocates is not ring fenced then local authorities are at liberty to cut the current, and often sparse funds, they commit to advocacy services and replace them with this funding, rather than building on and developing existing services.</td>
<td>The Mental Health Bill will establish for the first time a duty on the Secretary of State to provide advocacy for patients subject to the legislation. PCTs will be funded through their allocations to commission statutory advocacy. Within this context it is right that local bodies are responsible for planning and commissioning local advocacy services, enabling them to reflect local priorities and needs.</td>
<td>Encrypt (DMH 115)</td>
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<td>To avoid conflicts of interest the advocacy service should be funded by central government - not the same local statutory body that imposes the compulsion.</td>
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<td>National Voices Forum (DMH 240)</td>
<td>As above.</td>
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<td>Advocacy for victims of crime perpetrated by patients suffering from mental illness.</td>
<td>NHS Mental Health Trusts and PCTs providing mental health services should be required to appoint named advocates responsible for assessing the needs and concerns of victims and potential victims.</td>
<td></td>
<td>The Zito Trust (DMH 174)</td>
<td>The Government feels this is not an issue for the legislation.</td>
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<td>Roles of advocates, nominated persons and carers</td>
<td>In order to avoid confusion of roles the principal role of the nominated person and of the advocate (as a proxy for the patient, putting forward the patient’s views or what they believe are the patient’s views) should be clearly set out, preferably in primary legislation or in the Code of Practice.</td>
<td></td>
<td>MHA (DMH 105)</td>
<td>The Government agrees. The roles are clearly set out in primary legislation and, in addition to what is specified in the primary legislation, guidance about how these roles will work in practice will be given in the code of practice.</td>
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<td>Greater clarity is needed on the role of carers in relation to the Nominated Person.</td>
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<td>MHA (DMH 105)</td>
<td>As above.</td>
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<td>Part 9 Appeals</td>
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<td>249</td>
<td>Right to appeal to Mental Health Appeal Tribunal (1) ...references to a right of appeal are to a right of appeal to the Mental Health Appeal Tribunal on any point of law arising from a determination made by the Mental Health Tribunal ... in respect of a patient.</td>
<td>There is no right to appeal against a Mental Health Tribunal decision, except on a point of law. This constrains detainees’ rights to be less than that of a criminal, and may contravene their human rights.</td>
<td>Gwent Assoc of Voluntary Organisations (DMH 223)</td>
<td>249(a): The Government does not consider that it is necessary to allow appeals on issues of fact. This is in keeping with Government policy and practice in almost all tribunals. Appellate tribunals (such as the Employment Appeal Tribunal and the Social Security Commissioners) have been established to provide a more specialised forum than the High Court to ensure the law in a particular area is correctly applied in line with the statute and any relevant precedent; it is not the intention to second-guess the first tribunal on the facts or on matters of clinical judgement. Where there is an absence of evidence or sufficient evidence to support the decision made, this may amount to an error of law and could therefore be pursued by an application to the Appeal Tribunal.</td>
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<td>Part 10 Functions of Commission for Healthcare Audit and Inspection</td>
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<td>257</td>
<td>Abolition of Mental Health Act Commission The MHAC is abolished</td>
<td>The abolition of a small, standalone, semi independent, specialist Mental Health Act Commission will do enormous harm. The inclusion of some of its functions under the Healthcare Commission will dilute the MHAC's vital role and will result in the loss of the expert knowledge and skills developed over many years.</td>
<td>IMHAP (DMH 50) Church of England (DMH 298) Songhai (DMH 306)</td>
<td>257(a): The Government does not agree. Transfer of MHAC to Healthcare Commission will provide us with a single organisation across the NHS (and the independent sector) that will act as a powerful voice for patients under compulsion, dealing with all issues about the quality of their care and treatment. The Healthcare Commission will continue the specialist focus on the rights of mentally ill patients under compulsion through a variety of means including inspection, assessment, visits and working with service providers to drive forward improvements. Standards used to assess the treatment and care of patients under compulsion, in whatever healthcare setting, will be interpreted to take account of their needs and any breaches of their human rights will be vigorously pursued.</td>
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<td>260</td>
<td>Review of and investigations into exercise of functions</td>
<td>The work of CHAI in monitoring the operation of the Bill must be underpinned by the inclusion of legal principles.</td>
<td>ASS &amp; LGA (DMH 208)</td>
<td>260(a): See response 1(f).</td>
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<td>Monitoring of the Bill should not be the responsibility of the CHAI – there needs to be a specific Mental Health Act Inspectorate, since the proposed compulsion system is so extensive.</td>
<td>National Voices Forum (DMH 240)</td>
<td>260(b): See response 257(a).</td>
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<td>(6)(b)...functions which are excluded functions [from review by CHAI]</td>
<td>CHAI is specifically barred by clause 260(6)(b) from investigating the management of restricted patients by the Secretary of State. Decisions about these, often vulnerable patients, should be made in as open a way as possible and it is in everyone's interests that they should be subject to scrutiny. Opportunities to improve the system and so better protect the public will be missed.</td>
<td>West London mental Health NHS Trust (DM 243) Dr A Horne (DMH 308)</td>
<td>260(c): The Secretary of State's role is to manage risk and protect the public. He is not making clinical decisions. As is the case with MHAC at the moment, it will be beyond CHAI's statutory remit for it to consider the Secretary of State's decisions in this regard.</td>
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<td>262</td>
<td>Investigations into circumstances of deaths (3) The CHAI may investigate the circumstances of death</td>
<td>It is essential that every death is investigated in order to ensure that any mistakes in treatment are not repeated and that lessons which can save lives in the future are learnt.</td>
<td>Eating Disorders Association (DMH 205)</td>
<td>262(a): Where CHAI is informed that a person has died whilst subject to compulsion it has a power to investigate the circumstances of the death. The MHAC has been undertaking such investigations when the matter is within its remit, but the policy under the Bill gives CHAI this specific function. The Government agrees that the circumstances of these deaths should always be investigated, but CHAI may not always be best placed to undertake such an investigation. It is important to note that this power would be in addition to any existing statutory powers relating to investigations of circumstances of death held by coroners under the Coroners Act 1988 and the functions of the Health and Safety Executive, which also investigates deaths.</td>
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<td>270</td>
<td>Right of access</td>
<td>It is very important that the visiting and protective elements of the current MHAC are maintained. The power of the Healthcare Commission to visit establishments should become a duty to visit, comparable with that held currently by the Mental Health Act Commission, to ensure that services are submitted to regular inspections.</td>
<td>Tees &amp; NE Yorks Trust (DMH 196) ASS &amp; LGA (DMH 208)</td>
<td>270(a): The Bill will enable CHAI to carry out announced and unannounced investigations, where appropriate. Hence, CHAI will be able to visit and investigate where it has cause for concern or simply as a preventative measure (on a programmed or on an occasional basis) where there is no indication that something is amiss. Its new visiting function will therefore be very similar to that of the MHAC.</td>
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<td>271</td>
<td>Right of entry</td>
<td>There should be strict conditions governing the right of persons authorised by CHAI to enter and inspect private dwellings where patients live or have lived and remove documents or other items.</td>
<td>S Hensman (DMH 263)</td>
<td>271(a): The Bill does not provide any powers for CHAI to enter and inspect private dwellings.</td>
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Other comments:

Welsh language

CHAI will be expected to continue to implement the Welsh Language Scheme which was adopted by its predecessor.

Welsh Language Board (DMH 310)

The Healthcare Commission intends to operate a similar Welsh Language Scheme to that of the Commission for Health Improvement. This has been submitted to the Welsh Language Board for approval.
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| 278    | **Obstruction**  
(1) Any person who without reasonable cause – 
(a) refuses to allow an authorised person to enter or inspect any premises, 
(b) refuses to – 
(i) allow the visiting, interviewing, meeting or examination of a patient, or the visiting, interviewing or examination of a patient in private, by an authorised person, or 
(ii) give access to a patient to an authorised person, 
(c) refuses to produce for the inspection of an authorised person any information, record, document or other item the production of which is duly required by him, 
(d) refuses to provide to an authorised person an explanation which is duly required of him, or 
(e) otherwise obstructs an authorised person in the discharge of any of his functions, is guilty of an offence. | Obstruction is too broadly defined. | S Hensman (DMH 263) | 278(a): The Government does not agree that the definition of obstruction is too broad. The provision is closely based on the existing offence under the Mental Health Act 1983. The one addition is subsection (d) which ensures that the power of the Commission for Healthcare Audit and Inspection to require explanations (under clause 274) is enforceable. As with the existing offence under the Mental Health Act 1983, it is not anticipated that the provision will be used frequently. While prosecutions are expected to be relatively few, the offence is important for its deterrent effect in supporting other provisions, such as the investigation powers of the Commission for Healthcare Audit and Inspection. |
281

**Assisting patients to absent themselves without leave etc**

(6) A person guilty of an offence under this section is liable –

(a) on summary conviction, to imprisonment for a term not exceeding 12 months or to a fine not exceeding the statutory maximum, or to both,

(b) on conviction on indictment, to imprisonment for a term not exceeding two years or to a fine of any amount, or to both.

The penalties for assisting a patient to absent himself or herself without leave are too heavy, and making this an offence (except perhaps where the patient has been remanded for or convicted of a serious offence) could place family members and friends in a difficult situation.

S Hensman (DMH 263)

281(a): The Bill describes the maximum penalties that can be imposed. This enables appropriate penalties to be available for the full range of situations that may arise. The maximum penalty for conviction on indictment is the same as in the Mental Health Act 1983. In order to retain the option of imprisonment on summary conviction, when the Criminal Justice Act 2003 is fully implemented in 2006, the maximum penalty on summary conviction has been increased from 6 months to 12 months. When custody plus is implemented summary offences will need to have a maximum penalty of at least 51 weeks or become non-imprisonable.

**Other comments:**

Who has the duty to investigate and prosecute offences under the Bill should be made clear.

IMHAP (DMH 50)

It would be usual for prosecutions to be brought by the Crown Prosecution Service. It is likely that any offence would be identified by someone working in mental health services, by the Commission for Healthcare Audit and Inspection or perhaps by a patient or carer. Guidance in the Code of Practice will advise on the appropriate action to be taken, including informing the police who would investigate where appropriate.

Part 12 Miscellaneous

284

**Duty of hospital managers to give information about treatment**

(4) The managers of the relevant hospital need not take steps specified ...,to secure that each relevant person is provided with information about the provision of treatment] if –

(a) they think it would be inappropriate to do so, or

(b) it is impracticable to do so.

The circumstances in which a patient or other relevant person may be denied information about treatment should be more clearly defined.

S Hensman (DMH 263)

284(a): In most cases we do not envisage that a patient will be denied information about their treatment. The code of practice will give guidance on the circumstances when it may not be appropriate or practical to give information about treatment to a patient.
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<td>There should be a right to information for all children and young people whose parent or carer is subject to compulsory treatment.</td>
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<td>Barnado’s (DMH 315)</td>
<td>284(b): In setting out the requirement to consult and notify those involved in the patients care and treatment, we have had to balance carefully the interest of people to be informed about a patient’s condition with the right of the patient to privacy. In the case of children and young people there is the added need to ensure that any information given is appropriate to the age, understanding and circumstances of the child or young person, for example, where the young person is the main carer. Where health and social care professionals are required to consult a carer, they must have regard to the patient’s wishes and feelings in deciding whether it is appropriate to do so. The Bill sets out the minimum consultation and notification requirements, full guidance will be set out in the Code of Practice.</td>
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| 298    | **Protection for acts done in pursuance of this Act**  
   (1) In any civil proceedings against an individual in respect of any act purporting to be done under or in pursuance of this Act, or any regulations or rules made under it, it is a defence that the act was done in good faith and with reasonable care. | A balance needs to be struck between the rights of patients to a fair trial, and the need for health professionals to be protected from spurious litigation. Under the Mental Health Act 1983, an action could not succeed unless the complainant could prove that professionals were acting in bad faith or without reasonable care. In the draft Bill, the onus is shifted onto the person complained against to prove that they acted in good faith and with reasonable care. | BMA (DHM 248)                             | 298(a): The 2002 consultation document asked whether the proposals struck the right balance between the rights of patients and the protection of staff from inappropriate allegations. Broadly, there was an even split among key stakeholders between those in favour and those against the proposal, reflecting, as one might expect, the concern of professional staff organisations to protect staff and the concern of service user groups to protect vulnerable patients. As the BMA and other stakeholders acknowledge, the balance between protecting vulnerable patients and protecting staff is a difficult one to get right. While the draft clause provides less protection for staff than the current Act, it does retain some additional protection for staff acting under the provisions of the Bill. Those who agreed with the proposal thought that the right to take action, combined with the defence of good faith and reasonable care, represented a sensible solution to a difficult problem. The draft clause represents a compromise between the equivalent provision in the Mental Health Act 1983, and having no provision at all, as is the case for proceedings brought by other patients. |
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<td>2 (Constitution of MHTs for England and Wales)</td>
<td>If members of the Tribunal are known to each other, these should be declared.</td>
<td>This proposal is considered to be impracticable. Given the need for both specialist expertise and efficiency in the operation of the Tribunal system (ie the need to take geography into account), it is to be expected that Tribunal members may have met previously. The Government does not accept that the fact that Tribunal members know each other, or even work together regularly, means that they would be more likely to collude together against the interests of patients. Additionally, it would be very bureaucratic for the Tribunal Secretariat to have to establish and keep account of which Tribunal members “know” each other. It might also be difficult to determine a practical threshold as to how “known to each other” might be defined. It is also unclear what the purpose of such declarations might be. Since the Government does not accept that Tribunal members being known to each other would be of detriment to patients’ interests, the provision of such information to patients would be of little assistance and may even prove misleading to them (for example, it would not be appropriate to encourage patients to consider that it provided grounds to object to particular members or to appeal against Tribunal decisions).</td>
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<td>There should be a right to request another member of the Tribunal if the person under assessment wishes.</td>
<td>A blanket right for the patient to be able to request the replacement of a member of the Tribunal would be impracticable. The Government accepts that potential conflicts of interest can arise which would make it inappropriate for a member to be involved in certain individual cases. As now, this will be dealt with in Tribunal Rules, for example, where a Tribunal member has a personal connection with the patient or has recently treated the patient in a professional medical capacity they should not be selected to hear that patient’s case. A member should refuse an appointment to a tribunal panel if that appointment would raise legitimate questions about their ability to exercise an independent judgement. If necessary, a patient, or their representative, could raise an objection to a Tribunal member at the hearing and the Tribunal would consider whether the grounds for their objection justified reconvening the Tribunal with a replacement member.</td>
<td>Life Craft (DMH 220)</td>
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| 2(1)    | the other members must fall within the following descriptions:  
(a) persons who have a 7 year general qualification (within the meaning of section 71 of the Courts and Legal Services Act 1990 (cl. 41) (“legal members”),  
(b) persons who have such knowledge or experience of the treatment of mentally disordered persons as the Lord Chancellor thinks fit (“clinical members”),  
(c) persons (not falling within paragraph (a) or (b)) who have such knowledge or experience of the provision of mental health services as the Lord Chancellor thinks fit. | We do not accept that there must be a clinical member on the Tribunal but would support that role being extended to professionals from a social work background. We accept that clinical expertise needs to be available to the Tribunal but believe that this should be supplied through the mandatory examination from a doctor on the expert panel and by any other experts that may be recruited. Expertise in such issues as housing or other accommodation, benefits and social services are relevant. Other mental health professionals may also have a broader expertise to offer. The automatic membership of a clinical member will lead to hearings being based exclusively on the medical model of mental health care. | MIND (DMH 210)  
MHA (DMH 105) | The Government is looking carefully at the definition and criteria of Tribunal membership to ensure that the right mix of experience and expertise is available for all Tribunals, including both the social care and service user perspectives, to ensure flexibility is provided for the successful operation of the new system, while still maintaining expertise. Under the Bill, medical members are superseded by clinical members and so this category of Tribunal member may in future be drawn from non-medical professions such as psychology. As explained above, the Government is aware of the importance of the Tribunal having expertise, or access to expertise via the Expert Panel, in the social care model and any other specialist areas that may be relevant to a case, for example, the treatment of child or adolescent patients, or patients with a mental disorder who have a learning disability. |
|         | As a matter of principle the lay member of the Tribunal should be a person who has experience of mental health services as a user or carer, family member, volunteer or employee who works with and can represent any of these groups. | | MIND (DMH 210)  
MHA (DMH 105) | The intention is that the panel of “lay” members will include people with appropriate experience of mental health services as users, carers, family members, volunteers and employees. |
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<td>4(1)</td>
<td>The functions of the Mental Health Tribunal for England or the Mental Health Tribunal for Wales are to be discharged by panels consisting of one, two or three members chosen by the President of the Tribunal.</td>
<td>There should not be scope for Tribunals to be heard by just one person.</td>
<td>Welsh Nursing &amp; Midwifery Committee (DMH 100)</td>
<td>In keeping with current Government policy for Tribunals, the Bill will provide maximum flexibility for one, two or three member Tribunal panels. The power will be exercised by the President when listing cases to be heard, according to Tribunal Rules made by the Lord Chancellor. Single member sittings will only be used in circumstances set out in Rules, for example, non-medical matters such as failure to appoint a nominated person and technical, procedural or preliminary matters. It will not be an option because there is difficulty convening a three member panel. Further work is being carried out to examine what type of cases might be appropriate for one or two member panels.</td>
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<td>There should be strict control of the circumstances in which a one or two person Tribunal should be permitted.</td>
<td>FortUs &amp; Mind Wales (DMH 36)</td>
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<td>One person hearings are unacceptable even in the case of “purely procedural or other technical hearings”.</td>
<td>Westminster Users Group (DMH 172)</td>
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<td>Tribunals should consist of a minimum of three members in order to be in every way fair (and be seen to be fair).</td>
<td>S Johnson (DMH 167)</td>
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<td>5 (Relationship Between Parts 2 and 3 etc)</td>
<td>As to whether the proposals are clear, the Law Society refers the Committee to Schedule 5 of the Bill as just one of many examples of impenetrable lack of clarity.</td>
<td></td>
<td>Law Society (DMH 111)</td>
<td>The Government’s view is that the drafting achieves its aim.</td>
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<td>11 (List of Official Communications for Purposes of section 289)</td>
<td>IMHA Advocates should be included in the list of official communicants in Schedule 11 as this will safeguard the patient’s right to correspond with his or her representative without interference by hospital or other authorities.</td>
<td></td>
<td>Association for Mental Health Advocates (DMH 267)</td>
<td>IMHA Advocates are already included in the list of official communicants (Schedule 11 paragraph 13).</td>
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Extract from the House of Lords Minute 14 July 2004
Mental Health—It was moved by the Lord President (Baroness Amos) that it is expedient that a Joint Committee of Lords and Commons be appointed to consider and report on any draft Mental Health Bill presented to both Houses by a Minister of the Crown, and that the Committee shall report on the draft Bill by 31st March 2005; the motion was agreed to; and a message was ordered to be sent to the Commons to seek their agreement thereto.

Extract from the Votes and Proceedings of the House of Commons 20 July 2004
Draft Mental Health Bill (Joint Committee),—Ordered, That the Lords Message of 15th July relating to a Joint Committee of both Houses to consider and report on any draft Mental Health Bill presented to both Houses by a Minister of the Crown, be now considered;

That this House concurs with the Lords that it is expedient that a Joint Committee of Lords and Commons be appointed to consider and report on any draft Mental Health Bill presented to both Houses by a Minister of the Crown, and that the Committee should report on the draft Bill by 31st March 2005;

That a Select Committee of 12 honourable Members be appointed to join with the Committee appointed by the Lords to consider the draft Mental Health Bill;

That the Committee shall have power—

(i) to send for persons, papers and records;
(ii) to sit notwithstanding any adjournment of the House;
(iii) to report from time to time;
(iv) to appoint specialist advisers;
(v) to adjourn from place to place within the United Kingdom;

That the quorum of the Committee shall be two; and

That Mrs Liz Blackman, Mrs Angela Browning, Mr David Hinchliffe, Mr George Howarth, Tim Loughton, Mr Paul Marsden, Laura Moffatt, Ms Meg Munn, Dr Doug Naysmith, Mr Gwyn Prosser, Dr Howard Stoate and Hywel Williams be members of the Committee. — (Gillian Merron.)

Message to the Lords to acquaint them therewith.

Extract from the House of Lords Minute 22 July 2004
Mental Health—It was moved by the Chairman of Committees that the Commons message of yesterday be now considered, and that a Committee of twelve Lords be appointed to join with the Committee appointed by the Commons to consider and report on any draft Mental Health Bill presented to both Houses by a Minister of the Crown;
That, as proposed by the Committee of Selection, the Lords following be named of the Committee:

B. Barker
L. Carlile of Berriew
L. Carter
B. Cumberlege
B. Eccles of Moulton
B. Finlay of Llandaff
Lord Mayhew of Twysden
B. McIntosh of Hudnall
B. Murphy
B. Pitkeathley
L. Rix
L. Turnberg

That the Committee have power to agree with the Commons in the appointment of a Chairman;
That the Committee have leave to report from time to time;
That the Committee have power to appoint specialist advisers;
That the Committee have power to adjourn from place to place within the United Kingdom;
That the quorum of the Committee shall be two;
That the reports of the Committee from time to time shall be printed, notwithstanding any adjournment of the House;
That the Committee do report on the draft Bill by 31st March 2005; and
That the Committee do meet with the Committee appointed by the Commons on Wednesday 15th September at 10 o’clock;

the motion was agreed to and a message was ordered to be sent to the Commons to acquaint them therewith.

Extract from the House of Lords Minute 14 September 2004
Mental Health—It was moved by the Chairman of Committees that the Lord Mayhew of Twysden be appointed a member of the Select Committee in the place of the Baroness Fookes; the motion was agreed to.

Extract from the House of Lords Minute 29 November 2004
Mental Health—It was moved by the Chairman of Committees that a Committee of twelve Lords be appointed to join with a Committee appointed by the Commons to consider and report on any draft Mental Health Bill presented to both Houses by a Minister of the Crown;

That, as proposed by the Committee of Selection, the Lords following be named of the Committee:

B. Barker
L. Carlile of Berriew
L. Carter
B. Cumberlege
B. Eccles of Moulton
B. Finlay of Llandaff
Lord Mayhew of Twysden
B. McIntosh of Hudnall
B. Murphy
B. Pitkeathley
L. Rix
L. Turnberg
That the Committee have power to agree with the Commons in the appointment of a Chairman;

That the Committee have leave to report from time to time;

That the Committee have power to appoint specialist advisers;

That the quorum of the Committee shall be two;

That the Committee have power to adjourn from place to place within the United Kingdom;

That the proceedings of the Joint Committee on the draft Mental Health Bill in the last session of Parliament be referred to the Committee;

That the reports of the Committee from time to time shall be printed, notwithstanding any adjournment of the House;

And that the Committee do report on the draft Bill by 31st March 2005;

the motion was agreed to and a message was ordered to be sent to the Commons to acquaint them therewith.

*Extract from the Votes and Proceedings of the House of Commons 30 November 2004*

Draft Mental Health Bill (Joint Committee).—Ordered, That the Lords Message [29th November] relating to the draft Mental Health Bill be now considered.

That this House concurs with the Lords in the said Resolution.

That, in accordance with the Order of the House of 20th July in the last Session of Parliament, a Select Committee of twelve Members be appointed to join with a Committee appointed by the Lords, as the Joint Committee on the draft Mental Health Bill, with the same terms of reference, powers and membership as in the last Session and that the proceedings of the Joint Committee on the draft Mental Health Bill in the last Session of Parliament be referred to the Committee; and

That the Committee do meet with the Committee appointed by the Lords on Wednesday 1st December at half-past Nine o’clock in the Boothroyd Room. — (Mr Vernon Coaker.)

Message to the Lords to acquaint them therewith.
Wednesday 15 September 2004

Present:
Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Dr Howard Stoate
Hywel Williams

Baroness Barker
Lord Carlile of Berriew
Baroness Eccles of Moulton
Baroness Finlay of Llandaff
Baroness McIntosh of Hudnall
Lord Mayhew of Twysden
Baroness Pitkeathley
Lord Rix

The Orders of Reference are read.

The declarations of relevant interests are made:

Baroness Barker declared an interest as Employee of Age Concern England.

Lord Carlile of Berriew QC declared an interest as a barrister; Vice Chair and Trustee of REKINDLE (a mental health charity); and a relative had received treatment for mental illness.

Baroness Finlay of Llandaff declared an interest as Professor of Palliative Medicine and Vice Dean, University of Wales College of Medicine; Clinical Consultant to the Velindre NHS Trust; Director of the Institute of Medical Ethics; and Patron of Westminster Education Forum.

The Rt Hon Lord Mayhew of Twysden QC declared an interest as the minister with responsibilities for the bill which became the Mental Health Act 1983; and President of Tonbridge and Tunbridge Wells MENCAP.

Baroness Pitkeathley declared an interest as Chair of the Children and Families Court Advisory and Support Service (CAFCASS); President of Volunteering England (formerly National Centre for Volunteering); Vice President of Carers UK; and Vice President of the Princess Royal Trust for Carers.

Lord Rix declared an interest as President of the Royal Mencap Society; President of Friends of Normansfield (financial grants for projects concerned with learning disabled people); Chairman of the Mencap City Foundation (financial grants for projects concerned with learning for disabled people); President of MCIS Ltd, who make an annual contribution to the Mencap City Foundation (it was originally Mencap City Insurance Services Ltd); and an honorary fellow of the Royal College of Psychiatrists.

Mrs Liz Blackman declared an interest as chair of the All-Party Parliamentary Group on Autism.
Mrs Angela Browning declared an interest as Vice President of the National Autistic Society; Patron of Interventions into Autism Research Trust; and Vice President of the Alzheimer’s Disease Society.

Tim Loughton declared an interest as a Vice President of MIND in West Sussex.

Laura Moffatt declared an interest as chair of the All Party Depression Group, the secretariat of which is provided by the Depression Alliance.

Dr Howard Stoate declared an interest as a general medical practitioner and a general practice tutor in the South Thames Region.

It is moved that Lord Carlile of Berriew do take the Chair. — (Baroness Eccles of Moulton.)

The same is agreed to.

The Joint Committee deliberate.

Ordered, That Strangers be admitted during the examination of witnesses unless otherwise ordered.

Ordered, That the uncorrected transcripts of oral evidence given, unless the Committee otherwise orders, be published on the Internet.

Ordered, That the Joint Committee be adjourned to Wednesday 13 October at 9.30 a.m.

Wednesday 13 October 2004

Present:

Mrs Liz Blackman  Mrs Angela Browning  Mr David Hinchliffe  Mr George Howarth  Tim Loughton  Mr Paul Marsden  Laura Moffatt  Dr Doug Naysmith  Mr Gwyn Prosser  Dr Howard Stoate  Baroness Barker  Lord Carter  Baroness Cumberlege  Baroness Eccles of Moulton  Baroness Finlay of Llandaff  Baroness Flather  Baroness McIntosh of Hudnall  Lord Mayhew of Twysden  Baroness Pitkeathley  Lord Rix  Lord Turnberg

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 15 September are read.
Further declarations of relevant interests are made:

Lord Carter declared an interest as Trustee of the Andrew Carter Trust – to be renamed the Andrew and Catherine Carter Trust – (which is a small family charity which makes grants to disabled people); Patron of the Shaw Trust (employment of disabled people); Vice Patron of Vocal Eyes (audio description for the visually impaired); and member of the OFCOM Advisory Committee on older and disabled persons.

Baroness Cumberlege declared an interest as Chair of Council of St. George’s Hospital Medical School; Council Member of the Sussex University Brighton and Sussex Medical School; and as Senior Associate of the King’s Fund; and as Director of Cumberlege Connections Ltd.

Baroness Flather declared an interest as her husband was the chairman of a mental health tribunal.

Lord Turnberg declared an interest as Vice President of the Academy of Medical Sciences; Scientific Advisor to the Association of Medical Research Charities; and retired Physician and Professor of Medicine.

The Joint Committee deliberate.

Ordered, That the Committee be adjourned to Wednesday 20 October at 9.30 a.m.

**Wednesday 20 October 2004**

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Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 13 October are read.

The Joint Committee deliberate.

Resolved, That the Committee do visit South London and Maudsley NHS Trust and Wales.—(*The Chairman.*)
The following witnesses are examined:

Professor Genevra Richardson; Professor Kamlesh Patel, Chairman, and Mr Christopher Heginbotham, Chief Executive, Mental Health Act Commission.

Ordered, That the Committee be adjourned to Wednesday 27 October at 9.30 a.m.

### Wednesday 27 October 2004

Present:

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Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 20 October are read.

The Joint Committee deliberate.

Ordered, That Professor Philip Fennell and Professor Thomas Burns be appointed as Specialist Advisers to assist the Committee in its inquiry into the draft Mental Health Bill.

The following witnesses are examined:

Dr Tony Zigmond, Vice-President, Professor Sue Bailey, Chair, Faculty of Child and Adolescent Psychiatry, Professor Greg O’Brien, Chair, Faculty of the Psychiatry of Learning Disability, and Dr John O’Grady, Chair, Faculty of Forensic Psychiatry, Royal College of Psychiatrists; Mr Yens Marsen-Luther, Chief Executive Officer, Mrs Jennifer Scudamore, Chairman, Mr Guy Davis, Honorary Treasurer, and Miss Melanie Woodcock, North Thames Regional Group Chair, Institute of Mental Health Act Practitioners.

Ordered, That the Committee be adjourned to Wednesday 3 November at 9.30 a.m.
Wednesday 3 November 2004

Present:
Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Gwyn Prosser
Dr Howard Stoate
Hywel Williams

Baroness Barker
Lord Carter
Baroness Cumberlege
Baroness Finlay of Llandaff
Baroness Flather
Baroness McIntosh of Hudnall
Lord Mayhew of Twysden
Baroness Pitkeathley
Lord Rix
Lord Turnberg

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 27 October are read.

The Joint Committee deliberate.

The following witnesses are examined:

Mr Paul Farmer, Director of Public Affairs, Rethink, Chair of the Mental Health Alliance, Dr Rowena Daw, Head of Policy Development, Mind, Chair of Mental Health Alliance Policy Group, Dr Mike Shooter, President, Royal College of Psychiatrists, Mr Graham Estop, Voices Forum; Ms Lucy Scott-Moncrieff, Joint Chair of the Mental Health and Disability Committee, Mr Tim Spencer-Lane, Policy Adviser to the Mental Health and Disability Committee, Law Society; Mr Paul Bowen, Barrister, and Ms Aswini Weereratne, Barrister, Bar Council.

Ordered, That the Committee be adjourned to Wednesday 10 November at 9.30 a.m.
Wednesday 10 November 2004

Present:
Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Gwyn Prosser
Dr Howard Stoate
Hywel Williams
Baroness Barker
Lord Carter
Baroness Cumberlege
Baroness Finlay of Llandaff
Baroness McIntosh of Hudnall
Baroness Pitkeathley
Lord Rix

Lord Carlile of Berriew in the Chair
The Order of Adjournment is read.
The proceedings of Wednesday 3 November are read.
The Joint Committee deliberate.
The following witnesses are examined:
Mr Richard Brook, Chief Executive Officer, Mind, Ms Kay Sheldon, representative of Mindlink, Mind’s service user network, Ms Lindsey Foyster, Director, Mind Cymru; Dr Anneke Westra and Mr Roger Keeling, No Force; Mr Cliff Prior, Chief Executive Officer, Mr Mike Took, service user and National Policy Officer, Ms Elaine Barnes, carer, Ms Mary Teasdale, Advice Service Manager, Rethink; Ms Jo Roberts, service user, and Ms Vicky Yates, carer, Hafal.

Ordered, That the Committee be adjourned to Wednesday 17 November at 9.30 a.m.

Wednesday 17 November 2004

Present:
Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Dr Howard Stoate
Hywel Williams
Baroness Barker
Lord Carter
Baroness Cumberlege
Baroness Eccles of Moulton
Baroness McIntosh of Hudnall
Lord Mayhew of Twysden
Lord Rix
Lord Turnberg

Lord Carlile of Berriew in the Chair
The Order of Adjournment is read.

The proceedings of Wednesday 10 November are read.

The Joint Committee deliberate.

The following witnesses are examined:

Ms Angela Greatley, Chief Executive, Mr Malcolm King, Programme Lead, Sainsbury Centre for Mental Health; Mr Niall Dickson, Chief Executive, Mr Simon Lawton-Smith, Senior Policy Adviser (Mental Health), King’s Fund; Mr David Hewitt, Solicitor, Ms Lucy Scott-Moncrieff, Solicitor; Mr David Congdon, Head of External Affairs, Mencap; Mr Richard Kramer, Director of Policy, Turning Point and Co-Chair, Mr Jonathan Coe, Chief Executive, Prevention of Professional Abuse Network (POPAN) and Chairman of the Association of Mental Health Advocates, and Ms Henrietta Marriage, Barrister, Head of Mind Legal Unit, Making Decisions Alliance.

Ordered, That the Committee be adjourned to Wednesday 1 December 2004 at 9.30 a.m.

The Joint Committee was re-appointed with the same powers on Tuesday 30 November, session 2004-05. Baroness Flather was discharged from the Joint Committee and Baroness Murphy added.

Wednesday 1 December 2004

Present:

Mrs Liz Blackman  
Mrs Angela Browning  
Mr David Hinchliffe  
Mr George Howarth  
Tim Loughton  
Laura Moffatt  
Ms Meg Munn  
Dr Doug Naysmith  
Hywel Williams  
Baroness Barker  
Lord Carter  
Baroness Eccles of Moulton  
Baroness McIntosh of Hudnall  
Lord Mayhew of Twysden  
Baroness Murphy  
Baroness Pitkeathley  
Lord Rix  
Lord Turnberg

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 17 November are read.

A further declaration of relevant interests is made:

Baroness Murphy declared an interest as Visiting Professor (Hon.) in the Psychiatry Department of Queen Mary College, University of London; former Vice Chair of the Mental Health Act Commission; recent UK adviser to the World Health Organization in mental health; Chairman of the North East London Strategic Health Authority (NHS); and Vice President of the Alzheimer’s Society (England and Wales).
The Joint Committee deliberate.

Resolved, That the Joint Committee do visit Broadmoor Hospital.—(The Chairman.)

The following witnesses are examined:

Dr Brian Jacobs, Child Psychiatrist, Dr Patrick Byrne, Adolescent Psychiatrist, South London and the Maudsley NHS Trust; Mr Gavin Baylis, Senior Policy Officer, Mr Gul Y Davis, YoungMinds, Ms Nancy Kelley, Principal Policy Officer, Barnardo’s, and Ms Christine Daly, Social Policy Adviser, Children’s Legal Centre.

Ordered, That the Committee be adjourned to Wednesday 8 December at 9.30 a.m.

**Wednesday 8 December 2004**

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<td>Lord Rix</td>
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Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 1 December are read.

The Joint Committee deliberate.

The following witnesses are examined:

Professor Nigel Eastman, Professor of Law and Ethics in Psychiatry, University of London, and Head of Forensic and Personal Disorder Psychiatry, St George’s Hospital Medical School, London, Professor Tony Maden, Professor of Forensic Psychiatry, Imperial College London, Honorary Consultant, West London Mental Health NHS Trust and Lead Clinician, Dangerous Severe Personality Disorder Service, Broadmoor Hospital; Mrs Jayne Zito, Patron, Mr Michael Howlett, Director, the Zito Trust, Mr Nick O’Shea, Director of Development, Ms Ethel Samkange, Director of Link Worker Schemes, Revolving Doors Agency, Ms Sue Kesteven and Ms Lucy Smith, NACRO.

Ordered, That the Committee be adjourned to Wednesday 15 December at 9.55 a.m.
Wednesday 15 December 2004

Present:
Mrs Liz Blackman
Mrs Angela Browning
Mr David Hinchliffe
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Hywel Williams
Baroness Eccles of Moulton
Baroness Finlay of Llandaff
Baroness McIntosh of Hudnall
Lord Rix

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 8 December are read.

The Joint Committee deliberate.

The following witnesses are examined:
Ms Jane Hutt AM, Minister for Health and Social Services, Welsh Assembly Government; Mr David Melding AM, Chairman, Ms Kirsty Williams AM, Health Spokesperson for the Liberal Democrats, Mr Rhodri Glyn Thomas AM, Health Spokesperson for Plaid Cymru, Health and Social Services Committee of the National Assembly for Wales; Ms Mag Richards and Mrs Celia Cowie, development workers, Powys Agency for Mental Health; Mr Prys Davies, Director of Strategic Operations, and Mr Andrew White, Leader of the Health and Care Unit, Welsh Language Board.

Ordered, That the Committee be adjourned to Wednesday 12 January at 9.30 a.m.

Wednesday 12 January 2005

Present:
Mrs Liz Blackman
Mrs Angela Browning
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Dr Howard Stoate
Hywel Williams
Baroness Barker
Lord Carlile of Berriew
Lord Carter
Baroness Cumberlege
Baroness Eccles of Moulton
Baroness Finlay of Llandaff
Baroness McIntosh of Hudnall
Lord Mayhew of Twysden
Baroness Murphy
Baroness Pitkeathley
Lord Rix
Lord Turnberg

Lord Carlile of Berriew in the Chair
The Order of Adjournment is read.

The proceedings of Wednesday 15 December are read.

The Joint Committee deliberate.

The following witnesses are examined:

Dr Paddy Power, Lead Consultant Psychiatrist and Honorary Senior Lecturer, South London and Maudsley NHS Trust; Mr Colin McKay, Scottish Executive, formerly Leader of the Mental Health Bill Team, Mr Colin Faulkner, Scottish Executive, Policy Officer working on Implementation of the new Act, Ms Fiona Tyrell, Scottish Executive, Implementation Team Leader, Mental Health Act and Dr Madeline Osborne, Deputy Director of the Mental Welfare Commission for Scotland.

Ordered, That the Committee be adjourned to this day at 2.30 p.m.

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**Wednesday 12 January 2005**

*Present:*

- Mrs Angela Browning
- Mr George Howarth
- Tim Loughton
- Laura Moffatt
- Ms Meg Munn
- Dr Doug Naysmith
- Mr Gwyn Prosser
- Dr Howard Stoate
- Hywel Williams

- Baroness Barker
- Lord Carter
- Baroness Cumberlege
- Baroness Eccles of Moulton
- Baroness Finlay of Llandaff
- Baroness McIntosh of Hudnall
- Lord Mayhew of Twysden
- Baroness Murphy
- Baroness Pitkeathley
- Lord Rix
- Lord Turnberg

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 12 January at 9.30 a.m. are read.

The Joint Committee deliberate.

The following witnesses are examined:

His Honour Judge Phillip Sycamore, Liaison Judge for Mental Health Review Tribunals, Mrs. Carolyn Kirby, Regional Chairman Mental Health Review Tribunals for Wales, Rt Hon Lord Newton of Braintree OBE, Chairman of the Council on Tribunals, Ms Penny Letts, member of the Council on Tribunals; Ms Jenny Goodall, Director of Social Services, London Borough of Brent, and Mrs Paula Hallam, Strategic Service Manager for Mental Health, Hampshire County Council, Association of Directors of Social Services, Cllr Maureen Robinson, New Forest District Council, Local Government Association, Mr
Ordered, That the Committee be adjourned to Wednesday 19 January at 9.30 a.m.

**Wednesday 19 January 2005**

Present:

Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Dr Doug Naysmith
Mr Gwyn Prosser
Dr Howard Stoate
Hywel Williams

Lord Carter
Baroness Cumberlege
Baroness Eccles of Moulton
Baroness McIntosh of Hudnall
Baroness Pitkeathley

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 12 January are read.

The Joint Committee deliberate.

The following witnesses are examined:

Ms Rosie Winterton MP, Minister of State, Department of Health, Mr Paul Goggins MP, Parliamentary Under-Secretary of State, Home Office, Professor Louis Appleby, Mental Health Clinical Director, Mr Adrian Sieff, Head, Mental Health Legislation Branch, Department of Health, and Mr Nigel Shackleford, Deputy Head, Mental Health Unit, Home Office.

Ordered, That the Committee be adjourned to this day at 2.30 p.m.
**Wednesday 19 January 2005**

Present:
- Mrs Angela Browning
- Mr David Hinchliffe
- Mr George Howarth
- Tim Loughton
- Laura Moffatt
- Dr Doug Naysmith
- Dr Howard Stoate
- Hywel Williams
- Lord Carter
- Baroness Cumberlege
- Baroness Eccles of Moulton
- Baroness McIntosh of Hudnall
- Baroness Pitkeathley

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 19 January at 9.30 a.m. are read.

The Joint Committee deliberate.

*Ordered*, That the Committee be adjourned to Wednesday 26 January at 9.30 a.m.

**Wednesday 26 January 2005**

Present:
- Mrs Liz Blackman
- Mrs Angela Browning
- Mr David Hinchliffe
- Mr George Howarth
- Tim Loughton
- Ms Meg Munn
- Dr Doug Naysmith
- Mr Gwyn Prosser
- Hywel Williams
- Lord Carter
- Baroness Eccles of Moulton
- Baroness Finlay of Llandaff
- Baroness McIntosh of Hudnall
- Lord Mayhew of Twysden
- Baroness Murphy
- Baroness Pitkeathley
- Lord Rix
- Lord Turnberg

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 19 January are read.

The Joint Committee deliberate.

The following witnesses are examined:

Lord Adebowale, Chief Executive, and Mr Ronnie Watson, Mental Health Act Coordinator, Turning Point, Dr Joanna Bennett, Workforce Development Manager, Breaking the Circles of Fear Project, Mr Chinyere Inyama, mental health lawyer, Mr Nisar
Khan, mental health voluntary worker and service user, BME Mental Health Network; Mr Richard Mills, Director of Research, and Dr Julu Crocombe, Consultant Psychiatrist of Care Principles, National Autistic Society; Mr Clive Evers, Director of Information and Education, and Professor Clive Ballard, Director of Research, Alzheimer’s Society.

Ordered, That the Committee be adjourned to this day at 2.30 p.m.

Wednesday 26 January 2005

Present:

Mrs Liz Blackman
Mr David Hinchliffe
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Dr Howard Stoate

Baroness Barker
Lord Carter
Baroness Eccles of Moulton
Baroness Finlay of Llandaff
Baroness McIntosh of Hudnall
Lord Mayhew of Twysden
Baroness Murphy
Baroness Pitkeathley
Lord Rix

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 26 January at 9.30 a.m. are read.

The Joint Committee deliberate.

The following witnesses are examined:

Mr Roger Hargreaves, Chair, Mental Health Special Interest Group, and Ms Hazelanne Lewis, Member, Mental Health Special Interest Group, British Association of Social Workers, Mr Ian Hulatt, Adviser, Royal College of Nursing, Ms Gail Adams, Head of Nursing, and Mr Owen Davies, Senior National Officer, Local Government, Unison; Dr David Harper, Senior Lecturer in Clinical Psychology, University of East London, Professor Peter Kinderman, Professor of Clinical Psychology, University of Liverpool, Ms Sue Ledwith, Consultant Clinical Psychologist and Clinical Lead, North Yorkshire Forensic Psychiatry Service, and Dr Graham E Powell, President Elect, British Psychological Society.

Ordered, That the Committee be adjourned to Wednesday 2 February at 9.30 a.m.
Wednesday 2 February 2005

Present:

Mrs Angela Browning  Baroness Barker
Mr George Howarth   Lord Carter
Tim Loughton        Baroness Cumberlege
Laura Moffatt       Baroness Eccles of Moulton
Ms Meg Munn         Baroness McIntosh of Hudnall
Dr Doug Naysmith    Lord Mayhew of Twysden
Mr Gwyn Prosser     Baroness Murphy
Dr Howard Stoate    Baroness Pitkeathley

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 26 January are read.

The Joint Committee deliberate.

The following witnesses are examined:

Ms Imelda Redmond, Chief Executive, and Mr Mark Robertson, Public Affairs Manager, Carers UK, Dr Gwen Wallace, Chair, and Mrs Linda Lansdell, Forum Committee Member, North Derbyshire Forum for Mental Health Carers; Mr Rick Henderson, Director, and Ms Karen Mellonby, Policy and Communications Manager, Action for Advocacy, Ms Hilary Dyter, Director, Leeds Mental Health Advocacy Group and member of the Association for Mental Health Advocates Steering Committee, Mr Jonathan Coe, Chair of AMHA Steering Committee, Chief Executive of POPAN (Prevention Of Professional Abuse Network) and Chair, Mental Health Alliance Advocacy Special Interests Group, Mr Peter Munn, Secretary, Cymar, and Ms Beverly Mills, Member, Management Committee, United Kingdom Advocacy Network (UKAN).

Ordered, That the Committee be adjourned to this day at 2.30 p.m.
Wednesday 2 February 2005

Present:

Tim Loughton
Ms Meg Munn
Dr Doug Naysmith
Dr Howard Stoate

Baroness Barker
Lord Carter
Baroness Cumberlege
Baroness Eccles of Moulton
Baroness McIntosh of Hudnall
Lord Mayhew of Twysden
Baroness Murphy
Baroness Pitkeathley
Lord Rix

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Wednesday 2 February at 9.30 a.m. are read.

The Joint Committee deliberate.

The following witnesses are examined:

Mr Mike Firn, Chairperson, Mr Michael Hicks, Northern and Yorkshire, Ms Judith Fairweather, London area, National Forum for Assertive Outreach; Professor Graham Thornicroft, Professor of Community Psychiatry at the Institute of Psychiatry, King’s College London, and Director of Research and Development of the South London and Maudsley NHS Trust, and Dr Peter Bartlett, Senior Lecturer in Law at the University of Nottingham; Dr Michael Wilks, Chair, Ethics Committee, Dr JS Bamrah, Chair, Psychiatric Sub-Committee, Dr Robin Arnold, Member, Psychiatric Sub-Committee, British Medical Association, Professor Andre Tylee, and Dr Alan Cohen, Royal College of General Practitioners.

Ordered, That the Committee be adjourned to Thursday 24 February at 9.30 a.m.

Thursday 24 February 2005

Present:

Mrs Angela Browning
Mr David Hinchliffe
Mr George Howarth
Tim Loughton
Laura Moffatt
Ms Meg Munn
Dr Doug Naysmith
Mr Gwyn Prosser
Dr Howard Stoate
Mr Hywel Williams

Lord Carter
Baroness Eccles of Moulton
Baroness Finlay of Llandaff
Baroness McIntosh of Hudnall
Lord Mayhew of Twysden
Baroness Murphy
Baroness Pitkeathley
Lord Rix
Lord Turnberg

Lord Carlile of Berriew in the Chair
The Order of Adjournment is read.

The proceedings of Wednesday 2 February are read.

The Joint Committee deliberate.

Ordered, That the Committee be adjourned to this day at 2.00 p.m.

**Thursday 24 February 2005**

Present:

- Mrs Angela Browning
- Mr George Howarth
- Tim Loughton
- Laura Moffatt
- Ms Meg Munn
- Dr Doug Naysmith
- Mr Gwyn Prosser
- Dr Howard Stoate
- Mr Hywel Williams

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.

The proceedings of Thursday 24 February at 9.30 a.m. are read.

The Joint Committee deliberate.

Ordered, That the Committee be adjourned to Wednesday 9 March at 9.30 a.m.

**Wednesday 9 March 2005**

Present:

- Mrs Liz Blackman
- Mrs Angela Browning
- Mr David Hinchliffe
- Tim Loughton
- Laura Moffatt
- Ms Meg Munn
- Dr Doug Naysmith
- Dr Howard Stoate
- Baroness Barker
- Lord Carter
- Baroness Cumberlege
- Baroness Eccles of Moulton
- Baroness Mayhew of Twysden
- Baroness Mcintosh of Hudnall
- Baroness Murphy

Lord Carlile of Berriew in the Chair

The Order of Adjournment is read.
The proceedings of Thursday 24 February are read.

The Joint Committee deliberate.

It is moved that the draft Report before the Committee be read.

The same is agreed to.

Paragraphs 1 to 444 are agreed to.

Paragraph 445 is read.

It is moved that paragraph 445 stand part of the Report.

<table>
<thead>
<tr>
<th>Contents</th>
<th>Not Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lord Carlile of Berriew</td>
<td>Baroness Barker</td>
</tr>
<tr>
<td>Lord Carter</td>
<td>Mr David Hinchliffe</td>
</tr>
<tr>
<td>Baroness Cumberlege</td>
<td></td>
</tr>
<tr>
<td>Baroness McIntosh of Hudnall</td>
<td></td>
</tr>
<tr>
<td>Lord Mayhew of Twysden</td>
<td></td>
</tr>
<tr>
<td>Baroness Murphy</td>
<td></td>
</tr>
<tr>
<td>Mrs Liz Blackman</td>
<td></td>
</tr>
<tr>
<td>Mrs Angela Browning</td>
<td></td>
</tr>
<tr>
<td>Laura Moffatt</td>
<td></td>
</tr>
<tr>
<td>Ms Meg Munn</td>
<td></td>
</tr>
<tr>
<td>Dr Doug Naysmith</td>
<td></td>
</tr>
</tbody>
</table>

Paragraph 445 is agreed to.

Paragraphs 446 to 458 are agreed to.

The Summary is agreed to.

Resolved, That the draft Report be the Report of the Joint Committee to both Houses.

Ordered, That the following papers be appended to the Report:

1. Extract from Press Notice No. 1 issued on 16 September 2004 by the Committee

2. Programme of visits undertaken by the Committee during the course of its inquiry

3. Glossary

4. Schedule of detailed comments on the draft Mental Health Bill with responses from the Government.

Ordered, That the memoranda received by the Joint Committee be appended to the Minutes of Evidence.

Ordered, That the provisions of Commons Standing Order No. 134 (Select committees (reports)) be applied to the Report.
Ordered, The guide to the Report in easy read format be published separately.

Ordered, That the Chairman do make the Report to the House of Lords and Mr David Hinchliffe do make the Report to the House of Commons.
Witnesses

Wednesday 20 October 2004

Professor Genevra Richardson, Professor of Law, Queen Mary University of London
Ev 1

Professor Kamlesh Patel OBE, Chairman of the Mental Health Act Commission and Mr Christopher Heginbotham, Chief Executive of the Mental Health Act Commission
Ev 39

Wednesday 27 October 2004

Dr Tony Zigmond, Vice-President, Professor Sue Bailey, Chair, Faculty of Child and Adolescent Psychiatry, Professor Greg O’Brien, Chair, Faculty of the Psychiatry of Learning Disability, Dr John O’Grady, Chair, Faculty of Forensic Psychiatry, Royal College of Psychiatrists
Ev 79

Mr Yens Marsen-Luther, Chief Executive Officer, Ms Jennifer Scudamore, Chairman, Mr Guy Davis, Honorary Treasurer, Miss Melanie Woodcock, North Thames Regional Group Chair, Institute of Mental Health Act Practitioners
Ev 107

Wednesday 3 November 2004

Mr Paul Farmer, Director Public Affairs, Rethink, Chair of the Mental Health Alliance; Dr Rowena Daw, Head of Policy Development, Mind, Chair of the Mental Health Alliance Policy Group; Dr Mike Shooter, President, Royal College of Psychiatrists, and Mr Graham Estop, Voices Forum
Ev 155

Ms Lucy Scott-Moncrieff, Joint Chair of the Mental Health and Disability Committee, Law Society, Mr Tim Spencer-Lane, Policy Adviser to the Mental Health and Disability Committee, Law Society, Mr Paul Bowen, Barrister, and Ms Aswini Weereratne, Barrister, Bar Council
Ev 182

Wednesday 10 November 2004

Mr Richard Brook, Chief Executive Officer, Mind, Ms Kay Sheldon, representative of Mindlink, Mind’s service user Network, Ms Lindsay Foyster, Director, Mind Cymru, Dr Anneke Westra and Mr Roger Keeling, No Force
Ev 218

Mr Cliff Prior, Chief Executive Officer, Mr Mike Took, Service User and National Policy Officer, Ms Elaine Barnes, Carer, Ms Mary Teasdale, Advice Service Manager, Rethink, Ms Jo Roberts, Service User, and Ms Vicky Yates, Carer, Hafal
Ev 246
Wednesday 17 November 2004

Ms Angela Greatley, Chief Executive and Mr Malcolm King, Programme Leader, Sainsbury Centre for Mental Health, Mr Niall Dickson, Chief Executive, and Mr Simon Lawton-Smith, Senior Policy Adviser, Mental Health, King's Fund  

Mr David Hewitt and Ms Lucy Scott-Moncrieff, solicitors

Mr David Congdon, Head of External Affairs, Mencap; Mr Richard Kramer, Director of Policy, Turning Point and Co-Chair Making Decisions Alliance; Mr Jonathan Coe, Chief Executive, POPAN (Prevention of Professional Abuse Network), and Ms Henrietta Marriage, Head of Mind Legal Unit (Making Decisions Alliance)

Wednesday 1 December 2004

Dr Brian Jacobs, Child Psychiatrist, and Dr Patrick Byrne, Adolescent Psychiatrist, South London and Maudsley NHS Trust

Mr Gavin Baylis, Senior Policy Officer, Mr Gul Y Davis, YoungMinds, Ms Nancy Kelly, Principal Policy Officer, Barnardo’s, Ms Christine Daly, Social Policy Adviser, Children’s Legal Centre

Wednesday 8 December 2004

Professor Nigel Eastman, Professor of Law and Ethics in Psychiatry, University of London and Head of Forensic and Personal Disorder Psychiatry, St George’s Hospital Medical School, London, Professor Tony Maden, Professor of Forensic Psychiatry, Imperial College, London, Honorary Consultant, West London Mental Health NHS Trust and Lead Clinician Dangerous Severe Personality Disorder Service, Broadmoor Hospital

Ms Jayne Zito, Patron, Mr Michael Howlett, Director, the Zito Trust, Mr Nick O’Shea, Director of Development, Revolving Doors Agency, Ms Ethel Samkange, Director of Link Worker Schemes, Revolving Doors Agency, Ms Sue Kesteven, Policy Development Manager, and Ms Lucy Smith, Research and Information Officer, Nacro
Wednesday 15 December 2004

Ms Jane Hutt AM, Minister for Health and Social Services, Welsh Assembly Government

Mr David Melding AM, Chairman of the Health and Social Services Committee of the National Assembly for Wales, Ms Kirsty Williams AM, Health Spokesperson for the Liberal Democrats, Mr Rhodri Glyn Thomas AM, Health Spokesperson for Plaid Cymru, National Assembly for Wales

Ms Mag Richards, Development Worker, Powys Agency for Mental Health, and Ms Celia Cowie, Development Worker, Powys Agency for Mental Health

Mr Prys Davies, Director of Strategic Operations and Mr Andrew White, Leader of the Health and Care Unit, Welsh Language Board

Wednesday 12 January 2005 (morning)

Dr Patrick Power, Lead Consultant Psychiatrist and Honorary Lecturer at the South London and Maudsley NHS Trust

Mr Colin McKay, Scottish Executive, formerly Leader of the Mental Health Bill Team; Mr Colin Faulkner, Scottish Executive, Policy Officer working on implementation of the new Scottish Mental Health Act, Ms Fiona Tyrrell, Scottish Executive, Implementation Team Leader, Mental Health Act, and Dr Madeline Osborne, Deputy Director of the Mental Welfare Commission for Scotland

Wednesday 12 January 2005 (afternoon)

His Honour Judge Phillip Sycamore, Liaison Judge for Mental Health Review Tribunals, Mrs Carolyn Kirby, Regional Chairman, Mental Health Review Tribunals for Wales, Rt Hon Lord Newton of Braintree OBE, Chairman of the Council on Tribunals, and Ms Penny Letts, member of the Council on Tribunals

Mrs Paula Hallam, Strategic Service Manager for Mental Health, Hampshire County Council, Ms Jenny Goodall, Director of Social Services, London Borough of Brent, both on behalf of the Association of Directors of Social Services, Cllr Maureen Robinson, New Forest District Council, Local Government Association, Mr Martyn Ayre, Head of Policy (Adult Services), Mr Don McLeod, Strategic Policy and Performance Manager, Kent County Council
Wednesday 12 January 2005 (afternoon) (continued)

Mr Nigel Edwards, Director of Policy, NHS Confederation, Mr Jeremy Taylor, Chief Executive, Nottinghamshire Healthcare NHS Trust, Ms Mel Wilkinson, MHA/CPA Advisor, and Mr Nigel Maguire, Director, Tees and Northeast Yorkshire NHS Trust, Dr Tim Bullock, Associate Medical Director, and Mr Kevin Towers, Patient Services Manager, West London Mental Health Trust

Wednesday 19 January 2005

Ms Rosie Winterton MP, Minister of State, Department of Health, Paul Goggins MP, Parliamentary Under-Secretary of State, Home Office, Professor Louis Appleby, Mental Health Clinical Director, Mr Adrian Sieff, Head of the Mental Health Legislation Branch, Department of Health, and Mr Nigel Shackleford, Deputy Head of the Mental Health Unit, Home Office.

Wednesday 26 January 2005 (morning)

Lord Adebowale, Chief Executive, and Mr Ronnie Watson, Mental Health Act Coordinator, Turning Point, Dr Joanna Bennett, Workforce Development Manager, Breaking the Circles of Fear Project, Mr Chinyere Inyama, Mental Health Lawyer, and Mr Nisar Khan, mental health voluntary worker and service user, BME Mental Health Network

Mr Richard Mills, Director of Research, and Dr Juli Crocombe, Consultant Psychiatrist of Care Principles, National Autistic Society

Mr Clive Evers, Director of Information and Education and Professor Clive Ballard, Director of Research, The Alzheimer’s Society

Wednesday 26 January 2005 (afternoon)

Mr Roger Hargreaves, Chair, Mental Health Special Interest Group, Ms Hazelanne Lewis, Member of the Mental Health Special Interest Group, British Association of Social Workers, Mr Ian Hulatt, Adviser, Royal College of Nursing; Ms Gail Adams, Head of Nursing, and Mr Owen Davies, Senior National Officer, Local Government, UNISON

Dr David Harper, Senior Lecturer in Clinical Psychology, University of East London, Professor Peter Kinderman, Professor of Clinical Psychology, University of Liverpool, Ms Sue Ledwith, Consultant Clinical Psychologist and Clinical Lead, North Yorkshire Forensic Psychiatry Service, Dr Graham E Powell, President Elect, British Psychological Society
Wednesday 2 February 2005 (morning)

Ms Imelda Redmond, Chief Executive, and Mr Mark Robertson, Public Affairs Manager, Carers UK, Dr Gwen Wallace, Chair, and Mrs Linda Lansdell, Forum Committee Member, North Derbyshire Forum for Mental Health Carers

Mr Rick Henderson, Director, and Ms Karen Mellanby, Policy and Communications Manager, Action for Advocacy, Ms Hilary Dyter, Director, Leeds Mental Health Advocacy Group and member of the Association for Mental Health Advocates Steering Committee, Mr Jonathan Coe, Chair of AMHA Steering Committee, Chief Executive of POPAN (Prevention Of Professional Abuse Network) and Chair, Mental Health Alliance Advocacy Special Interests Group, Mr Peter Munn, Secretary, Cymar, and Ms Beverly Mills, Member, Management Committee, United Kingdom Advocacy Network (UKAN).

Wednesday 2 February 2005 (afternoon)

Mr Mike Firn, Chairperson, Mr Michael Hicks, Northern and Yorkshire, Ms Judith Fairweather, London area, National Forum for Assertive Outreach

Dr Peter Bartlett, Senior Lecturer in Law at the University of Nottingham, and Professor Graham Thornicroft, Professor of Community Psychiatry at the Institute of Psychiatry, King’s College London, and Director of Research and Development of the South London and Maudsley NHS Trust

Dr Michael Wilks, Chair, Ethics Committee, Dr JS Bamrah, Chair, Psychiatric Sub-Committee, Dr Robin Arnold, Member, Psychiatric Sub-Committee, British Medical Association, Professor Andre Tylee, and Dr Alan Cohen, Royal College of General Practitioners.
### List of written evidence

**Volume II**

<table>
<thead>
<tr>
<th>Author/Institution</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Genevra Richardson (DMH 378) (DMH 408)</td>
<td>Ev 9, Ev 12</td>
</tr>
<tr>
<td>Mental Health Act Commission (DMH 20) (DMH 90)</td>
<td>Ev 13, Ev 48</td>
</tr>
<tr>
<td>Royal College of Psychiatrists (DMH 24) (DMH 61) (DMH 330)</td>
<td>Ev 50, Ev 76, Ev 79, Ev 88, Ev 90</td>
</tr>
<tr>
<td>Institute of Mental Health Act Practitioners (IMHAP) (DMH 50) (DMH 410)</td>
<td>Ev 92, Ev 113</td>
</tr>
<tr>
<td>Mental Health Alliance (DMH 105) (DMH 382)</td>
<td>Ev 119, Ev 164</td>
</tr>
<tr>
<td>Law Society (DMH 111)</td>
<td>Ev 165</td>
</tr>
<tr>
<td>Law Reform Committee of the Bar Council (DMH 191)</td>
<td>Ev 175</td>
</tr>
<tr>
<td>Mind (DMH 210) (DMH 400)</td>
<td>Ev 189, Ev 228</td>
</tr>
<tr>
<td>No Force Campaign (DMH 44)</td>
<td>Ev 210</td>
</tr>
<tr>
<td>Ms Kay Sheldon (DMH 377)</td>
<td>Ev 226</td>
</tr>
<tr>
<td>Rethink (DMH 192)</td>
<td>Ev 230</td>
</tr>
<tr>
<td>Hafal (DMH 161) (DMH 413) (DMH 414)</td>
<td>Ev 244, Ev 256, Ev 257</td>
</tr>
<tr>
<td>Sainsbury Centre for Mental Health (DMH 107) (DMH 394)</td>
<td>Ev 259, Ev 273</td>
</tr>
<tr>
<td>King’s Fund (DMH 269) (DMH 448)</td>
<td>Ev 263, Ev 274</td>
</tr>
<tr>
<td>Mr David Hewitt (DMH 21)</td>
<td>Ev 279</td>
</tr>
<tr>
<td>Lucy Scott-Moncrieff (DMH 304)</td>
<td>Ev 282</td>
</tr>
<tr>
<td>Making Decisions Alliance (DMH 230)</td>
<td>Ev 297</td>
</tr>
<tr>
<td>Mencap (DMH 268)</td>
<td>Ev 299</td>
</tr>
<tr>
<td>YoungMinds (DMH 64)</td>
<td>Ev 316</td>
</tr>
<tr>
<td>Children’s Legal Centre and the National Children’s Bureau (DMH 194)</td>
<td>Ev 319</td>
</tr>
<tr>
<td>Barnardo’s (DMH 315) (DMH 419)</td>
<td>Ev 321, Ev 331</td>
</tr>
<tr>
<td>Revolving Doors Agency (DMH 324)</td>
<td>Ev 348</td>
</tr>
<tr>
<td>Zito Trust (DMH 174)</td>
<td>Ev 350</td>
</tr>
<tr>
<td>Nacro (DMH 156)</td>
<td>Ev 352</td>
</tr>
<tr>
<td>Ms Jane Hutt AM, Minister for Health and Social Services, Welsh Assembly Government (DMH 312)</td>
<td>Ev 371</td>
</tr>
<tr>
<td>Health and Social Services Committee, National Assembly for Wales (DMH 389)</td>
<td>Ev 380</td>
</tr>
<tr>
<td>Powys Agency for Mental Health (DMH 181)</td>
<td>Ev 389</td>
</tr>
<tr>
<td>Welsh Language Board (DMH 310)</td>
<td>Ev 395</td>
</tr>
<tr>
<td>Scottish Deputy Minister for Health Services and Community Care (DMH 393)</td>
<td>Ev 408</td>
</tr>
<tr>
<td>Professor Jeremy Cooper, Mrs Carolyn Kirby, His Honour Judge Phillip Sycamore and Mr John Wright (DMH 200) (DMH 444)</td>
<td>Ev 424, Ev 438</td>
</tr>
<tr>
<td>Council on Tribunals (DMH 305)</td>
<td>Ev 427</td>
</tr>
<tr>
<td>Association of Directors of Social Services (ADSS) and the Local Government Association (LGA) (DMH 208)</td>
<td>Ev 442</td>
</tr>
<tr>
<td>Kent County Council (DMH 217)</td>
<td>Ev 446</td>
</tr>
<tr>
<td>NHS Confederation (DMH 283)</td>
<td>Ev 454</td>
</tr>
<tr>
<td>Tees and North East Yorkshire NHS Trust (DMH 196)</td>
<td>Ev 458</td>
</tr>
<tr>
<td>West London Mental Health NHS Trust (DMH 243)</td>
<td>Ev 462</td>
</tr>
</tbody>
</table>
Ms Rosie Winterton MP, Minister of State, Department of Health (DMH 396)
(DMH 405) (DMH 429) Ev 471, Ev 505, Ev 523
Department of Health (DMH 404) (DMH 428) (DMH 439) Ev 473, Ev 522, Ev 528
Home Office (DMH 434) Ev 529
Turning Point (DMH 162) (DMH 438) Ev 532, Ev 549
National Black and Minority Ethnic Mental Health Network (DMH 241)
(DMH 445) Ev 539, Ev 552
Mr Nisar Khan (DMH 435) Ev 550
National Autistic Society (DMH 271) Ev 561
Alzheimer’s Society (DMH 242) Ev 568
British Association of Social Workers (DMH 60) (DMH 433) Ev 575, Ev 593
Royal College of Nursing of the United Kingdom (DMH 301) Ev 579
UNISON (DMH 328) (DMH 415) Ev 582, Ev 584
British Psychological Society (DMH 19) (DMH 402) (DMH 431) Ev 594, Ev 600, Ev 603
Carers UK (DMH 193) Ev 607
North Derbyshire Forum for Mental Health Carers (DMH 259) (DMH 442) Ev 611, Ev 621
Action for Advocacy (DMH 46) Ev 623
Association for Mental Health Advocates (DMH 267) Ev 627
Cymar (DMH 45) Ev 638
UK Advocacy Network (UKAN) (DMH 227) Ev 639
Cymar and UKAN (DMH 436) Ev 647
National Forum for Assertive Outreach (DMH 406) Ev 649
Dr Peter Bartlett (DMH 418) Ev 657
Professor Graham Thornicroft (DMH 420) Ev 659
British Medical Association (DMH 248) (DMH 446) Ev 682, Ev 698
Royal College of General Practitioners (DMH 222) Ev 689

Volume III

Sandra Banawich (DMH 1) (DMH 440) Ev 717, Ev 1174
Pat Cull (DMH 2) (DMH 379) Ev 717, Ev 1135
Stewart Ingram (DMH 3) Ev 718
Sam Ismail (DMH 4) Ev 718
Mr Ralph Hill (DMH 5) Ev 719
Dr Michael Cavadino (DMH 7) Ev 721
Mrs A Edwards (DMH 8) Ev 722
Grethe Hansen (DMH 9) Ev 723
Julie Knighton (DMH10) Ev 723
Miss Begonia Serrano (DMH 11) Ev 723
Patrick Olszowski (DMH13) Ev 724
Keith Kinsella (DMH 14) Ev 725
Leslie Carr (DMH 15) Ev 725
Keith Halsall (DMH 16) Ev 726
Janet Cresswell (DMH 17) Ev 727
Dr P Lepping, Prof D Menkes, Dr G Harborne, Dr R Poole, Dr M Zinkler (DMH 18)  Ev 727
Gary Elliott (DMH 22)  Ev 728
Mental Health Alliance in West Yorkshire (DMH 23)  Ev 728
Alan Craig (DMH 25)  Ev 729
Mr Clive Hawkins (DMH 26)  Ev 732
John Short (DMH 27)  Ev 734
Martin Jermiah (DMH 28)  Ev 734
Victoria Hanson (DMH 29)  Ev 734
Trudy Allen (DMH 30)  Ev 735
Annie Flores (DMH 31)  Ev 736
Eric Stark (DMH 32)  Ev 737
Bridgend Approved Social Workers (DMH 35)  Ev 737
ForUs and Rhymni Valley Mind (DMH 36)  Ev 737
Steven Dawes (DMH 37)  Ev 741
Victoria Dawes (DMH 38)  Ev 742
C Stevenson (DMH 41)  Ev 744
A J Rimmer (DMH 43)  Ev 744
N Morris (DMH 47)  Ev 745
The Schizophrenia Association of Great Britain (DMH 48)  Ev 745
Carolyn Godfrey (DMH 49)  Ev 747
Leslie Smith (DMH 52)  Ev 748
Ronald Archer (DMH 53)  Ev 749
Miss Emma Clarke (DMH 54)  Ev 750
Lynda Oakley (DMH 55)  Ev 751
Mr and Mrs C Waldren (DMH 56)  Ev 752
Letchworth Mind (DMH 58)  Ev 753
George Talbot (DMH 62) (DMH 82)  Ev 756, Ev 784
N Fletcher (DMH 63)  Ev 758
A Colgan (DMH 65)  Ev 758
Derbyshire Mind Advocacy Service (DMH 66)  Ev 759
Peter Campbell (DMH 67)  Ev 760
Mrs Swierocki (DMH 68)  Ev 761
North East Lancs Association for Mental Health (DMH 69)  Ev 761
C Perris (DMH 71)  Ev 762
B Diamond (DMH 72)  Ev 762
Nottingham Mental Health Alliance (DMH 73)  Ev 763
Dr George J Lodge (DMH 74)  Ev 764
A Bruce-Kingsmill (DMH 75)  Ev 767
Michael Elvin (DMH 76)  Ev 772
Professor David Pilgrim (DMH 77)  Ev 773
Mr John Allman (DMH 78) (DMH 411)  Ev, 775, Ev 1163
Mrs C J Hillman (DMH 80)  Ev 777
King’s College London (DMH 81)  Ev 779
Carol Jeavons (DMH 83)  Ev 785
Keith Cornford (DMH 84)  Ev 787
Robert Cary Fogg (DMH 85)  Ev 788
Tony Gray, on behalf of Service Users (DMH 87)  Ev 789
Dr A Perera (DMH 88)  Ev 790
James D Hargreave (DMH 89)  Ev 790
L Booth (DMH 91)  Ev 790
R Voyce (DMH 92)  Ev 791
Camden and Islington AIM Advocacy Partnership (DMH 93)  Ev 791
S Clark (DMH 94)  Ev 793
Cardiff Mind Ltd (DMH 95)  Ev 793
A Mitchell (DMH 96)  Ev 795
Dr Melluish (DMH 97)  Ev 795
Heather Armitt (DMH 98)  Ev 795
The Welsh Nursing and Midwifery Committee (DMH 100) (DMH 401)  Ev 798, Ev 1161
Dr Richard House (DMH 101)  Ev 800
Dr Steve Jefferies (DMH 102)  Ev 800
Vera M Marx (DMH 103)  Ev 801
R C and IL Reichardt (DMH 108)  Ev 802
Sheffield Mental Health Advocacy Service (DMH 109)  Ev 803
Isobel McEwen (DMH 110)  Ev 804
North East London Mental Health Trust (DMH 112) (DMH 113)  Ev 805, Ev 807
Mike Cox (DMH 114)  Ev 809
Working Futures (DMH 115)  Ev 814
Lizzie Maitland (Local Mind Group Organiser) (DMH 116)  Ev 816
Diane Wright (DMH 117)  Ev 817
Matilda MacAttram’s Independent Race Relations Health Consultancy (IRRHC)  (DMH 118)  Ev 817
Mark Sacco (DMH 119)  Ev 820
Mind in Bexley (DMH 120)  Ev 822
J Rowland (DMH 121)  Ev 823
Redcar and Cleveland Mind (DMH 122)  Ev 824
Mr R Keys (DMH 123)  Ev 825
Hospital Managers’ Committee, North East London Mental Health Trust (DMH 124)  Ev 828
Citizens Advice (DMH 125) (DMH 282)  Ev 829, Ev 1019
S Holt (DMH 126)  Ev 834
Simon Charrington (DMH 127)  Ev 836
Sallie Cooper (DMH 128)  Ev 837
West Sussex County Council (DMH 129)  Ev 839
Salford Primary Care Trust (DMH 130)  Ev 841
W A Leason (DMH 131)  Ev 843
St Anne’s Community Services (DMH 132)  Ev 844
Janet Lally (DMH 133)  Ev 845
C Pelikan (DMH 134)  Ev 846
T Lewis (DMH 135)  Ev 847
Dr Wendy Franks (DMH 136) Ev 848
Mary Kibblewhite (DMH 137) Ev 849
Mr M K Foolchand (DMH 138) Ev 849
P D Green (DMH 139) Ev 851
Leeds Mind (DMH 140) Ev 852
Crewe and Nantwich Mental Health Sector Planning Group (DMH 141) Ev 854
Alan Priestner (DMH 142) Ev 855
Members of the Bude Mental Health Resource Centre (DMH 144) Ev 856
Charles and Maxine Wilson (DMH 145) Ev 856
Lindy Herrington (DMH 146) Ev 857
Pauline Bispham (DMH 147) Ev 857
William Aldred (DMH 149) Ev 858
S Byhurst (DMH 151) Ev 858
The Approved Social Work Interest Group (ASWIG) (DMH 153) Ev 860
J Rosen-Webb (DMH 154) Ev 861
Mind in Birmingham (DMH 155) Ev 862
The National Mental Health Partnership (DMH 157) Ev 863
Touchstone (DMH 158) Ev 865
Mental Health Act Steering Group on behalf of Leicestershire Partnership NHS Trust (DMH 159) Ev 866
Gloucestershire Survivors Forum (DMH 160) Ev 867
Sylvia Landells (DMH 163) Ev 869
Robert Mundy (DMH 164) Ev 870
Alison Leslie (DMH 165) Ev 870
David Hutchinson, Chairman of Mind in Manchester (DMH 166) Ev 871
Shaun Johnson (DMH 167) Ev 873
Mind in Manchester (DMH 168) Ev 874
Steven Richards (DMH 169) Ev 874
J Hembrow (DMH 170) Ev 876
Cardiff and Vale of Glamorgan Mental Health Service User Forum (DMH 171) Ev 877
South Westminster Involvement Group (DMH 172) Ev 877
Mr Edwin Martin (DMH 175) Ev 878
S.B. (DMH 177) Ev 879
People currently in receipt of hospital care in Epsom, Surrey (DMH 178) Ev 881
Derbyshire Patients Council (DMH 180) Ev 882
Committee of Leeds Consultant Psychiatrists (DMH 182) Ev 882
Sarah Dewey (DMH 183) Ev 883
PLUS (DMH 184) Ev 883
Dr David Fryer (DMH 185) Ev 885
Albertine Euphemia McNeill (DMH 186) Ev 886
Sefton Recovery Group (DMH 187) Ev 888
Sam Button (DMH 189) Ev 892
T Basset (DMH 190) Ev 895
Depression Alliance Cymru (DMH 195) Ev 895
Xpress Advocacy (DMH 197) Ev 900
A group of mental health service users and voluntary sector mental health workers in the London Boroughs of Tower Hamlets and Newham

J Cave (DMH 202)
Hambleton and Richmondshire Primary Care Trust (DMH 203)
W Aldred (DMH 204)
Eating Disorders Association (EDA) (DMH 205)
Independent Police Complaints Commission (DMH 206)
Suffolk User Forum (SUF) for Mental Health (DMH 209)
Miss E Lyons (DMH 211)
Wedge Black (DMH 212)
Emma Pheby – Independent Mental Health Advocate (Information), Mind in Tower Hamlets (DMH 213)
John Parker (DMH 214)
Wendy Andrews (DMH 215)
Self-Injury Support in North Cumbria (DMH 216)
L. L., Stockport Mind (DMH 218)
Transcultural Psychiatry Society (UK) (DMH 219)
Lifecraft (DMH 220)
South Cambs User Forum (SCUF) (DMH 221)
The Mental Health Team of the Gwent Association of Voluntary Organisations (GAVO) together with the Monmouthshire Rural Outreach Project (DMH 223)
Esther Cook, East Suffolk Mind (DMH 224)
South East Advocacy Project (DMH 225)
Malcolm Turner, Chair, Peterborough and Fenland Mind (DMH 226)
Imagine (DMH 228)
Mental Health Foundation and the Foundation for People with Learning Disabilities (DMH 229)
U Parker (DMH 231)
Ernest B Upton (DMH 232)
Allen Barker (DMH 233)
Wales Senior Nurse Advisory Group (DMH 234)
Mr John Myers (DMH 235)
Herefordshire User Group (HUG) (DMH 236)
S Davey (DMH 237)
Approved Social Workers of the London Borough of Hammersmith and Fulham (DMH 238)
Anonymous memorandum (DMH 239)
National Voices Forum (DMH 240)
Dr Adam Dierckx (DMH 244)
Harrow Users Group (DMH 245)
G Woodward (DMH 246)
Service Users and Staff from the forensic low secure wards at Leeds Mental Health Trust (DMH 247)  Ev 967
South London and Maudsley NHS Trust (DMH 249)  Ev 969
Bristol Mind and the Service Users Reference Group (Avon) (DMH 250)  Ev 971
Mind – Basildon (DMH 251)  Ev 974
Andy Atkins (DMH 252)  Ev 976
S Cramp (DMH 253)  Ev 977
Steven Miller (DMH 254)  Ev 977
Debra Ramchurn (DMH 255)  Ev 978
J Sen (DMH 256)  Ev 979
Anne Dawson (DMH 257)  Ev 979
D Smith (DMH 258)  Ev 982
Verity Murricane (DMH 260)  Ev 982
Dr Bob Johnson (DMH 261)  Ev 983
A Priestley (DMH 262)  Ev 985
Savitri Hensman (DMH 263)  Ev 986
Barnet Voice for Mental Health (DMH 264)  Ev 988
WISH (Women in Secure Hospitals) (DMH 265)  Ev 994
Professor Anselm Eldergill (DMH 266) (DMH 399)  Ev 995, Ev 1146
J Millington (DMH 270)  Ev 1015
JUSTICE (DMH 272)  Ev 1016
Justice for Patients (DMH 281)  Ev 1019
Nottingham Senior Medical Staff Committee (DMH 284)  Ev 1020
Dr Niall Moore (DMH 285)  Ev 1022
Nottingham Healthcare NHS Trust (DMH 286)  Ev 1023
A Woodcock (DMH 287)  Ev 1025
US NETWORK (All Wales User Survivor Network) (DMH 288)  Ev 1025
Religious Society of Friends (Quakers) (DMH 289)  Ev 1026
Manic Depression Fellowship (DMH 290)  Ev 1029
Citizens Commission on Human Rights (DMH 291)  Ev 1033
College of Occupational Therapists (DMH 292)  Ev 1035
Stoneham (DMH 293)  Ev 1038
Leeds North West Primary Care Trust (DMH 294)  Ev 1040
Parkinson’s Disease Society (DMH 295)  Ev 1041
Maca (DMH 296)  Ev 1043
Bevan Brittan (DMH 297)  Ev 1047
Mission and Public Affairs Council of the Church of England (DMH 298)  Ev 1050
P Howes (DMH 299)  Ev 1052
Alcohol Concern (DMH 300)  Ev 1055
Vicky Yeates (DMH 302)  Ev 1057
M Jessop (DMH 303)  Ev 1059
Songhai (DMH 306)  Ev 1060
Bedfordshire, Buckingham, Luton and Milton Keynes Consortium (DMH 307)  Ev 1062
Dr Andrew S Horne, Consultant Forensic Psychiatrist, Broadmoor Hospital (DMH 308)  Ev 1062
People currently in receipt of hospital care, Epsom General Hospital (DMH 309)  
All Wales Senior Nurse Advisory Group (DMH 311)  
African and Caribbean Mental Health Commission (DMH313)  
R Brunstrom, BSc (Hons), Chief Constable, North Wales Police (DMH 314)  
J Capon (DMH 316)  
Mrs D Phillips (on behalf of a Service User) (DMH 317)  
W & G Enderby (DMH 318)  
Hampshire Partnership NHS Trust (DMH 319)  
E Penrose (DMH 320)  
Ms J Andrews (DMH 321)  
Penny Priest (DMH 322)  
V D Medley (DMH 323)  
Wayne David Frost (DMH 325)  
P Houghton (DMH 326)  
T Riding (DMH 327)  
General Medical Council (GMC) (DMH 329)  
A Leader (DMH 331)  
Christians Against Mental Slavery (DMH 332)  
L Nixon (DMH 333)  
B Sutton (DMH 334)  
R Moore (DMH 335)  
SURE (DMH 336)  
B Broderick (DMH 337)  
Janey Antoniou (DMH338)  
A Davies (DMH 339)  
C Smith (DMH 340)  
J Bostock (DMH 341)  
M Colquhoun (DMH 342)  
User Voice (DMH 343)  
Amanda Collins (DMH 344)  
Anthony R Burton (DMH 345)  
Commission for Social Care Inspection (DMH 346)  
Ms N Hays, University of Leicester (DMH 348)  
Michelle Caine (DMH 349)  
John Moffett (DMH 351)  
British Geriatrics Society (DMH 352)  
User Group Members, Lambeth Mencap (DMH 353)  
Service User Committee at Southside Partnership (DMH 354)  
IMHL and Peter Edwards Law – Solicitors (DMH 355)  
Scarborough and Rydale Mind (DMH 356)  
Mr Ian Smith (DMH 369)  
Nina Clarke (DMH 370)  
LINXS House, Hull and East Yorkshire Mind (DMH 371)  
MIND in Barnet (DMH 372)  
Jay Watts (DMH 373)
SANE (DMH 374)  Ev 1128
Rachel Ball (DMH 375)  Ev 1134
G A and E Albiston (DMH 380)  Ev 1137
Ealing Meeting of the Religious Society of Friends (Quakers) (DMH 383)  Ev 1138
Imma Maddox (DMH 384)  Ev 1138
Rebecca Farrant (DMH 386)  Ev 1139
Dr J Soffe (DMH 387)  Ev 1139
C Griffiths (DMH 388)  Ev 1140
D McKay (DMH 390)  Ev 1141
Dr A Forrest (DMH 391)  Ev 1141
Lee Mark Langford (DMH 392)  Ev 1142
Phillip Partridge, Co-Ordinator of the Supporting Carers Better Network (DMH 395) Ev 1143
Tom Hamilton, Maca (DMH 397)  Ev 1144
Hull and East Yorkshire Mind (DMH 398)  Ev 1145
Dr Jill Peay (DMH 407)  Ev 1161
Dr J C O’Grady, Consultant Forensic Psychiatrist (DMH 409)  Ev 1162
B Harris (DMH 412)  Ev 1164
M Telfer (DMH 416)  Ev 1164
Robin Williams (DMH 417)  Ev 1165
Clerk / Chief Executive of the Scottish Parliament (DMH 423)  Ev 1166
Presiding Officer, National Assembly for Wales (DMH 424)  Ev 1167
Clerk to the Northern Ireland Assembly (DMH 425)  Ev 1167
Clerk of the House of Commons (DMH 426)  Ev 1168
Mark Vero (DMH 430)  Ev 1168
Advocacy Safeguards Agency (DMH 432)  Ev 1169
Stone Ashdown Trust (DMH 443)  Ev 1174
Mental Health Act Commission (DMH 452)  Ev 1175
Department of Health (DMH 453)  Ev 1177
Government (DMH 456)  Ev 1180
House of Lords Select Committee on Delegated Powers and Regulatory Reform (DMH 457)  Ev 1205
Policy Study Institute (PSI) Health of the Muslim Patients & Carers International Health Foundation (DMH 421)  Ev 1206
List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House of Commons but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

Mrs M J A Turner (DMH 6) (DMH 422)
Mr Jeffery Thomas (DMH 12)
Mr Stephen Weelderburn (DMH 33)
Ms Mary Wren (DMH 34)
Confidential (DMH 39)
Mrs C E Statham (DMH 40)
Cecil Foggitt (DMH 42)
Miss Vivienne Norgate (DMH 51)
Confidential (DMH 57)
Confidential (DMH 70)
Ms Freda Gray (DMH 79)
Sheila B Howe (DMH 86)
E Booth (DMH 99)
Robert James Lewis (DMH 104)
Mrs Iris Linton (DMH 106)
Susan A Nicholson (DMH 143)
Mr W J Clark (DMH 148)
Mary Bannon (DMH 150)
Anonymous (DMH 152)
C Gillen (DMH 173)
Emma Burraway (176)
Anne Kathleen Pringle (DMH 179)
Sefton Recovery Group (DMH 188) (DMH 357 – 364) (DMH 366 & 367)
B Bertie (DMH 273)
Lis Brown (DMH 274)
M Hashim (DMH 275)
Alison Wyatt (DMH 276)
Adam Foreman (DMH 277)
Miss S A Jefford (DMH 278)
May Henry (DMH 279)
Jackie Moeffeli (DMH 280)
Confidential (DMH 347)
East Living (DMH 350)
Jill and Hamish Walker (DMH 365)
Opendoor (DMH 368)
Anonymous (DMH 376)
Fiona Bloomfield (DMH 385)
Croydon Voluntary Action (DMH 403)
G Cornell (DMH 437)
West Yorkshire Mental Health Alliance (DMH 441)
Dr Kevin Murray (DMH 447)
John Bowis OBE MEP (DMH 449)
Gabriel Adamson (DMH 450)
Gillian Downham (DMH 451)
Mental Health Act Hospital Manager’s Committee, Cardiff and Vale NHS Trust (DMH 454)
Rhona Brankin (DMH 455)