



# **Reform of the Mental Health Act 1983**

## **Proposals for Consultation**

Presented to Parliament by the Secretary of State for Health  
by Command of Her Majesty November 1999

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# Foreword

We need to modernise the nation's mental health services. To do that, our modernisation programme has three interlocking elements.

First, the Government's new resources for the NHS and social services are delivering sustained extra investment.

Second, we need modern services, clear standards, and joined up care processes. That is what the new Mental Health National Service Framework for England sets out and similar standards are being planned for Wales.

And third, we need to modernise the legal framework within which mental health care is delivered. That is what this Green Paper is about.

All three elements need to be in place and in balance if we are to have mental health services that are genuinely safe, sound and supportive.

This consultation paper sets out our proposals for a new Mental Health Act for England and Wales. It proposes a fundamental overhaul of the old 1959 and 1983 legal frameworks.

They assumed that the bulk of care would inevitably involve hospitalisation.

New treatments and care options have changed all that, but equally a decade or more of 'community care' has shown that people with mental health problems often need more active and intensive support.

These proposals for a new Mental Health Act, backed by extra investment and new services, aim to do just that.



The Rt Hon. Alan Milburn MP  
Secretary of State for Health

A handwritten signature in dark ink, appearing to read 'Alan Milburn'.



The Rt Hon. Alun Michael JP MP AM  
First Secretary, National Assembly for Wales

A handwritten signature in dark ink, appearing to read 'Alun Michael'.

# Chapter 1

## Introduction

<sup>1</sup>This consultation paper sets out our proposals for a new Mental Health Act for England and Wales. *Modernising Mental Health Services*<sup>1</sup> outlined our strategy to improve the way that services respond to people with mental illness and other mental disorders. The review of the Mental Health Act is a key part of that overall strategy. In Wales, the review will inform the work of the Advisory Group, which is drawing up a revised All Wales Strategy for mental health services.

<sup>2</sup>The other two main elements of the strategy - establishing a Mental Health National Service Framework<sup>2</sup> and investment of major new resources - are already being implemented.

<sup>3</sup>The purpose of this consultation paper is to describe a framework for new legislation that will bring up to date the principles and processes established by the 1959 and 1983 Mental Health Acts. It covers those areas where there will be major change, but does not set out in detail everything that a new Act would include. This will be done in the full formal proposals for future mental health legislation which we hope to be able to publish next year. In Wales, the new Strategy will lay the foundations for the introduction of standards closely allied to those of the National Service Framework.

<sup>4</sup>The proposals in this paper sit alongside a number of other areas of major policy development. First, the Lord Chancellor's statement of the Government's proposals for making decisions on behalf of mentally incapacitated adults, *Making Decisions*,<sup>3</sup> published on 27th October 1999, explained the way that we intend to take forward policy on mental incapacity following responses to the consultation paper *Who Decides?*<sup>4</sup> Second, the consultation document "*Managing dangerous people with severe personality disorder - proposals for policy development*"<sup>5</sup> sets out our policy objectives for one particular high-risk group of those with mental disorder (summary at annex C). These two sets of proposals are designed to deal with very different policy areas but both will impact on some people who also come within the remit of the Mental Health Act. New legislation following this consultation exercise will be framed in a way that takes this into account.

### *Background to the review of the Mental Health Act*

<sup>5</sup>In September 1998 we announced the appointment of an expert committee, to be chaired by Professor Geneva Richardson, which was commissioned to take forward the first phase of the review of the Mental Health Act. The Committee was asked to consider what changes in legislation were needed, taking account of the aims set out in our mental health strategy. And, specifically, how the scope of new legislation might be extended beyond hospitals to cover care and treatment<sup>6</sup> provided in community settings.

<sup>6</sup>The Committee submitted their advice to Department of Health ministers in July. Their report<sup>7</sup> is being published alongside this consultation paper and a summary is included at annex B.

<sup>7</sup>The work undertaken by the Committee has been a very valuable first phase of the review of the Act. Although not all of their recommendations are accepted (and in some areas the Committee advise further consultation), the overall framework for new legislation described in the Committee's report has been adopted as the framework for the proposals in this consultation paper.

<sup>8</sup>Our proposals have also been informed by discussion with researchers who are currently engaged in an extensive programme of projects that we commissioned to look into the way that the 1983 Mental Health Act operates. The first - a literature review - is complete and is also being published alongside this consultation document<sup>8</sup>. The remainder of these projects will report by the end of this year and the findings will be made available early in 2000.

### *Format of this consultation paper*

<sup>9</sup> Chapter 2 of this paper discusses the reasons for changing the 1983 Act and the way that the changes we propose link to our other policy initiatives.

<sup>10</sup> Chapters 3-11 describe in outline the main features that we intend to include in a new Mental Health Act. The text is shaded

blue where it relates directly to recommendations made by the Expert Committee. These chapters include a number of specific points on which we would particularly welcome comments. A full list of consultation questions is at annex A.

It will assist analysis of the responses if comments are related to these questions but we would also welcome views on other aspects of the proposals.

Responses should be sent by 31st March 2000, to: Will Niblett Department of Health Wellington House 135-155 Waterloo Road London SE1 8UG

Additional copies of this paper are available from the outlets listed on the back cover.

It is also available on the Department of Health website at: [www.doh.gov.uk/mentalhealth.htm](http://www.doh.gov.uk/mentalhealth.htm)

<sup>1</sup> Department of Health, December 1998

<sup>2</sup> Department of Health 1999

<sup>3</sup> TSO October 1999 Cm 4465

<sup>4</sup> TSO December 1997 Cm 3803

<sup>5</sup> Managing Dangerous People with Severe Personality Disorder proposals for policy development Home Office/Department of Health 1999

<sup>6</sup> The definition of treatment is discussed in Chapter 9

<sup>7</sup> "Report of the Expert Committee : Review of the Mental Health Act 1983" [Department of Health 1999]

<sup>8</sup> A systematic review of research relating to the Mental Health Act [1983] Department of Health 1999.

## Chapter 2

# The Case for Change

1Our approach to the development of comprehensive mental health services is founded on the principle that people with mental illness or other mental disorders should be treated in the same way as people with any other illnesses or medical conditions. Care and treatment needs should be properly assessed and, wherever possible, provided on an informal basis with full agreement between the patient and care team. Over 80% of patients who are treated in a mental hospital or psychiatric unit are cared for in this way now.

2For most patients the primary role of Government is to ensure that the right kinds of health and social care services are available to support them and those who care for them. Such services should be of high quality and not be dependent on where people live. That is why we are putting in place a new quality framework for health and social services and why we developed the *Mental Health National Service Framework*. In England, we are also committing substantial new resources to mental health care in both the NHS and local social services - an additional £700 million over the three years from April 1999. In Wales, the question of resources will be addressed by the National Assembly, which will be considering this issue in the context of the new All Wales Strategy.

3A small minority of people with serious mental disorders are, however, unwilling or unable to seek the care and treatment they need voluntarily and as a result may pose a risk to their own health and safety or to the safety of the public or those caring for them. The Government has a role in establishing mechanisms to ensure that the needs of people in this group are assessed, that they receive the care and treatment they need, and that their rights are properly protected. This was the prime purpose of the 1959 and 1983 Mental Health Acts and remains the prime purpose of the proposals in this paper.

4The last full review of mental health legislation took place in the 1950s through the Royal Commission chaired by Lord Eustace Percy. That review led to the establishment of a framework that has been in place for nearly 40 years.

5Many of the principles and processes recommended by the Percy Commission remain valid. But there have been major changes over the past 40 years in the patterns of care and treatment for people with mental disorders. These have been brought about by development of new drug treatments, a growing understanding of the role of other therapeutic approaches, and recognition of the important part that social care plays in treatment and support of people with mental disorder. Many patients, for whom long spells of inpatient treatment in hospital would once have been the only option, now get appropriate care at home or in other non-institutional settings.

6Despite the introduction of new powers to provide statutory aftercare under supervision for some patients following discharge from detention<sup>9</sup>, the focus of the 1983 Act is still the compulsory assessment and treatment of patients *in hospital*. This is an area where the powers in the Act no longer fit with contemporary patterns of service provision.

7In some cases care outside hospital may offer the prospect of a good therapeutic outcome, but may not be a practical or safe option if there is a risk that the patient will not keep to their care and treatment plan. The 1983 Act does not allow sufficient flexibility for care and treatment under compulsion to be provided in the least restrictive environment. ***Our proposals for a new Mental Health Act are designed to provide greater flexibility in this area by breaking the automatic link between compulsory care and treatment and detention in hospital.***

8Another key aim of our proposals is to ensure that the provisions of a new Mental Health Act are fairly and consistently implemented. The provisions of the 1983 Act are complex. Those who apply it are mostly people with professional training in clinical and social care, but few have specialist training in or understanding of the law. There is wide variation in the way that the provisions are applied in different parts of the country, variation that cannot be explained simply on the basis of differences in availability of services or population characteristics. This is not an acceptable situation given the seriousness with which powers to deprive people of their liberty must be regarded.

9We want the principles that lie behind the provisions of a new Act to be clear to those who are responsible for applying it, to the patients who come within its scope and to their carers. The processes of the Act should be as clear as possible. ***We are***

*therefore proposing that certain key principles should be expressly stated in the Act itself. The framework set out in this paper is designed to ensure greater consistency and transparency in application of the Act. We intend to introduce clearer assessment procedures for all patients who come within the scope of compulsory powers, and a process for independent decision making in all cases where patients are subject to compulsory care and treatment for longer than 28 days.*

### ***Interface with other measures***

10The proposals in this paper do not stand alone. The review of the Act is an important part of our mental health strategy which is itself part of the overall programme for modernising the NHS and social care services. These initiatives will have a major impact on practice and set the context within which we have framed proposals for a new Mental Health Act.

### ***Modernising the NHS and Social Services***

11Our White Paper *The New NHS*<sup>10</sup> and the Welsh equivalent *Putting Patients First*<sup>11</sup> set the broad framework for modernisation. The aim is to provide effective and safe services more easily and quickly, in an acceptable and fair manner, making the best use of resources. *Modernising Social Services*<sup>12</sup> sets a similar agenda to support welfare reform and social inclusion by promoting people's independence, improving the protection of vulnerable people and raising standards so that everyone can be assured of high quality social services. The Welsh White Paper on Social Services *Building for the Future*<sup>13</sup> also emphasised these key themes.

12We have set strategies to achieve a reduction in stigma and social exclusion; involvement of service users and carers; partnership working; and a focus on quality. The framework to improve quality includes establishment of clear national standards in national services frameworks, development of national guidelines through the National Institute of Clinical Excellence; legislative change to modernise professional self-regulation and, through guidance, promote Continuing Professional Development; and local action through clinical governance.

13We are setting up new systems for checking and improving quality. We have published a new performance framework for health, and the performance framework for social care is being developed. The Commission for Health Improvement has been established to help monitor progress made in putting these improved standards into practice across the NHS. And we have outlined plans for other regulatory bodies to set and monitor standards in local authority social care, and in private and voluntary healthcare provision.

### ***The strategy for mental health***

14Our commitments to improve mental health services form part of this overall modernisation agenda. *Modernising Mental Health Services* set out a radical programme for improving mental health care and building public confidence in mental health services. It described our vision of mental health services which are:

**Safe** - to protect the public and provide effective care for those with mental illness when they need it;

**Sound** - to ensure that patients and service users have access to the full range of services that they need; and

**Supportive** - working with patients and service users, their families and carers to build healthier communities.

15The *Mental Health National Service Framework* sets out how this vision will be implemented. It establishes standards designed to improve the quality of mental health services and particularly to reduce variations across the country. Implementation of the national service framework is being supported by investment of significant extra resources in this year and the next two. Mental health services need to be underpinned by modern legislation that supports current patterns of treatment and service provision. The proposals for a new Mental Health Act in this paper form the third strand of work to turn our vision for modern mental health services into reality.

16Our strategy for public health set out in *Saving Lives: Our Healthier Nation*,<sup>14</sup> confirmed mental health as a priority area. The aims of the actions in the strategy are to reduce the rates of death, extend the quality of years of life lived to the full, and improve health for the many as well as the few. A target to reduce the rate of death from suicide by one fifth by 2010 is set for mental health. The Welsh public health agenda was set by *Better Health, Better Wales*<sup>15</sup> which contained similar suicide reduction targets. The proposals in this paper, alongside those in the *Mental Health National Service Framework*, will help ensure that people who are at risk get the care and treatment they need, when they need it.

### ***Other policy initiatives***



## *Managing dangerous people with severe personality disorder*

17A separate, but related area of policy development, is the work we are doing to address the problems presented by the small group of people with severe personality disorder who because of their disorder pose a risk of serious offending. Proposals for change in service provision and legislation were published for consultation in July and we have commissioned a substantial programme of work to support development of better assessment procedures for this group.

18The focus of the proposals in the July consultation paper, as with the proposals set out in this paper, is on managing risk and providing better health outcomes within a framework that safeguards the rights of individuals and the interests of the public. The special problems of managing dangerous people with severe personality disorder require special legislative and service responses. But it is clear that decisions on the shape of new legislation to address the problem of managing dangerous people with severe personality disorder must fit with the framework of the proposals for a new Mental Health Act in this paper. In determining what action to take we will ensure that both sets of proposals are considered together. These issues are discussed more fully in Chapter 8, which covers the criminal justice disposals within the Mental Health Act.

## *Mental incapacity*

19The proposals in this paper also need to be considered in the context of policy for changes in the law relating to mentally incapacitated adults. The Lord Chancellor's statement of the Government's proposals for making decisions on behalf of mentally incapacitated adults *Making Decisions*, published on 27th October 1999 set out our policy intentions following consideration of responses to consultation on the paper *Who Decides?*

20In Chapter Eleven we set out proposals for dealing with people with long-term mental incapacity who need treatment for mental disorder. Policy in this area will be developed in the context of the likely shape of legislation on mental incapacity more generally.

<sup>9</sup> Mental Health (Patients in the Community) Act 1995

<sup>10</sup> TSO 1997 Cm 3807

<sup>11</sup> TSO January 1998

<sup>12</sup> TSO 1998 Cm 4169

<sup>13</sup> TSO March 1999

<sup>14</sup> TSO July 1999 Cm 4386

<sup>15</sup> TSO May 1998

## Chapter 3

# Guiding Principles For a New Mental Health Act

<sup>1</sup>In common with most UK legislation, there is nothing specifically within the 1983 Act describing the principles that underpin it. But it is important that legislation that affects the lives and liberty of many patients is properly understood, especially when responsibility for applying the provisions falls to a range of practitioners working in different settings. That is why we included a set of broad principles in the revised version of the Code of Practice on the Act<sup>16</sup> to guide those who use it.

<sup>2</sup>The Committee proposes that the principles underlying the provisions of a new Mental Health Act should be included in the Act itself as an aid to its interpretation. [see paragraphs 2.1 - 2.25 of their report]

<sup>3</sup>We agree with this recommendation. There is a precedent for such an approach in the Family Law Act (1996)<sup>17</sup>, which includes guiding principles specifically within the Act, as well as the Children Act 1989.<sup>18</sup>

<sup>4</sup>Any principles to be included in legislation must have practical effect. We propose, on that basis, to include in a new Mental Health Act principles covering the following key areas:

*Informal care and treatment should always be considered before recourse to compulsory powers;*

*Patients should be involved as far as possible in the process of developing and reviewing their own care and treatment plans;*

*The safety of both the individual patient and the public are of key importance in determining the question of whether compulsory powers should be imposed;*

*Where compulsory powers are used, care and treatment should be located in the least restrictive setting consistent with the patient's best interests and safety and the safety of the public.*

<sup>5</sup>This list does not specifically cover all of the principles suggested by the Committee. They recommend including: non-discrimination, patient autonomy, consensual care, reciprocity, respect for diversity, equality, respect for carers, effective communication and provision of information and a principle of evidence based practice. We agree that these points are important, and many of the underlying values reflected in the Committee's principles are covered by the list we have suggested above. But we consider that the right place for specific guidance on these issues will be in the Code of Practice on the new Act. This is for a number of reasons.

<sup>6</sup>Some of the principles the Committee proposes - notably the principles of diversity and equality - are already covered by primary legislation. Others - such as the principle of evidence-based practice - are already part of clinical governance and a fundamental component of the Mental Health National Service Framework, which will guide the delivery of frontline Mental Health Services into the future. Issues regarding recognition for carers will also be picked up through the Mental Health National Service Framework and implementation of the strategy for carers "Caring about Carers."<sup>19</sup> All of these issues will be covered in the Code of Practice on a new Act. Duplicating them in the Act itself would not have any practical effect.

<sup>7</sup>Legislating in this field necessarily involves balancing different rights and interests. This balance might be upset if some of the remaining principles identified by the Committee were given statutory force. We accept that, for most people with mental illness or other mental disorders, care and treatment must reflect the principles of autonomy and consensual care. But we are not convinced that these issues could be usefully stated as guiding principles in legislation that, like the 1983 Act, will be primarily concerned with provisions covering compulsory care and treatment. Instead we intend that the new Mental Health Act will be

framed in a way that supports informal consensual care wherever this is consistent with the patient's best interests and safety and the safety of the public. This approach is in line with the approach we have taken in the Mental Health National Service Framework. Standard Five specifies that service users assessed as requiring a period away from home should have timely access to an appropriate hospital bed, or alternative bed or place, "in the least restrictive environment consistent with the need to protect them and the public."

<sup>8</sup>So far as the issue of reciprocity is concerned, we fully intend that where a patient is required to comply with care and treatment the relevant authorities should have the responsibility to provide the services that are specified in the patient's care plan. This will be reflected in the duties to be placed on health and social services authorities in a new Mental Health Act. This approach is consistent with the Mental Health National Service Framework standards on good practice concerning the creation and use of care plans.

<sup>9</sup>The Committee also proposed a statutory duty for agencies with responsibilities under the Act to work together. The Health Act 1999 (sections 26-27) already imposes a duty on Health Authorities, Special Health Authorities, Primary Care Trusts and NHS Trusts to co-operate with each other and with local authorities to secure and advance health and welfare. Therefore, an express duty along the lines proposed by the Committee would be unnecessary.

*Consultation point A: The Government would welcome views on whether the inclusion of principles would aid the interpretation of a new Mental Health Act and on the list of principles proposed in paragraph 4 above.*

### *Code of Practice*

<sup>10</sup>Under the 1983 Act the Secretary of State has a specific duty, following consultation, to prepare and publish a Code of Practice. The Code provides detailed guidance for those directly, and indirectly, involved in applying the powers of the Act. It has a very important role in promoting good practice. We share the Committee's appreciation of the importance of the Code of Practice and accept their recommendation that provision for it should receive greater prominence in a new Mental Health Act.

<sup>16</sup> Code of Practice: Mental Health Act [1983] TSO March 1999

<sup>17</sup> Section 1 of the Act

<sup>18</sup> Section 1 of the Act

<sup>19</sup> February 1999 Department of Health

## Chapter 4

# The Processes of Applying Compulsory Powers

### *The Scope of a new Act*

1If a new Mental Health Act is to be effective its scope must be clear to those who use it and to those who may fall within its provisions.

### *Diagnostic Criterion mental disorder*

2The Committee advise in their report that new legislation should apply to those with a "mental disorder" and should not define the group more tightly - for example by reference to definitional schemes such as the International Classification of Diseases<sup>20</sup> or the Diagnostic and Statistical Manual.<sup>21</sup> They suggest that "mental disorder" should be taken to mean "any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of Mental Functioning". This is consistent with the definition of **mental disability** adopted by the Law Commission in their report on Mental Incapacity.<sup>22</sup> A broad definition would ensure that all those who might benefit from the safeguards provided by legislation covering compliance with care and treatment or to whom the legislation should apply for the protection of others would, initially, come within its remit. A more specific definition might result in unwittingly excluding some of those who should be within its scope. However, definitional schemes might be referred to in the Code of Practice.

3Within this broad definition the Committee recommends a small number of specific exclusions where the diagnosis of mental disorder relates solely to:

- disorders of sexual preference, [such as paedophilia],
- misuse of alcohol and drugs.

4However the Committee are concerned to ensure that where such patients have a secondary diagnosis of another mental disorder, then they should come within the scope of the legislation.

5This broad definition of mental disorder would bring within the scope of the legislation people suffering from mental illnesses such as schizophrenia. People with a primary diagnosis of personality disorder, brain injury, or learning disability would also be included.

*Consultation point B: The Government accepts the Committee's recommendation in principle, but would welcome comments. In particular, what are the advantages and disadvantages of including a more specific definition of mental disorder:*

- *in legislation;*
- *in a Code of Practice?*

### *Children*

6We agree with the Committee's recommendation that children should continue to be covered by the provisions in a new Mental Health Act. We also accept that, in principle, children subject to compulsory care and treatment should be entitled to accommodation within an environment that is appropriate to their age and clinical need. Where an admission of a young person

to an adult ward is required for a short period, in order to ensure the safety and welfare of the individual or others, we recommend that it should be a ward or setting identified as better suited to the needs of young people. The Mental Health National Service Framework specifies that a protocol must be agreed between child and adolescent mental health services and adult services for this eventuality. Guidance on children's accommodation will be included in the Code of Practice.

### *The process for applying care and treatment under compulsory powers*

7A new Mental Health Act must be as clear as possible so that the legal processes can more easily be explained to patients and informal carers. It must also define a decision making process that is fair and transparent. And it must incorporate rigorous safeguards so that the dual aims of ensuring the health and safety of individual patients and public safety are achieved in a way that is consistent with the provisions of the Human Rights Act 1998.

8The Committee recognises the need to address these issues and recommends a simpler process for the initial application of compulsory powers. They recommend that admission to assessment should continue to require a formal application by a suitably trained professional. This is discussed at paragraph 5.7 - 5.13 of their report. This application would need to be supported by a doctor with specialist training in psychiatry and another medical professional. Copies of the application would be lodged with the "registered person"<sup>23</sup> in the authority responsible for providing care under compulsory powers. One admission route would replace the several distinct procedures in the 1983 Act.

9Under the Committee's proposals, the new assessment process would apply initially for up to 7 days. During that time the Committee recommends that, if the patient is previously unknown to services, only emergency treatments that would save the patient's life, prevent deterioration of their condition, or alleviate suffering, might be given. However, they recommend that, in some circumstances, other treatments may be given to a patient who has had previous contact with services.

10The prime purpose of this initial period would be to thoroughly assess the patient's condition, to prepare an outline care and treatment programme, and to apply in writing to an independent reviewer for a "provisional order". If the reviewer accepted the application, then a 21 day provisional order would be issued. This independent review, would not usually involve an oral hearing. The reviewer would consider, on the basis of scrutiny of written information whether the criteria for use of compulsory powers had been fully met, and whether there was a properly constituted care plan in respect of the application for a provisional order.

11The independent reviewer would have the power to confirm a provisional order (applicable either in hospital or in the community) if he or she is conclusively satisfied that the criteria for use of compulsory powers are met. He or she may also call for a full tribunal hearing, normally scheduled to consider applications beyond the provisional order, to be brought forward.

12Under the Committee's proposals the assessment and provisional treatment period would last for a maximum of 28 days.

13The Committee acknowledges that the recommendation to maintain the involvement of 3 professionals as the gatekeepers to assessment might pose problems if compulsory powers need to be used in an emergency. They recommend that where such an emergency arises in a hospital mental health unit, nurses with relevant specialist training<sup>24</sup> should have the power to detain the patient for up to 24 hours. Staff with relevant specialist training should always be available in specialist mental health units. However, in other situations emergency powers would only be available on the basis of involvement of both a person with specialist training in mental health and a medical practitioner. Use of compulsory powers beyond the initial 24 hour emergency period would require an application supported by three people, in the same way as other applications made under the procedures set out above.

14The Committee recommends that beyond the 28 day initial assessment and treatment phase, compulsory care and treatment must be authorised by a new mental disorder tribunal at a full hearing, which the patient could attend. This tribunal would have the power to authorise an application from the care team for the continuation of compulsory care and treatment. It would be for the care team to demonstrate that a further period of compulsory care was justified. Patients would be able to challenge the application, and such challenges would result in an oral hearing. If the tribunal considered that continued use of compulsory powers was justified, they could determine, acting on the evidence before them, whether compulsory care and treatment should take place in an in-patient setting or elsewhere, such as in a registered care home or the patient's own home. The tribunal would be empowered to confer an order for up to six months initially.

15The Committee recommends that a patient who wishes to challenge the decision to use compulsory powers during the

initial phase should have the right to request an expedited tribunal hearing at any time during the first fourteen days of assessment and treatment. The tribunal would then be under a duty to hear the patient's application within 7 days. An expedited tribunal would have the same powers as a tribunal at 28 days. It would replace, not supplement, the 28 day hearing.

### *The single point of entry*

16We recognise the advantages of moving to a system such as the Committee recommends and particularly favour the concept of a single point of entry for all patients (apart from those who enter from the criminal justice system) who are to be subject to compulsory care and treatment. We propose that all such patients should undergo an initial structured assessment (formal assessment) before an order for continuing use of compulsory powers is considered.

17Entry into formal assessment under compulsory powers must involve a process of application to the hospital (or mental health unit) responsible for managing provision of compulsory care and treatment. The application must be based on medical evidence, usually from two clinicians, and should take account of the patient's wishes and social circumstances including social care needs. It is essential that the person responsible for making the application is independent of the hospital that will be providing care and treatment. The applicant should always consider whether care and treatment can be provided without recourse to compulsory powers.

18A clinician who is a member of the team that will be responsible for carrying out the formal assessment under compulsory powers should always take part in the initial application process. This indicates that at least two people must be involved - a member of the clinical team that will be carrying out the formal assessment under compulsory powers and an independent person who makes the application. The Committee proposes that, as at present, three professionals should be involved. They suggest that the applicant should be an approved social worker or other person with specialist training. They recommend that there should also be preliminary assessments by two other people - a medical practitioner, usually a psychiatrist from the trust providing specialist mental health services and another mental health professional. The second person should either be specifically trained in the process of making applications under the Act, or have recent knowledge of the patient.

19We accept that two mental health professionals should be involved in the initial application process and that one should usually be a psychiatrist. But we are not convinced that the second mental health professional could not also fulfil the role of independent applicant.

### *Consultation point C: The Government would welcome views on the following points:*

- *Whether the applicant for admission must be an approved social worker or whether they might be a mental health professional either with specialist training or recent knowledge of the patient?*
- *If the applicant is a mental health professional is it essential that the application is supported by two other opinions or would one opinion from a psychiatrist working in the hospital providing specialist services be sufficient?*

20In cases where a patient is already known to services the formal assessment process will not usually take as long as 7 days.

21Formal assessment should be carried out according to the general criteria laid down in the Mental Health National Service Framework. These include not only attention to the patient's psychiatric, psychological and social functioning and the risk posed to self and others, but also an assessment of physical health needs and personal circumstances. We propose that under the new Mental Health Act it will be possible for formal assessment to take place in the community as well as in hospital.

22We accept the need to include emergency powers to cover crisis situations. We recognise that any use of compulsory powers is a serious matter but need to consider carefully whether it would be appropriate to reduce the period to 24 hours as the Committee propose. Under the 1983 Act emergency holding powers run for up to 72 hours. Also, under the 1983 Act, registered mental health nurses (typically ward managers) have the power to detain a patient who is already in hospital for up to 6 hours so that a doctor can be called. Although the Committee makes no recommendations about this, we are concerned that there should be sufficient short-term emergency powers to detain an in-patient until a gate-keeping assessment can be carried out. We also agree with the Committee that common law must continue to provide authority to detain and to treat, through the principle of necessity, in cases where the need for treatment is so urgent that it is inappropriate to wait for the statutory emergency procedures to be implemented. The case of the highly disturbed person who presents to the Accident and Emergency Department of a general hospital is an example.



*Consultation point D: The Government would welcome views on the proposals for emergency powers of detention:*

- *Would a period of 24 hours be sufficient to ensure assessment by the 3 professionals who act as the gatekeepers? And would it be necessary, or practicable to require the involvement of 2 professionals where an emergency situation occurred outside a hospital mental health unit?*
- *Should the current six-hour holding power for ward managers be maintained?*

### ***Independent decision making body***

23The Committee recommends that all decisions to authorise use of compulsory powers beyond the initial 7 day assessment period should be taken by an independent decision making body. This would replace the current system under which medical professionals have the power to authorise detention of patients for substantial periods of time.

24We accept the case for introducing a process for decisions authorising compulsory care and treatment, beyond a defined maximum period, to be taken by an independent judicial body. The main arguments in favour of doing so are that it would:

- encourage more thorough assessment and care planning for many patients subject to compulsory care and, potentially, promote better health outcomes;
- provide the basis for greater consistency in use of compulsory powers; and
- ensure compliance with the provisions of the Human Rights Act 1998<sup>25</sup>.

25However, the Committee's recommendations for the introduction of procedures involving an independent review at 7 days followed by a mental disorder tribunal at 28 days need careful consideration. This is not least because implementing such procedures would, as the Committee recognise, have significant practical implications.

### ***The 7 day review***

26The purpose of an independent review at 7 days is to ensure that the criteria for a provisional order are met and continued compulsion is justified under the Act. Early reference to an independent reviewer would also help to ensure that the patient's condition is fully assessed and that the care plan for an initial phase of treatment is completed quickly. But we are not convinced that an essentially paper exercise, based on scrutiny of the statutory forms completed by the care team, would either influence the extent of the use of compulsory powers or drive up the quality of care to be provided after the completion of assessment. The Committee suggests that a legal member of the mental disorder tribunal should undertake the tasks involved. We recognise that such a person will be able to decide whether the processes of admission and assessment have been properly applied. But they will not usually have the expertise to determine, on the basis of information that will be available after 7 days, whether or not the provisional care plan proposed for a particular patient is appropriate.

27The registered person is initially accountable for ensuring that the statutory processes are properly followed and there are alternative ways of ensuring that care teams undertake prompt assessment and care planning. These aims might be achieved equally effectively through the mechanisms of internal audit and clinical governance. NHS organisations should set up procedures and identify who is responsible for their effective delivery. Provisions for a patient to call for an expedited tribunal hearing, which would take place between days 7 and 21, mean that a separate process for automatic independent review at 7 days is not necessary to ensure compliance with the provisions of the European Convention on Human Rights.

*Consultation point E: The Government would welcome views on whether there is a real need for an independent review within 7 days of the commencement of assessment and on what alternative measures might be put in place to ensure prompt assessment and care planning.*

### ***The tribunal***

28The Committee recommends that under a new Mental Health Act the care team should be required to apply to an independent tribunal for authority to impose compulsory care and treatment beyond the 28 day period of assessment and

initial treatment. The tribunal would be responsible for determining whether further use of compulsory powers was appropriate. In cases where the patient requested an expedited tribunal or where the application was submitted early the hearing would take place before 28 days.

29The tribunal's task would be to decide whether a patient should be made subject to a compulsory care and treatment order under the Act - either in hospital or in the community. It would need to consider the case for continued use of compulsory powers on the basis of evidence before it. This will include information from the formal assessment process and involve scrutiny of the proposed plan for continuing care and treatment. Unlike the current Mental Health Review Tribunal it will not simply be considering whether the criteria for detention under the Act are met on that particular day.

30The Committee suggest three models for the structure of the new tribunal:

### Model 1

**1 legal Chair**

**1 psychiatrist, who does not conduct assessment**

**1 member with experience of mental health services**

**Independent doctor with specialist qualification in psychiatry drawn from approved pool to assess patient and report to the tribunal**

### Model 2

**1 legal Chair**

**2 members with experience of mental health services**

**Reference to a panel of doctors, and access where necessary to a panel of people with social care expertise.**

### Model 3

**Single person panel likely to be specialist lawyer**

**Reference to a panel of doctors, and access where necessary to a panel of people with social care expertise.**

**(see discussion in paragraphs 5.66 - 5.73 of their report)**

31The tribunal must have its own source of medical expertise, but we have serious reservations, as does the Committee, about the concept of combining the role of medical member/expert witness and decision maker. All evidence to the tribunal should be available to all parties involved in the hearing, but it would be wrong for tribunal members to be subject to cross-examination. We therefore agree with the Committee that the new tribunal should not involve a medical member who assesses the patient.

32Model 1 would be very resource intensive, particularly with regard to consultant time. It would demand the participation of two consultant psychiatrists in addition to the patient's own clinical supervisor. This model is unlikely to be practicable and we do not intend to consider it further.

33The Committee also proposes a variation on Model 1 replacing the automatic independent medical opinion with a power for the tribunal to seek one where necessary. But this might lead to delays in hearings.

34Model 2 addresses the problem of drawing on a limited pool of doctors. The tribunal would have no medical member. Instead it would have advice from a panel of approved independent doctors. It could select a doctor from within the relevant specialty,



where necessary with particular expertise for example in forensic risk assessment, to examine the patient and advise it about the appropriateness of the proposed care and treatment plan. The tribunal could also have access to a parallel panel of independent experts in the provision of social services and community care.

35 Model 3, comprises a single specially trained lawyer with access to advice from a panel of experts. This model would place a heavy demand on the substantive tribunal member who would need to take decisions without the opportunity of discussion with colleagues.

36 The Committee considers that Models 2 and 3 achieve the aims of independence and expertise while at the same time reflecting both the demands of fairness and the realities of consultant availability. They recommend further consultation on the question of whether a single or multi-member approach would be most appropriate.

37 If a new Mental Health Act is to introduce a tribunal-based system for imposition of compulsory orders we must be clear that the intended benefits are not outweighed by problems created by introducing a new bureaucracy. Clinical resource is scarce and it is essential that the implementation of any new process does not result in professional staff having less time to spend on patient care.

38 The new arrangements will involve additional tribunal hearings. But, we do not anticipate that this will necessarily increase the workload on care staff. Any application to impose compulsory care and treatment must be based on full risk assessment and a properly worked up care plan. Under procedures set out in the Mental Health National Service Framework, both of these should have been undertaken already for a patient for whom compulsory care is being considered. This is a very considerable part of the work that is likely to be entailed in preparing for a tribunal hearing.

39 Nor should the tribunal draw unnecessarily on clinical staff time in reaching its decisions. Under the 1983 Act only about half of the number of patients who are detained for treatment currently appeal to the Mental Health Review Tribunal. We anticipate that under a new Mental Health Act a significant number of patients will decide not to contest the care team's application to the tribunal for a compulsory order. In such cases the tribunal decision should be straightforward, a one-person panel should be sufficient and there should usually be no need for an oral hearing. Although access to a panel of second opinion professionals should always be available we do not consider that in such cases it is essential for the tribunal to refer the case for a second medical opinion.

40 An alternative model would be to establish a single person tribunal (as in model 3) with discretion to bring in additional members and to refer the case to a panel of medical or social care experts. The lawyer member might wish to use this discretion in contested cases or in other cases if for example he had particular concerns about the proposed care plan.

*Consultation point F: The Government would welcome comments on the three models proposed by the Committee. We would also welcome views on the alternative model proposed in paragraph 40 on previous page.*

- *Would a one-person tribunal generally be sufficient to take decisions in respect of uncontested cases. If so, should there be discretion for the lawyer member to bring in additional members and should reference for a second medical opinion be discretionary?*

<sup>20</sup> ICD-10 Classification of Mental and Behavioural Disorders World Health Organisation Geneva

<sup>21</sup> Diagnostic and Statistical Manual of Mental Disorder, American Psychiatric Association

<sup>22</sup> Mental Incapacity Law Commission 231, 1995, paragraphs 3.8 3.13

<sup>23</sup> The registered person is the individual who represents the authority which, for legal purposes, takes responsibility for compulsion. This person would usually be the Chief Executive, although the function may be delegated.

<sup>24</sup> A person qualified as a registered mental health nurse, or qualified as a learning disability nurse but with suitable additional training

<sup>25</sup> Article 5(1)(e) of the European Convention on Human Rights, as implemented by the Human Rights Act [1998] allows for the lawful detention of people with unsound mind and under Article 5(4) a person who is detained must be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily and his release ordered if the detention is not lawful

## Chapter 5

# Criteria for Compulsory Care and Treatment

<sup>1</sup>This chapter considers the criteria that must be met if the tribunal is to approve the imposition of compulsory care and treatment. Two approaches are discussed the model proposed by the Committee and an alternative. The Committee recommends that the criteria to be considered by the tribunal for making a compulsory order should be sensitive to judgments about a patient's "capacity". They attach great importance to this, describing capacity as having "a central role within any future compulsory mental health structure".

<sup>2</sup>The Committee uses the definition of capacity put forward by the Law Commission. The Law Commission recommends that: a person should be considered to lack capacity if at the time when the decision needs to be made the mental disorder is such that, either:

- *he or she is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision;*

or,

- *he or she is unable to make a decision based on the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision.*

<sup>3</sup>In the Committee's view, the criteria for imposition of a compulsory order should take account of whether or not, based on this test, the patient is assessed as having capacity to consent to treatment for mental disorder. The ultimate decision would be in the hands of the tribunal, with a presumption in favour of capacity.

### *The capacity model*

<sup>4</sup>The Committee recommends that before the tribunal can authorise compulsory care and treatment the following criteria would need to be satisfied:

- evidence of the presence of mental disorder which is of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services;

AND

- that the care and treatment proposed for, and consequent upon, the mental disorder is the least restrictive and invasive alternative available consistent with safe and effective care;

AND

- that the proposed care and treatment is in the patient's best interests.

AND one of two alternative criteria, which make a distinction between the level of risk indicating use of compulsory powers in cases where patients retain capacity and where they lack capacity:

EITHER

- that, in the case of a patient who lacks capacity to consent to care and treatment for mental disorder, it is necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation that s/he be subject to such care and treatment, and that such care and treatment cannot be implemented unless s/he is compelled under this section;

OR

- that, in the case of a patient who has capacity to consent to the proposed care and treatment for her/his mental disorder, there is a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if s/he remains untreated, and there are positive clinical measures included within the proposed care and treatment which are likely to prevent deterioration or to secure an improvement in the patient's mental condition.

(see discussion in paragraphs 5.94 - 5.104 of their report)

5This approach is driven by the Committee's desire that the criteria should be consistent with their overarching principles of non-discrimination and patient autonomy and the aim to treat people suffering from mental disorders, as far as possible, in the same way as those suffering from physical disorders. Patients with capacity who need treatment for physical disorders are generally free to choose whether or not to accept treatment. The approach proposed by the Committee would mean that to meet the criteria for imposition of a compulsory order patients with capacity would have to be assessed as presenting a higher degree of risk than those without capacity.

6The principal concern about this approach is that it introduces a notion of capacity, which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the *degree of risk* that patients with mental disorder pose, to themselves or others, that is crucial to this decision. In the presence of such risk, questions of capacity - while still relevant to the plan of care and treatment - may be largely irrelevant to the question of whether or not a compulsory order should be made.

#### *A model without a capacity test*

7A possible alternative model, which does not involve a capacity test, is set out below. Before making a compulsory order the tribunal would have to be satisfied that the following criteria were met:

- the presence of a mental disorder which is of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services;

AND

- that the care and treatment proposed for the mental disorder, and for conditions resulting from it, is the least restrictive alternative available consistent with safe and effective care;

AND

- that the proposed care and treatment cannot be implemented without use of compulsory powers;

AND

- is necessary for the health or safety of the patient;

AND/OR

- for the protection of others from serious harm;

AND/OR

- for the protection of the patient from serious exploitation.

8In this model the notion of the patient's "health or safety" includes issues relating to welfare and to self-harm.

9The effect of this alternative approach is to remove the differentiated risk thresholds for those with and without capacity that

the Committee proposes. This is in line with our proposed principle that: *Issues relating to the safety of the individual patient and of the public are of key importance in determining the question of whether compulsory powers should be imposed* (see discussion in Chapter 3). Although assessment of capacity would still be integral to assessment of needs and risk, it would not be a primary factor in determining whether a compulsory order should be made.

**10** Under either approach, as a matter of good practice the care team would always be expected to take steps to promote the patient's ability to consent to treatment and involve them in decisions on their own care. This in line with the suggested principle of involvement and specific guidance will be included in the Code of Practice.

*Consultation point G: The Government would welcome views on whether a capacity-based approach to compulsory care and treatment for those with a mental disorder is helpful in terms of practical outcomes. In particular:*

- *What are the advantages and disadvantages of the two models presented?*
- *Would a common threshold of risk for both those with and those without capacity provide a better basis for determining the need for compulsion? Could a higher threshold of risk for those with capacity be justified?*
- *Is it likely that the introduction of a capacity test would lead to an increase, or decrease, in the number of people made subject to formal compulsion?*
- *Is it essential to deal with issues of capacity in the new Mental Health Act itself, or could they be addressed adequately in the Code of Practice?*

## Best Interests

**11** The Committee identifies two definitions of "best interests":

- one which gives priority to the professional opinion of the care team as to what would be in the patient's best interests, and
- one which gives priority to the presumed wishes of the patient as far as they are ascertainable.

**12** In our view, best interests should be determined by the members of the multi-disciplinary care team, and based on their professional opinion. The very fact that compulsory care and treatment is called for may imply that the clinical team is not acting in accordance with what the patient considers to be his or her best interests. As far as possible, however, the clinical team should take account of the patient's views; either expressed at the time or in advance statements.

**13** In making a judgement about best interests, the care team should follow the guidance set out in *Making Decisions* and *Who Decides?* and take into account:

- the ascertainable past and present wishes and feelings of the person concerned and the factors the person would consider if able to do so;
- the need to permit and encourage the person to participate or improve his or her ability to participate as fully as possible in anything done for and any decision affecting him or her;
- the views of other people whom it is appropriate and practical to consult about the person's wishes and feelings and what would be in his or her best interests; and
- whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of the person's freedom of action.

**14** Action taken in a patient's best interests should always involve the least restrictive form of treatment and care, taking account of the risk to the patient and others.

**15** Guidance on the interpretation of best interests will be provided in the Code of Practice.

## Chapter 6

# The New Tribunal's Remit

### *The Compulsory Order*

1We propose that the new tribunal should be able to make the following disposals whether the hearing is at 28 days or sooner:

- if it is not satisfied that the care team have demonstrated that the criteria for imposition, or continuation, of a compulsory order are met, it must not authorise any further use of compulsory powers. If a compulsory order is still current the tribunal must discharge the patient from the order;
- if it is satisfied that the criteria are met and a properly constituted care plan is in place, it must issue a compulsory order;
- if it is satisfied that the criteria are met but not satisfied that a properly constituted care plan is in place, it must issue a short term order pending submission of a fresh care plan.

2We do not intend that the tribunal should have the power to determine the content of the care plan. It will be for the care team to construct the most appropriate package of care in the light of their knowledge of what is available in the locality, following the guidance and standards set out in the Mental Health National Service Framework. The primary function of the tribunal will be to determine whether:

- the criteria for use of compulsory powers are met;
- the proposed care plan is consistent with the principles set out in the Act; and
- the interventions are appropriate to the treatment of the patient's mental disorder.

3If the tribunal is concerned about any of these matters it must ask the care team to reconsider the proposed care plan. The tribunal may also suggest - on the basis of the evidence put to it including information about the impact of any interim care plan and the views of the patient - that the care team consider revising the care and treatment regime proposed. But *details* of the treatment - for example what specific medication should be prescribed, or what types of non-medical therapies should be provided - would be for the care team to determine.

### *Alternatives to Hospital*

4The 1983 Act includes powers, through Guardianship and Aftercare under Supervision, to compel an individual to reside at a particular place and to attend specified locations for the purpose of treatment, occupation, education or training. But these powers are often criticised as inadequate and have been used infrequently. Under the 1983 Act, patients who require *compulsory treatment* must be detained in hospital. There are no powers to compel a patient to comply with treatment in the community.

5Modern treatment regimes mean that care outside hospital is potentially an option for many people who need treatment for mental disorder and who, a generation ago, would have had to be treated in hospital. But for some patients care and treatment outside hospital will not be a safe or practicable option if there is a significant risk that they will not keep to the care plan. It is the duty of health and local authorities to deliver appropriate services. But too often, patients treated in hospital - both formally and informally - fail to follow their treatment plans on discharge and need to be re-admitted to hospital because their condition deteriorates following loss of contact with care services. It is totally unacceptable that a group of patients who are known to pose a risk either to themselves or to others when they fail to comply with treatment, should so easily drop out of care in this way - sometimes with tragic results.

6We want the new Mental Health Act to bridge the gulf between the full compulsory treatment and detention powers, that are provided under the 1983 Act, and the comparatively weak and ineffective powers that it provides for care and supervision outside hospital. The 1983 Act does not provide adequate controls either for those who need to comply with care on leaving hospital or for those who would benefit from compulsory care, but who do not necessarily need hospitalisation.

7To address this problem, we asked the Committee to suggest ways of extending provisions for compulsory care and treatment

to the community. They recommend the creation of a new mechanism for ensuring compliance with care and treatment - the power to make a compulsory order in the community. The same criteria would apply whether the order was to take effect in hospital or in the community. The proposal has the merit of being very flexible. It allows for compulsory care to be provided, as now, on an in-patient basis. But it also allows for continuing compulsory care following a period in hospital.

8It also provides a mechanism for compulsory care and treatment in the community that is not based on a requirement that the patient is first admitted to hospital. The Committee recognises that in some cases it might be appropriate for both the initial assessment and provision of care under a compulsory order to take place in the community. This might apply, for example, to children and the elderly. In the period between assessment and the tribunal hearing such patients would be subject to compulsory care under an interim care plan. Although care would take place in the community the patient would have access to the same rights and safeguards as hospital patients.

9When applied in the community the compulsory order could:

- stipulate place of residence;
- define the proposed care and treatment plan;
- confer an obligation on the patient to allow access and to be present for scheduled visits by identified caseworkers;
- impose a duty on health and social services to comply with arrangements set out in the care plans;
- stipulate the consequences of non-compliance which could include powers to:
  - enter premises;
  - convey the patient to a stipulated place for such care and treatment as is prescribed in their care plan;
  - convey the patient to hospital.

(see paragraphs 5.106 - 5.116 of the Committee's report)

### **How the Compulsory Order might work.**

Mrs O is a 79 year-old woman. She lives in Part 3 accommodation. Her memory is deteriorating slightly but she has been well-settled in the accommodation. Over the past few weeks she has become agitated, depressed and has adamantly refused the medication her GP has offered her. The local old age psychiatric team has been called in, and decides to call for a gate-keeping assessment. Mrs O meets the criteria for formal assessment. Everyone (including Mrs O) agrees that it is unnecessary to admit her to hospital. The team members visit Mrs O and draw up a care plan, which includes drug treatment as well as Community Psychiatric Nurse support - all to take place in the community for up to 28 days. Mrs O complies with the order and is discharged to informal status by the team after 17 days without ever needing to leave her home.

10We accept the Committee's proposals for extending the powers of compulsory care and treatment beyond hospitals. We propose that the compulsory order issued by the tribunal should specify whether treatment is to be provided in hospital or in a community setting. This will usually reflect proposals included in the care plan, although an order imposing compulsory care and treatment in the community will routinely include the flexibility to convey the patient back to hospital. In cases of persistent non-co-operation, resulting in return to hospital, the patient should have the right to a tribunal hearing.

11This is a major innovation. For patients who meet the criteria for imposition of compulsory care and treatment a compulsory order in the community may offer the least restrictive alternative consistent with their own best interests and safety and the safety of the public. It will also mean that patients, who have been subject to compulsory care in hospital, can be discharged back into the community in a way that ensures necessary supervision but imposes minimal restrictions on their independence.

12The consequences of non-compliance with a compulsory order in the community will be laid out in the care plan. It will be for care teams locally to devise protocols covering the arrangements for patients to be conveyed to hospital. Our expectation is that this will usually be the task of trained paramedics; the police should only be used as a last resort.

*Consultation Point H: The Government would welcome views on the practicality of the proposals outlined for compulsory care and treatment in a community setting.*





## Chapter 7

# Discharge and Aftercare

<sup>1</sup>We are committed to ensuring that arrangements in a new Mental Health Act for discharge from compulsory care and treatment should reflect our overall aims of simplicity and transparency of decision making.

<sup>2</sup>The Committee recommends a procedure of imposing compulsory care and treatment through time limited orders. When the period of an order ends compulsory care and treatment will lapse unless the patient's clinical supervisor<sup>26</sup> applies to the tribunal for renewal and the tribunal makes a new order. During any order of longer than three months, the patient may apply once to the tribunal to review the order.

<sup>3</sup>The Committee recommends that the clinical supervisor should be able to discharge a patient from the compulsory order when their condition improves to such an extent that the criteria for imposing compulsory care and treatment are no longer met. There would be no need to seek the endorsement of the tribunal. But, the clinical supervisor would have a duty to report the discharge to the tribunal and would be obliged to provide details of ongoing care. The tribunal would be asked to confirm the content and the duration of the care package, and in cases where it was not satisfied could request further information. (This is very similar to trial court powers to call for details of hospital provision under Section 39 of the Mental Health Act 1983). The duty to report ongoing care arrangements would also apply when no application for renewal is made at the end of an order.

<sup>4</sup>The Committee's recommendations provide an effective framework for ensuring proper transition from care under compulsory powers to informal care. We agree that in most cases the clinical supervisor should be able to discharge a patient from a compulsory order without reference back to the tribunal. We also agree with the Committee's recommendation that the clinical supervisor should usually have the authority to relax some of the requirements of the care plan, for example by granting leave of absence. We would wish to see this as a standard flexibility.

<sup>5</sup>But in some cases the tribunal may decide at the outset that they will want to review the discharge plan *before the patient is released from the compulsory order*. This might occur if a patient is known to have a history of non-compliance with treatment, or to pose a serious risk to other people. In some circumstances clinicians may want to recommend that the extra safeguards of a tribunal review prior to discharge should apply.

<sup>6</sup>An alternative to the Committee's approach would be to give the tribunal the power to *regulate the discharge* of compulsory orders. This could be done by providing for the tribunal to reserve the decision about discharge to itself. In cases where it did not do so, the decision would rest with the clinical supervisor. In such cases the patient could not be released from the compulsory order unless the tribunal authorised an application for discharge. This approach would underline the tribunal's responsibility for the process as a whole and ensure that patients received appropriate care at the end of the period of a compulsory order.

*Consultation Point I: The Government would welcome views on whether the tribunal should have exclusive power to discharge compulsory orders unless they choose to leave this responsibility to the clinical supervisor.*

<sup>7</sup>Under either approach we consider that the tribunal should confirm the plan for care after discharge from a compulsory order. In most cases this would not happen until after the discharge had taken place. But the effect would be to ensure that the patient's ongoing care needs are fully considered and that arrangements are made for the necessary services to be provided.

<sup>8</sup>We share the Committee's view that the power and duty to discharge should be vested in the clinical supervisor and the tribunal and that these two routes to discharge are sufficient. We agree that the provisions in the 1983 Act for review by the

Hospital Managers will no longer be required. This should save considerable time and resources.

### *Charging Policy*

<sup>9</sup>Local authorities provide a wide range of non-residential social services to people with mental disorder. Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 gives them discretion to make reasonable charges for such services (including domiciliary services and day care). Where local authorities provide residential care services under Part III of the National Assistance Act 1948 they must assess the resident's ability to pay and charge for those services accordingly.

<sup>10</sup>Under Section 117 of the Mental Health Act 1983, local authorities and health authorities have a shared duty to provide certain patients with after-care services following discharge from detention. Aftercare may include health care and both non-residential and residential social care services. The 1983 Act contains no power to charge and where social care services are provided as part of an aftercare package under the Act patients cannot be charged.

<sup>11</sup>Under our proposals for a new Mental Health Act, health and local authorities will be required to provide health care and social care, including residential care, to people who are subject to an order providing for compulsory care and treatment. They will also be required to provide services for patients needing aftercare following discharge from a compulsory order, whether the order applied to care in hospital or in the community. NHS care will continue to be provided without charge.

<sup>12</sup>The Committee makes no recommendation in respect of charging for social care services, but suggests three approaches:

- charge for all services;
- charge for some services;
- provide all services free of charge.

<sup>13</sup>The Committee expresses concerns on a number of issues (see paragraph 3.11 - 3.15 of their report). One of these is that provisions to bar local authorities from charging for care provided to patients subject to compulsory orders might disadvantage informal patients and create a perverse incentive for patients to behave in a way that would attract a compulsory order.

<sup>14</sup>It is important that decisions regarding policy on charging for social care provided under a new Mental Health Act for those either subject to, or discharged from compulsory orders, should take account of the outcome of decisions on policy regarding charging for long-term non-residential care. We will develop proposals in respect of people subject to compulsory care in this broader context.

<sup>26</sup> The term "clinical supervisor" here broadly encompasses the current "responsible medical officer." It denotes whoever has overall responsibility for the oversight of the patient's clinical care normally a medical consultant. The change in terminology in part reflects the fact that the responsibility for compulsion now rests with the independent tribunal.

## Chapter 8

# Interface with the Criminal Justice System

<sup>1</sup>This paper has so far concentrated on the "civil" route into the compulsory provisions of mental health legislation. The vast majority of those subject to compulsory care and treatment will follow this path; they will not have committed an offence nor come into contact with the criminal justice system as a result of their illness.

<sup>2</sup>However, each year the criminal courts order the compulsory admission of about a thousand people to mental health service facilities instead of prison following conviction for a criminal offence. Others are admitted to hospital for assessment and treatment on remand, or transferred from prison to hospital during the course of a prison sentence. This reflects long-standing policy that, wherever possible, people who have offended but need specialist medical treatment for mental disorder should receive it in hospital.

<sup>3</sup>In many cases where a person with mental disorder comes before the courts there will be a link between the offending behaviour and their disorder. In other cases, even if there is not a direct link, treatment from specialist services is still appropriate. Often the likelihood of repeat offending is significantly reduced through successful treatment of the disorder.

<sup>4</sup>The focus of the provisions in Part III of the 1983 Act is on improving public safety by managing risk and promoting better health outcomes for offenders with mental disorder. Our proposals for a new Mental Health Act will preserve this aim. The guiding principles we propose in Chapter 3 will apply to anyone who is treated under the provisions of a new Mental Health Act. But it is important to note that for offenders, decisions on what constitutes the least restrictive alternative will always need to be interpreted in terms of potential risk of harm, whether to the patient or to other people.

### *The present system*

<sup>5</sup>For most offences, when sentencing a person with a mental disorder, a Magistrates Court or the Crown Court may impose a hospital order (or an interim hospital order pending final decision) instead of making a criminal disposal. This means that instead of being given a prison sentence, the offender is admitted to a psychiatric hospital and will be detained there for as long as they need specialist treatment for mental disorder. In these cases the patient's doctor is responsible for deciding when they should be discharged and the patient also has access to the Mental Health Review Tribunal.

<sup>6</sup>The Crown Court can supplement a hospital order with a restriction order in cases where it feels that it is necessary for the protection of the public from serious harm to do so. This gives the Home Secretary responsibility for assessing the risk of proposals that would increase the patient's liberty - in effect controlling the pace of rehabilitation based on that risk assessment. This system has proved to be very effective in preventing re-offending. Only 2% of discharged restricted patients are re-convicted of a grave offence within two years; a figure only slightly worse than that for life sentence prisoners released on licence, and much better than the reconviction rate of released determinate sentenced prisoners, which is in excess of 50%.

<sup>7</sup>The provisions for offenders in the 1983 Act have established a balance between patients' rights and liberties and the rights of others to be protected. The balance has proved effective in the great majority of cases. The Mental Health Review Tribunal provides a regular independent review of the need for a patient's continuing detention. The responsible medical officer considers risk in making recommendations for discharge decisions.

<sup>8</sup>The effectiveness of the balance depends primarily on the quality of the evidence before the sentencing court. The court needs to know, in making a hospital order, that medical treatment is likely to prove effective in addressing the offender's mental disorder. It needs advice that treatment could reduce the likelihood of re-offending to an extent that could be managed effectively within the controlled therapeutic regime of a hospital and subsequently in the community.

<sup>9</sup>If the Court concludes that medical treatment cannot be relied on to deliver that objective, then it may have to resort to a criminal justice disposal even though there is evidence that a patient is mentally disordered. However, that is unlikely to be in

the best interests of public safety. The length of a prison sentence is governed by the seriousness of the offence. Unless the offence attracts a life sentence, and the evidence before it leads the Court to impose one, a prison sentence cannot protect the public beyond the date of release. There have been well reported instances of offenders thought to be at high risk of re-offending, but who have had to be released at the end of their sentences.

10Provisions in the 1983 Act are designed to enable the Court to obtain expert evidence before sentencing mentally disordered offenders. The Court can call for information on the availability of medical facilities for assessment and treatment of the offender's disorder. It will look for evidence regarding the presence of mental disorder but also the likely effectiveness of treatment in reducing the risk of the mentally disordered offender re-offending.

### *The new system*

11The provisions of the 1983 Act in respect of offenders have proved fundamentally sound. They provide a foundation on which new legislation can build to provide a comprehensive structure for the management of mentally disordered offenders. That structure should have three principle elements:

- access to treatment through a judicial decision based on comprehensive clinical assessment of the offender's needs, and of the potential to address his offending behaviour through medical intervention,
- subsequent decisions about the requirement for continuing compulsory care and treatment based primarily on assessment of the level of risk whilst the mental disorder persists,
- access to regular independent review of the appropriateness of detention.

### *Applying the new system to offenders*

12We propose that under a new Mental Health Act offenders with a mental disorder should be subject to compulsory care and treatment on the decision of the court rather than the new tribunal. The Court will make a compulsory order, either with or without a restriction order.

### *Assessment*

13As in civil cases, the decision to make an order would need to be based on evidence from a formal assessment. At present Courts can seek information regarding the potential value of a hospital disposal by ordering assessment in hospital before sentencing. We envisage that under a new Mental Health Act the power to remand for assessment would be available, subject to regular review by the court, on a similar basis. The order for assessment would initially be for up to three months but renewable for further periods with a maximum of 12 months in total. This time-scale should be adequate to remove any doubts about the respective merits of a criminal justice or mental health disposal in protecting the public and providing effective treatment for the offender.

14In other words, the Court would make an order on the basis of a process of assessment in hospital. That process would enable healthcare professionals to assess whether:

- the offender is suffering from mental disorder which would justify use of compulsory powers;
- it is appropriate to offer facilities for treatment as an alternative to a criminal justice disposal. This would depend on assessment by mental health professionals of the effect of such treatment in helping the person concerned and in addressing his offending behaviour. This assessment would include evidence about the offender's insight and compliance with treatment.

15The Court would also consider whether the risk to public safety if the offender was prematurely at liberty in the community required an order making him liable to detention in hospital.

16This assessment process would inform a decision by the Court whether to make a mental health disposal: a decision which would encompass the availability of treatment for the offender's condition and provisions regarding consent to treatment. A finding that an offender suffered from mental disorder for which medical treatment was available should suffice to enable his subsequent safe management for as long as the disorder persisted.

17Our proposals for the management of dangerous severely personality disordered offenders involve a similar process of assessment to inform the sentencing Court. It would not always be clear before sentencing whether an offender suffered from severe personality disorder or another mental disorder. That would emerge from the assessment. A single power to remand for assessment irrespective of the likely outcome in terms of disposal would probably therefore meet the need of the Court. In the case of a person with severe personality disorder, the Court might follow an order for initial assessment in hospital with an order for assessment in a specialist unit.

## *Further Issues relating to assessment*

18The 1983 Act provides separate powers for the courts to remand for assessment and treatment. Remand for assessment prior to conviction does not invoke powers to treat without the patient's consent and so can be made on the basis of a single medical opinion. It has occasionally been necessary to resort to simultaneous detention under a civil power to enable compulsory treatment to be given. This practice suggests that the power of remand for assessment may not be of practical value. It may be that a single power of remand for assessment and treatment would be of greater benefit, although that may necessitate a second medical opinion.

19There is currently a distinction between the powers of magistrates and of the Crown Court in making these remands. Magistrates cannot remand without the defendant's consent unless they have convicted the defendant for an offence punishable with imprisonment on summary conviction. This may result in delay in effective medical intervention. We propose that provisions in a new Mental Health Act should allow both magistrates and higher courts to remand for assessment and treatment where they have the necessary medical evidence.

20A practical difficulty encountered under all the existing court powers of hospital detention before sentencing is that there is no explicit power to authorise the patient to be given leave from hospital. Patients detained on remand are held at the discretion of the court. So it should be for the court to agree any request for leave. The courts are sometimes reluctant to do so in the absence of powers on the face of the legislation. We therefore propose to include in the new Mental Health Act a power for the court to grant leave of absence to a patient remanded for assessment and treatment. There will also be provision for the court to decide, when the remand order is made, whether or not the power to grant leave of absence should be delegated to the patient's clinical supervisor.

*Consultation point J: The Government would welcome views on these proposals. Would a single power to order assessment and treatment meet the sentencing needs of the court, and enable the best disposal to be made, irrespective of the offender's actual mental disorder?*

*Consultation Point K: Should the court have the power to grant leave of absence to a patient remanded for assessment and treatment? Should there also be provision for the court to decide, when the remand order is made, whether or not the power to grant leave of absence should be delegated to the patient's clinical supervisor?*

## *Disposals of the Court: Compulsory order*

21After assessment, the court will move to sentencing. We accept the Committee's recommendation that the courts should retain the power to make an order for compulsory treatment under a Mental Health Act disposal rather than passing a custodial sentence. The existing hospital order is renewable for as long as the offender requires treatment in hospital, and enables compulsory treatment to be given. So it is unlikely to lead to an offender being discharged into the community whilst they present a risk to the public.

22In selecting an order for compulsory treatment, rather than a criminal justice disposal, for a convicted offender, the court must have confidence that the disposal really will serve to protect the public.

23The Court will be dependent on clinical evidence in reaching a decision on whether appropriate treatment for the offender's mental disorder is available. If the Court is not satisfied that a mental health disposal will address the danger of harm to others posed by a patient with mental disorder, it may make a disposal through the criminal justice system. Public safety is paramount and the final decision must rest with the Court.

24Under the 1983 Act, the effect of a hospital order is equivalent to detention in hospital for treatment for non-offenders. The effect of the new order we are proposing is that it should authorise compulsory care and treatment, rather than detention in hospital. We recognise that some mentally disordered offenders may be effectively treated in the community without undue risk to others. That is why the development of court diversion schemes has been encouraged. Where offending is a direct result of mental disorder, and where the offender is likely to comply with medical treatment, the safety of others may be better served under proposals which ensure compliance with medical treatment in the community than by detention in hospital. There seems no reason in principle why mentally disordered offenders should not be subject to a compulsory order on a similar basis to our proposals for non-offenders.

25Detention in hospital is clearly indicated, however, in the circumstances that currently lead the Court to make a restriction

order. If the offender's discharge is likely to pose a threat of serious harm to others, it must be right for the Court to be able to impose liability to detention in hospital, subject to certain controls exercised by the Home Secretary. In such cases the compulsory order would reflect this.

### ***Restriction order***

26The restriction order applies to those mentally disordered offenders assessed by the courts to be the most dangerous. It provides an assessment conducted entirely from the perspective of public safety.

27We are strongly of the view that the restriction order performs an indispensable function in the safe management of those offenders who pose a risk of serious harm to others. It provides for a safety audit of proposals to increase the liberty of these offenders. So the power will be preserved in the new legislation and will continue to invoke scrutiny of the management of the restricted patient on behalf of the Home Secretary.

28We recognise the merit of the Committee's proposal that a formal risk assessment should be a prerequisite to the imposition of a restriction order. We propose that the assessment should be undertaken during a period of remand to hospital and should include both psychiatric and social work, or Probation Service input. Since the purpose of the order is the protection of others, discretion to call for such an assessment, and to make the order, should rest with the Court.

29Given the significance of the restriction order for the patient's liberty, it seems right to limit its availability to the higher courts. There is, however, no necessary link between the specific offence for which a hospital disposal may be made and the potential harm to others that may result if the offender is discharged from detention too soon. So magistrates courts need to retain the power to commit for sentencing in the higher courts where they believe a restriction order is needed. We intend that this power should be extended to cover those cases where magistrates are satisfied that the accused did the act or made the omission charged, but believe a compulsory order under the Mental Health Act to be appropriate without conviction.

### ***Review arrangements***

30The proposals in this paper rest on the principle that all decisions on imposition of compulsory orders should be taken by a judicial body. Where offenders receive a compulsory order from the Court, that requirement will already be met. They will have been made subject to a compulsory order as a Court disposal following conviction for a criminal offence. The disposal will follow a period of assessment in hospital and the order will reflect evidence meeting the criteria for use of compulsory powers, and given by medical professionals.

31The Court would have the power to make a compulsory order for a period of up to six months. For patients not subject to restrictions the order would subsequently be renewable on application to the new tribunal for periods of up to 12 months. For patients subject to restrictions the Court order would be without limit of time but subject to review.

32Offenders would not have a right to request a tribunal hearing in the first six months of a compulsory order made by the court, but would have a right to request a review once during each subsequent 12 month period of any continuing period of compulsory care and treatment.

### ***Variation of orders and discharge***

33Where an offender is subject to a compulsory order without restrictions we propose that the Court making the original order, and then the tribunal making any subsequent order, should have the power to regulate decisions on variations in the order. Such variations might relate to leave of absence or transfer between hospitals, and to discharge (see discussion in chapter 7 regarding non-offender patients). This power could, at the discretion of the Court or the tribunal, be delegated to the clinical supervisor.

### ***Conditional discharge***

34The power to discharge restricted patients subject to conditions, and subject to potential recall to detention in hospital, is one of the most effective safeguards for the public in the management of potentially dangerous mentally disordered offenders. The Committee recognises that the structure provided by the compulsory treatment order for improved treatment and supervision in the community might not suffice in the cases of the most dangerous offenders. We agree. Where a court, after advice from a clinical assessment and risk assessment, concludes that a compulsory order is needed and that in addition a restriction order should apply, the existing provision enabling discharge subject to conditions and liability to recall will remain. As now, the conditions will be subject to review by the tribunal.

### ***Prisoners***



35 Some offenders who have been given prison sentences will have mental health problems requiring compulsory treatment; other prisoners will develop them. This issue is discussed at paragraph 16.1 - 16.10 of the Committee's report. Under current arrangements, if a prisoner's condition is sufficiently serious to require compulsory treatment, this is effected by way of transfer to hospital at the direction of the Home Secretary.

36 We are not convinced of the need for significant legislative change in the arrangements for transferring prisoners, but will consider alternative views.

*Consultation point L: the Government would welcome views on whether the arrangements for transferring prisoners to hospital for compulsory care and treatment for mental disorder should be changed.*

37 Prisoners directed to hospital by the Home Secretary will continue to have a right of immediate review by the tribunal. They would otherwise be liable to compulsory treatment on the basis of executive decision, rather than by judicial direction. If the tribunal found that the criteria for use of compulsory powers under the Mental Health Act was not justified the offender would be returned to prison.

38 Sentenced prisoners who have been transferred to hospital because of mental disorder sometimes need to remain in hospital after the end of sentence. We propose that where this happens the clinical team should apply to the tribunal for a compulsory order as for non-offender patients. There would need to be provision for the offender to remain subject to compulsory care and treatment pending a decision by the tribunal.

39 There are different arrangements for returning remand prisoners from hospital to prison custody, depending on whether they are remanded by magistrates or committed to the Crown Court. In the former case, the Home Secretary has no power to direct return to custody when treatment has been effected. Hospitals wishing to return magistrates' remands to custody must apply to the court. The reason for this distinction is no longer clear. It can cause confusion and delay, and we intend to end it by giving the Home Secretary the same power to return transferred magistrates court remand prisoners to custody as he has for those from the Crown Court.

### ***Police powers***

40 The police are often the first point of contact for the mentally disordered person in need of urgent care and treatment. Under the 1983 Act they are empowered to remove such people from public places and convey them to a place of safety for medical assessment.

41 The Committee recommends that when the police have legitimately entered private premises and discovered someone in similar need, they should - under the new Mental Health Act - have the same powers to convey to a place of safety.

42 The Committee also recommends that people who are arrested by the police should be able, where necessary, to get early access to a gate-keeping assessment. They suggest two routes for this :

- That the gate-keeping assessment should be carried out at the police station and that the relevant authorities would be under a duty to respond promptly; or
- That the police should be given the power to remand an alleged offender into hospital and, given the authorisation of the necessary three professionals, into compulsory assessment.

(see paragraph 15.27 of their report)

*Consultation point M: The Government would welcome views on whether police powers to remove people who appear to be in need of medical treatment from public places should be extended to cover cases where the person concerned is found by the police when they have legitimately entered private property.*

*Consultation Point N: The Government would welcome views on the Committee's proposals to ensure that people who have been arrested get early access to a gate-keeping assessment where necessary.*

## Chapter 9

# Treatment

1In this chapter we consider the definition of treatment for mental disorder, the special safeguards which should regulate certain prescribed treatments, and the need to regulate the long-term administration of treatment given against the will of the patient. Definitions of treatment and long-term treatment safeguards relate only to patients who are subject to compulsory powers. But the safeguards covering specified treatments apply to all patients whether being formally treated under the legislation or not. The Chapter also covers emergency treatments.

### *Definition of treatment for mental disorder*

2The 1983 Act gives a very broad definition of treatment: "care, habilitation and rehabilitation under medical supervision". The Committee considers that "this, combined with the notion of treatability has given rise to an unfortunate lack of clarity".

3The Committee recommends an approach based on definition in legislation of all those forms of treatment to which special safeguards should apply and to leave all other treatments for mental disorder, which may be given compulsorily, undefined, although they recommend the removal of any equivalent of section 63 of the current Act. In their view, the care plan would, in effect, define appropriate treatments for mental disorder on a case by case basis. "Approval [of the care plan] by the tribunal would help to ensure that all proposed interventions were directly related to the mental disorder from which the patient was suffering."

4The Committee goes on to say that in cases of uncertainty, the clinical supervisor could seek a view from the mental disorder tribunal or the independent doctor. Ultimately, where uncertainty continued, individual cases should be referred to the Family Division of the High Court. They suggest that this procedure would be very exceptional, but would resolve the difficulties that do from time to time arise.

(see paragraphs 6.1 - 6.8 of their report)

5We broadly accept the approach the Committee recommends. However, we are concerned that the provisions in a new Mental Health Act regarding the role of the tribunal in approving the care plan must allow a degree of flexibility. It should not be necessary for detailed changes to care and treatment to be referred time and again to the tribunal. It may therefore be that treatment would not in practice be adequately defined through the approach that the Committee suggests.

### *Treatments requiring special safeguards*

6The 1983 Act makes provision for special safeguards in respect of certain defined treatments. The treatments concerned fall into two categories:

- those requiring consent AND a second opinion;
- those requiring consent OR a second opinion.

### *Treatments requiring both consent and a second opinion.*

7The 1983 Act sets out very exact safeguards in respect of neurosurgery which cannot be undertaken without the express permission of the patient and three people appointed by the Mental Health Act Commission, one of whom must be a doctor. These three people must assess the patient's understanding of the proposed treatment and certify their comprehension and consent. If the patient is incapable of consenting, or does not consent, then neurosurgery may not be undertaken. A similar approach is taken in respect of hormone implantation to reduce a patient's sex drive. These safeguards apply to all patients, both formal and informal.



8The 1983 Act also makes provision for these safeguards to be applied to other forms of treatment. The Committee recommends that the equivalent safeguards be maintained in new legislation and that there should be flexibility to include further treatments in this category.

9We accept the Committee's recommendation.

### *ECT and Other Specified Treatments.*

10The Committee recommends that special safeguards should apply to the following treatments:

Electro Convulsive Therapy (ECT)  
Polypharmacy  
Feeding Contrary to the Will of the Patient.

#### **And possibly:**

Depot Medication  
Doses above British National Formulary (BNF)

11The Committee recommends that use of ECT should be subject to special safeguards. They do not give specific reasons but refer to a wide range of views expressed in response to their consultation. Opinion ranged from those who saw ECT as an effective, possibly life saving form of treatment, to others who urged its removal from the list of treatments that may be given without consent. The Committee made the following recommendations with regard to ECT:

- that ECT never be imposed on any patient who retains capacity and is not consenting.
- in the case of patients without capacity, whether under a compulsory order or not, ECT cannot be administered without the express approval of the tribunal through its medical member.<sup>27</sup>
- That ECT should not be available on the equivalent of section 62.

(see paragraphs 6.18 - 6.21 of the Committee's report)

12We recognise the concern that ECT arouses, particularly among service users. Some see this as a very invasive procedure, which has in the past, been used inappropriately. But on the available evidence we are satisfied that it can save lives in cases of very severe, generally psychotic, depression.

*Consultation point O: The Government would welcome views on the safeguards that should apply to use of ECT. In particular:*

- *Should the use of ECT be controlled as the Committee suggest?*
- *Should it ever be imposed on any patient who retains capacity and is not consenting?*
- *Must the express approval of the tribunal through its medical member be obtained before ECT is administered to patients without capacity, whether under a compulsory order or not?*
- *Should ECT be available under provisions covering urgent treatment?*

13The Committee recommends that a new Mental Health Act should place a duty on the Secretary of State to introduce special safeguards for other specified treatments and that criteria laid down in the Act should set out the matters to be taken into consideration. They suggest that these criteria should include patient safety and duration of impact.

14We agree that polypharmacy involving three or more drugs from the same BNF class justifies special safeguards and we propose that guidance on this should be included in the Code of Practice on the new Mental Health Act. We accept the need to consult further on the issue of doses higher than specified in pharmaceutical product licences.

15However, depot medication is a regular part of recognised treatment of mental illness and there are many occasions where its use is appropriate and in the best interests of the patient. We do not accept that depot medication should be subject to special safeguards.

*Consultation point P: The Government would welcome views on use of special safeguards for specified treatments. In particular: according to what criteria should the Secretary of State impose safeguards on treatments? Which treatments should be covered?*

### ***Treatment requiring consent or a second opinion***

16The 1983 Act permits the medication of a detained patient, in the absence of consent, for a period of 3 months. After that period, medication can only continue if the treating doctor either certifies that the patient consents, or obtains a second opinion from an independent doctor, appointed by the Mental Health Act Commission, supporting continued treatment. The Committee received many comments criticising the current approach.

*Consultation point Q: The Government would welcome views on the appropriate time to bring in a second opinion doctor. Should the period during which medication is allowed to continue without consent and without a second medical opinion be changed from the current period of three months? If so, what would be a better period?*

### ***The Second Opinion function***

17Second opinions are currently given by Second Opinion Appointed Doctors (SOADs) appointed by the Mental Health Act Commission. The Committee suggests that the medical member of the new tribunal (or one of the panel of independent doctors advising the tribunal) should take on the second opinion function. But in any particular case the same individual should not approve a compulsory order and give the second opinion.

18The Committee also recommends that the function of the second opinion doctor should be to consider any proposed treatment against the criteria for compulsory care and treatment, rather than simply considering whether it falls within acceptable psychiatric practice.

19We accept these recommendations.

### ***Emergency Treatments***

20The Committee recommends that provision for administering emergency treatments should continue. They also recommend that care teams be required to keep records of all emergency treatments and the reasons for them. These records should be made available:

- to the MHAC successor body either annually or on the occasion of their visits and
- to the tribunal on the next occasion when the patient's case fell to be considered.

The Committee advise that a provision be included in the new Act which would authorise the compulsory administration of the minimum treatment (primarily medication) necessary to:

- save the patient's life, or
- prevent a serious deterioration in his/her condition, or
- alleviate the patient's serious suffering.

(see paragraphs 6.26 - 6.30 of the Committee's report)

This provision would not authorise ECT and treatments of the same status as ECT.

<sup>21</sup>We welcome this approach. But we have some concerns about how soon the care team can move from emergency treatments to treatment according to a care plan. According to the Committee's recommendations (see paragraph 5.30 of their report) where a patient is not previously known to services, treatments other than emergency treatments could not be given without consent until the independent reviewer had ratified the interim care plan (normally on or before seven days). It is possible that this may lead to patients being denied treatment that is in their best interests. For example, there is evidence that delaying treatment with anti-psychotic drugs leads to poorer long-term outcomes for those with schizophrenic illness.<sup>28</sup> But if the new Mental Health Act does not include a formal 7 day review the care team could treat on the basis of an interim care plan as soon as assessment had taken place.

The quality of care plans including any interim measures would be monitored through the process of clinical governance.

*Consultation point R: the Government would welcome views on the issues of treatment without consent in the period before a formal compulsory order is issued:*

- *Should the initial assessment phase preclude all but emergency treatment for patients not previously known to services?*
- *Should the care team be able to move beyond emergency treatment as soon as an interim care plan is drawn up?*

<sup>27</sup> Under those tribunal models not including a medical member the Committee proposed that a doctor drawn from the independent panel would take on this role.

<sup>28</sup> See the article by Wyatt, R.J, Green, M.F, and Tuma, A.H in Psychological Medicine 27, 261 268 (1997) cited in the Mental Health National Service Framework, page 44

# Chapter 10

## Safeguards

### *The Need for Safeguards*

1The human rights of all patients should be respected and guaranteed at all times. But those whom society requires to accept treatment and restrictions to their personal liberty without consent require special safeguards.

2Many provisions to safeguard the interests of patients subject to compulsory orders have already been mentioned in preceding chapters. The guiding principles for a new Mental Health Act outlined in Chapter 3 will apply to all patients. The preference for informal care where possible and the use of least restrictive alternative are of particular relevance. It is also a major advance that compulsory care and treatment will not continue beyond 28 days for any patient without the authorisation of an independent tribunal. At present only those patients who request an independent review get one. We also intend to build a number of specific safeguards into the new system.

### *Mental Health Act Commission*

3The Mental Health Act Commission (MHAC) has a major role in protecting the interests of patients who are subject to the provisions of the 1983 Act. Its principle functions are to:

- appoint Second Opinion Appointed Doctors;
- review treatments given under sections 57(2) or 58(3)(b) of the Act - i.e. treatment that requires a second opinion;
- visit detained patients and investigate complaints;
- keep under review the exercise of statutory powers relating to detained patients;
- submit proposals for a code of practice;
- look into matters relating to informal patients, when directed to do so by the Secretary of State, and
- report to the Secretary of State every two years on the operation of the Act.

4The Committee recommends that the MHAC should continue, in some form, as a guardian of the interests of individual patients (principally formal patients, but not exclusively so). They suggest that under a new Mental Health Act the MHAC should have the power to fulfil the following functions:

- to monitor the treatment and care of all patients with mental disorder in hospital, whether formal or informal or who are subject to compulsory orders in the community;
- to monitor compliance with mental health legislation and the Code of Practice, and report and record breaches;
- to provide legal practice advice about the implementation of compulsory powers;
- to be involved (possibly through accreditation) in the provision of the training of professional staff who operate under the Act ;
- to receive notification of all admissions to, extensions of and discharges from compulsory power, and be responsible for monitoring, analysing and publishing relevant data in a biennial report to Parliament;
- to refer a patient's case to the tribunal;
- to create working links with all relevant regulatory and other similar bodies and to provide a focus for all agencies and bodies involved in the provision of mental health care;
- to receive reports of all patients who die while under compulsion and to have the power to investigate;
- to have the right to be consulted in relation to the drafting or redrafting of the Code of Practice.

(see paragraphs 12.5 - 12.11 of the Committee's report)

5Our proposals in this area will be framed in the context of other measures that we have put in place to improve the quality of

health and social services. We have introduced a duty of quality in the Health Act 1999 and established the Commission for Health Improvement and the National Institute for Clinical Excellence. New measures to regulate provision of healthcare in the independent sector are included in the Social Services Bill. Patients who wish to complain about their care already have access to the Health Service Commissioner or, for social care, to their local authority complaints procedures and the Local Government Ombudsman. The MHAC successor body should complement these provisions through additional safeguards for patients subject to compulsory powers. It is important that it does not duplicate the functions already covered by these provisions. We intend to define the functions of the MHAC successor body in the context of final decisions on the shape of the new Mental Health Act. But in the meantime we would welcome comments on the list of functions proposed by the Committee.

### *Hospital managers*

6The function of the hospital managers under the 1983 Act, in respect of reviewing detention, will be abolished. Other duties under the Act that are currently undertaken by the managers will become the duty of the registered person.

### *Nearest relative or nominated persons*

7The value of a detained person maintaining contact with someone outside the psychiatric system is clear. Under the 1983 Act, the nearest relative of a patient subject to compulsory powers has certain rights and functions in connection with applications for admission, discharge and aftercare under supervision, and applications to the Mental Health Review Tribunal. The nearest relative is defined in the Act, a patient cannot choose who this person is or remove these rights from them.

8The Committee recommends that future legislation should make no reference to the nearest relative. Instead a new Mental Health Act should make provision for the identification of a 'nominated person' who would be given certain rights and responsibilities. Where possible this person should be nominated by the patient, using advance agreements where appropriate. The tribunal should have power to appoint such a person for patients who do not nominate anyone and who lack the capacity to do so. The tribunal should also have the power to remove a nominated person and appoint a replacement.

9The Committee recommends that:

- the nominated person should be notified when a patient is made subject to compulsory powers; and
- consulted during the course of a compulsory assessment and prior to either discharge or substantial variation of the order.

The nominated person should also be:

- empowered to apply to the tribunal for a discharge on behalf of the patient, and
- have the right, if the patient so wished, to attend any tribunal hearing and to be present at any consultation with a tribunal approved doctor with a view to authorising treatment.

The nominated person should not have the powers of application and discharge currently possessed by the nearest relative.

(see paragraphs 12.17 - 12.23 of the Committee's report)

10We accept these recommendations. But the procedures suggested by the Committee will need to be considered in detail. For example, should the tribunal be required to apply specific criteria when appointing a nominated person for a patient who lacks capacity? If so what criteria should apply? Where the patient does express a choice, this should be respected subject to the consent of the nominee. But what happens when the patient changes this choice frequently? Does an advance agreement take precedence over a decision at the time in this area?

*Consultation point S: The Government would welcome views on how this recommendation might be implemented:*

- *What criteria should the tribunal use to appoint a nominated person for an incapable patient?*
- *How should provision for a nominated person relate to other preferences the patient might express?*

## Advocacy

11The benefits detained patients can derive from an advocate have become more and more apparent in recent years. An advocate is someone who can represent and defend the views, needs, wishes, worries and rights of patients who do not feel able to do this themselves. Advocacy can also help patients participate and make decisions. Advocates are wholly independent; they represent their patients without taking a view on their "best interests".

12The importance the Committee accorded to advocacy stems from a preference for consensual care and treatment that we share.

The Committee recommends that:

- the Secretary of State should have a duty to ensure, by whatever means he thinks fit, the adequate provision of advocacy for those subject to compulsory powers;
- advocates should be given specific rights of access to patients subject to compulsory powers;
- relevant authorities have a duty to respond to a patient's advocate;
- a statutory right to advocacy is created at the earliest opportunity.

They also recommend that independent advocacy should be available to patients at the second opinion doctor visit.

(see paragraphs 12.24 - 12.27 of the Committee's report)

13The Committee recognises the resource implications of setting up a state funded advocacy service and did not recommend this. The regulatory framework for training and accreditation required would also involve a significant commitment of resources. There are many different types of advocacy and a large variety of schemes operating around the country. We will commission further work to determine and develop models of good practice and will keep under review the case for introducing a right to advocacy when we have more evidence about the value of existing schemes.

14Any provision for advocacy would not affect the arrangements for patients who are subject to compulsory powers to have access to legal aid. These provisions will continue.

## Carers

15Carers play a vital role in helping to look after people with serious mental disorders. This is recognised in the Mental Health National Service Framework, and Standard Six sets out clear expectations regarding their needs. We specifically asked the Committee to consider the role of carers in a new Mental Health Act. They recommend:

- \* the introduction of a right for carers to ask for a patient to be assessed and a principle of recognition of the important role of carers;
- \* that the care team inform and consult the carer as well as the nominated person, if the two are different, in the course of a compulsory assessment and before any discharge from hospital or any variation to a community order (within the guidelines in relation to information-sharing).

(see paragraph 11.1 of the Committee's report)

16We accept these recommendations, which are in line with the approach we are taking in our carers strategy "*Caring about Carers*".

## Advance agreements

17The Committee recommends a right for patients subject to compulsory care and treatment to information about, and assistance with, drawing up an advance agreement.

18 Guidance on the status and use of advance agreements will be included in the new Code of Practice. In the case of patients meeting the criteria for compulsory treatment under the Act, we envisage that advance agreements will be used to promote consensual care and facilitate the speedy identification of treatments that have proved effective for them in the past. Advance agreements will not be given special status in the Act. If an advance agreement exists it should be taken into account in deciding what treatment is in a patient's best interests, but this will complement rather than substitute for the normal process of clinical decision making.

19 The Lord Chancellor's statement *Making Decisions* outlined a further mechanism for substitute decision-making - the Continuing Power of Attorney. This enables a patient to give an attorney the general authority to take financial and welfare decisions on his or her behalf. It should however be noted that the Continuing Power of Attorney will not authorise an attorney to consent to compulsory treatment under the Mental Health Act on someone else's behalf.

### *Information sharing*

20 A patient will typically come into contact with a variety of services as he or she passes through the system we have been describing. It is vital that the various individual professionals and agencies involved share relevant information. The particular importance of passing on assessments of risk factors for suicide and serious violence to appropriate services and individuals was highlighted in "*Safer Services*" (the 1999 report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness). It is also essential, however, that this necessary collaboration does not infringe the patient's legal right to confidentiality.

21 The Expert Committee recommended that the Code of Practice be expressly required by the new Act to provide guidance about sharing information in relation to mental health care. The following principles should be reflected in the guidance:

- good information is fundamental to the effective care, treatment and support of those with mental health problems;
- sharing information between a service user, carer, nominated person, advocate and professionals is good practice for those people working together to provide care;
- wherever possible information should only be shared with the agreement of the service user;
- where the user lacks capacity to consent to information being shared any sharing should be on the following basis:
  - the level of need and dependency,
  - the nature and degree of assessed risk,
  - the relevance of the information to ensuring that the user receives the appropriate level of care, treatment and support;
- where the user has capacity but disagrees, information sharing will take place only on the following basis:
  - there is a serious risk of harm to the user or to others,
  - the user will know who has made the decision, and the nature of and reasons for that decision, unless this risks serious harm;
  - where significant risk to self or others is indicated, information relevant to managing such risk will be shared on a 'need-to-know' basis;
  - training on the principles governing the sharing of information should be provided to all mental health practitioners

22 We recognise the sensitivities around sharing patient information generally and any guidance concerning those compelled under the Mental Health Act should take account of wider information policies. Recently revised guidance on the Care Programme Approach<sup>29</sup> reinforces the importance of information sharing between relevant agencies, including the criminal justice system, as part of effective care co-ordination and risk management. A new system has been established throughout the NHS to oversee the development of information sharing protocols, which will enable information to be shared confidently and



effectively within agreed and appropriate parameters. We will also be issuing guidance on information sharing between health and social services, which will be informed by best practice

<sup>23</sup>With regard to patients subject to the Mental Health Act, compliance with Department of Health guidance (*The Protection and Use of Patient Information March 1996*) has been included in the guiding principles of the current Code of Practice (March 1999). Further guidance on sharing of information in respect of patients subject to compulsory powers will be included in the Code of Practice on the new Mental Health Act.

*Consultation Point T: The Government would welcome views on whether the principles outlined by the Committee are the best way to achieve the right balance between confidentiality, the patient's health and welfare and the protection of others?*

### ***Victims***

<sup>24</sup>There are further sensitive issues about the extent to which information about offenders who receive care and treatment for mental disorder under compulsory powers in the Mental Health Act should be made available to victims of the offence.

<sup>25</sup>The Victims' Charter sets out the rights of victims and their families to receive information about perpetrators of serious sexual or violent offences while they remain in **prison**, and at the stage when they are released. But where offenders are admitted to **hospital** for treatment for a mental disorder they are not currently covered by this aspect of the Charter. This is because the information about their status as hospital patients and any proposals for discharge may be regarded as falling within the normal rules of patient confidentiality.

<sup>26</sup>In our view there is a distinction between clinical information - concerning a patient's treatment - and information relating to detention and release from compulsory provisions under the Mental Health Act. There is a need for the victim to be able to receive information about the offender's discharge from hospital. We therefore propose that victims and their families' rights to information about detention and release should be extended to cover those restricted patients who have committed serious violent or sexual offences. Guidance on how this information should be provided will be included in the Code of Practice.

*Consultation Point U: The Government would welcome views on whether rights in the Victims' Charter for victims and their families to be given information about detention and release of offenders should be extended to cover those restricted patients who have committed serious violent or sexual offences.*

<sup>29</sup> Effective Care Co-ordination in Mental Health Services, Department of Health October 1999



## Chapter 11

# Safeguards for Patients with Long-Term Mental Incapacity

1Our proposals for a new Mental Health Act focus on the provision of care and treatment for people with a mental disorder who pose a risk to themselves or to others and who refuse to accept it voluntarily.

2But some patients who need treatment for mental disorder, lack the ability to consent or refuse treatment as a result of long-term mental incapacity arising from a severe learning disability, degenerative disease or brain injury. These patients are often not capable of deciding whether any treatment proposed for their mental disorder is in their best interest. Even where they do not object to it, they cannot truly be regarded as having accepted treatment "voluntarily". This becomes an issue if, as part of necessary treatment, a patient needs to be confined or have their liberty otherwise restricted. Where this is the case, but the patient is not subject to powers of compulsory care and treatment, they will not be covered by the safeguards that mental health legislation provides.

3Very few people with long-term mental incapacity are currently detained under the Mental Health Act 1983 and the use of compulsory powers of detention for this group of patients is often not appropriate - a view shared by the House of Lords in a recent judgement<sup>30</sup>. But we recognise that such patients should be provided with statutory safeguards to ensure that care and treatment for mental disorder, particularly where restrictions of liberty are concerned, is in their best interests.

4The Committee expresses a similar view. They suggest that there is an urgent need for a comprehensive statutory framework for substitute decision making to provide safeguards for patients with long-term incapacity. They argue that the Mental Health Act is rarely an appropriate vehicle for this. Instead, they suggest that informal patients with long-term incapacity might be covered by a decision-making framework, building on the work already undertaken by the Lord Chancellor's Department and which was taken forward in *Who Decides?*

5We recognise the need for a new statutory framework for these patients. However, we have already taken steps to improve the position of those with long-term mental incapacity through the establishment of good practice measures. These will continue to be applicable, or be developed further, when a new Mental Health Act is introduced. For example, recent guidance issued by the Department of Health<sup>31</sup> recommends procedures to ensure that account is taken both of a patient's ascertainable wishes and feelings and the views of their immediate relatives or carers on what would be in the patient's best interests. The guidance also recommends that clinical teams should ensure that hospital in-patients who lack capacity are visited periodically, either by the hospital managers or by independent advocates. Additional guidance in the Code of Practice is aimed at ensuring that where a patient lacks capacity every effort should be made to ensure that any proposed treatment and its implications are explained as fully as possible.

6Clinical governance applies to all NHS patients - irrespective of where they are receiving treatment. Particularly when the NHS is dealing with vulnerable groups, it is imperative that there are clear systems in place for dealing with their needs. Clinical governance should provide this framework and systematic approach.

7We have not yet come to a conclusion on the precise nature of any new arrangements to provide safeguards for this particular group of patients. However, in the statement on 29th October 1999, *Making Decisions*, the Lord Chancellor referred<sup>32</sup> to our intention to extend the powers of the Court of Protection to enable it to approve or refuse particular forms of health care for a patient or to appoint a manager with certain defined powers. The Lord Chancellor's proposals were not specifically intended to provide safeguards for people who lack the capacity to consent to treatment for mental disorder, especially where it is likely that long-term care and treatment may be needed. However, they do provide a potential framework and the Government will consider how this might be developed further.

<sup>8</sup>One approach might be for the new mental disorder tribunals to have similar powers to those proposed for the Court of Protection in respect of patients with long-term mental incapacity referred to them following formal assessment under the Mental Health Act. The tribunal could then appoint a healthcare manager with the duty to ensure that decisions on provision of care and treatment for a patient's mental disorder are in that patient's best interests. This group of patients would then fall under the overall remit of the new Mental Health Act Commission.

<sup>9</sup>In developing these proposals we will consult closely with interested parties. Any proposals will also inform the forthcoming National Service Framework for Older People.

<sup>30</sup> *R v Bournewood Community and Mental Health National Health Service Trust ex parte L* (1998) All ER 319

<sup>31</sup> Department of Health circular HSC 1998/122

<sup>32</sup> At paragraph 3.7

## Chapter 12

# The Benefits of the Proposed Changes

<sup>1</sup>This consultation paper makes proposals for a modern legislative framework to support our mental health strategy. The key reforms we propose are as follows:

- Formal assessment procedures would apply to all patients for whom a compulsory treatment order was sought. Entry to compulsory care and treatment would be through one gateway;
- All patients subject to compulsory care and treatment beyond 28 days would have their case *automatically* considered by an independent mental disorder tribunal;
- It would be for the care team to demonstrate that the criteria for making a compulsory order were met, unlike the current MHRT process where it is for the patient to prove that he should no longer be detained;
- Compulsory orders might for the first time apply in the community as well as, at present, in a hospital;
- The legislation governing provision of care and treatment under compulsory powers will be based on principles explicitly contained in it.

<sup>2</sup>We are confident that the proposals in this paper provide a robust framework for compulsory intervention, which keeps pace with modern patterns of care and safeguards both the rights of patients and the safety of the public.

# Annex A

## Consultation Points

### Chapter 3

*Consultation point A (page 17):* The Government would welcome views on whether the inclusion of principles would aid the interpretation of a new Mental Health Act and on the list of principles proposed in paragraph 4 above.

### Chapter 4

*Consultation point B (page 19):* The Government accepts the Committee's recommendation in principle, but would welcome comments.

In particular, what are the advantages and disadvantages of including a more specific definition of mental disorder:

- in legislation;
- in a Code?

*Consultation point C (page 23):* The Government would welcome views on the following points:

- Whether the applicant for admission must be an approved social worker or whether they might be a mental health professional either with specialist training or recent knowledge of the patient?
- If the applicant is a mental health professional is it essential that the application is supported by two other opinions or would one opinion from a psychiatrist working in the hospital providing specialist services be sufficient?

*Consultation point D (page 24):* The Government would welcome views on the proposals for *emergency powers of detention*:

- would a period of 24 hours be sufficient to ensure assessment by the 3 professionals who act as the gatekeepers? And would it be necessary, or practicable to require the involvement of 2 professionals where an emergency situation occurred outside a hospital mental health unit?
- Should the current six-hour holding power for ward managers be maintained?

*Consultation point E (page 25):* The Government would welcome views on whether there is a real need for an independent review within 7 days of the commencement of assessment and on what alternative measures might be put in place to ensure prompt assessment and care planning.

*Consultation point F (page 29):* The Government would welcome comments on the three models proposed by the Committee. We

would also welcome views on the alternative model proposed in paragraph 40 above.

- Would a one-person tribunal generally be sufficient to take decisions in respect of uncontested cases? If so, should there be discretion for the lawyer member to bring in additional members and should reference for a second medical opinion be discretionary?

### Chapter 5

*Consultation point G (page 34):* The Government would welcome views on whether a capacity-based approach to compulsory care and treatment for those with a mental disorder is helpful in terms of practical outcomes.

In particular:

- what are the advantages and disadvantages of the two models presented?

- would a common threshold of risk for both those with and those without capacity provide a better basis for determining the need for compulsion? Could a higher threshold of risk for those with capacity be justified?
- is it likely that the introduction of a capacity test would lead to an increase, or decrease, in the number of people made subject to formal compulsion?
- is it essential to deal with issues of capacity in the new Mental Health Act itself, or could they be addressed adequately in the Code of Practice?

## **Chapter 6**

*Consultation Point H (page 39):* The Government would welcome views on the practicality of the proposals outlined for compulsory care and treatment in a community setting

## **Chapter 7**

*Consultation Point I (page 41):* The Government would welcome views on whether the tribunal should have exclusive power to discharge compulsory orders unless they choose to leave this responsibility to the clinical supervisor.

## **Chapter 8**

*Consultation point J (page 49):* The Government would welcome views on these proposals. Would a single power to order assessment and treatment meet the sentencing needs of the court, and enable the best disposal to be made, irrespective of the offender's actual mental disorder?

*Consultation Point K (page 49):* Should the court have the power to grant leave of absence to a patient remanded for assessment and treatment? Should there also be provision for the court to decide, when the remand order is made, whether or not the power to grant leave of absence should be delegated to the patient's clinical supervisor?

*Consultation point L (page 53):* the Government would welcome views on whether the arrangements for transferring prisoners to hospital for compulsory care and treatment for mental disorder should be changed

*Consultation point M (page 54):* The Government would welcome views on whether police powers to remove people who appear to be in need of medical treatment from public places should be extended to cover cases where the person concerned is found by the police when they have legitimately entered private property.

*Consultation Point N (page 54):* The Government would welcome views on the Committee's proposals to ensure that people who have been arrested get early access to a gate-keeping assessment where necessary

## **Chapter 9**

*Consultation point O (page 58):* The Government would welcome views on the safeguards that should apply to use of ECT. In particular:

- Should the use of ECT be controlled as the Committee suggest?
- Should it ever be imposed on any patient who retains capacity and is not consenting?
- Must the express approval of the tribunal through its medical member be obtained before ECT is administered to patients without capacity, whether under a compulsory order or not?
- Should ECT be available under provisions covering urgent treatment?

*Consultation point P (page 59):* The Government would welcome views on use of special safeguards for specified treatments. In particular: according to what criteria should the Secretary of State impose safeguards on treatments? Which treatments should be covered?

*Consultation point Q (page 59):* The Government would welcome views on the appropriate time to bring in a second opinion doctor. Should the period during which medication is allowed to continue without consent and without a second medical opinion be changed from the current period of three months? If so, what would be a better period?

*Consultation point R (page 61):* the Government would welcome views on the issues of treatment without consent in the period before a formal compulsory order is issued:

- Should the initial assessment phase preclude all but emergency treatment for patients not previously known to services?
- Should the care team be able to move beyond emergency treatment as soon as an interim care plan is drawn up?

## ***Chapter 10***

*Consultation point S (page 66):* The Government would welcome views on how this recommendation might be implemented:

- What criteria should the tribunal use to appoint a nominated person for an incapable patient?
- How should provision for a nominated person relate to other preferences the patient might express?

*Consultation Point T (page 70):* The Government would welcome views on whether the principles outlined by the Committee are the best way to achieve the right balance between confidentiality, the patient's health and welfare and the protection of others?

*Consultation Point U (page 71):* The Government would welcome views on whether rights in the Victims' Charter for victims and their families to be given information about detention and release of offenders should be extended to cover those restricted patients who have committed serious, violent or sexual offences.

# Annex B

## Summary of the Expert Committee Report

<sup>1</sup>This summary follows the structure of the Report. It aims to cover the principal issues raised. These will appear under the headings used in the Report for the ease of cross referencing.

### INTRODUCTION

<sup>2</sup>The Committee was commissioned to advise on how mental health legislation should be shaped to reflect contemporary patterns of care within a framework which balances the need to protect the rights of individual patients and the need to ensure public safety. The Committee has been primarily concerned with providing a framework for compulsion in respect of certain people with mental disorder and, within the time constraints imposed, it is satisfied that it has devised a structure capable of delivering modern mental health care in a way which is acceptable to those whose co-operation is crucial to the successful implementation of policy. However, the Committee is very aware of the complexity of the issues involved and urges government to engage in extensive further consultation.

### GENERAL PRINCIPLES

<sup>3</sup>The desire to promote the principle of non-discrimination on grounds of mental ill health has been fundamental to the Committee's approach, and this has led to an emphasis on patient autonomy. The Committee recommends the inclusion within new legislation of statements of principle which will set the tone of the new act and guide its interpretation. Principles to be expressed include informal care, the provision of the least restrictive alternative compatible with the delivery of safe and effective care, consensual care, reciprocity, respect for diversity and the recognition of the role of carers.

#### *The Code of Practice*

<sup>4</sup>The Committee is keen to enhance the authority of the Code of Practice and makes recommendations as to how this might be achieved, including an express statutory presumption of compliance.

### ENTITLEMENTS

<sup>5</sup>The Committee is convinced that if society is to impose a duty to comply with care and treatment on some of those who suffer from mental disorder it must impose a parallel duty on health and social care authorities to provide an appropriate standard of care and treatment for those subject to compulsion. However, the Committee is concerned that this principle of reciprocity should not result in diverting resources from informal care. The report therefore recommends measures to ensure that a balance is struck between the quality of care provided to informal and compelled patients.

#### *Rights which Flow from Compulsion*

<sup>6</sup>The Committee recommends a number of specific rights to be accorded to patients under compulsion. In addition to the right to receive the approved care and treatment and ongoing care for a determined period, these rights would include, at the earliest possible opportunity, the right to advocacy, the right to information about and assistance with drawing up an advance agreement and, for those detained in hospital, the right to safe containment consistent with respect for human dignity. With regard to the right to receive care and treatment including ongoing care after a period of compulsion, the Committee makes some specific recommendations and emphasises the need for a comprehensive review of charging policy.

#### *Access to Services*

<sup>7</sup>The Committee recommends the introduction of both a user's right to an assessment of mental health needs, and a carer's right to request such an assessment.



## *The Protection of Remaining Civil Liberties*

8The Committee recommends measures designed to ensure that no further deprivation of liberty is imposed on the patient under compulsion save that which is expressly authorised by the legislation or is necessarily implied by the need to achieve safe containment.

## **THE SCOPE OF COMPULSION**

9In seeking to define those people who should come within the scope of the compulsory framework the Committee adopts the following approach: a broad diagnostic criterion with some express exclusions, coupled to rigorous entry criteria, the strictness of which increases as the patient progresses from assessment to a compulsory order.

### *The Diagnostic Criterion*

10The Committee favours retaining the term 'mental disorder' and including a broad definition within the act. Reference to specific definitional schemes should be made in the Code of Practice.

### *Personality Disorders*

11While the Committee recommends dropping the term 'psychopathic disorder' from any new act, it assumes personality disorders will be included within the broad definition of mental disorder and does not wish to see them expressly excluded.

### *Learning Disability, Dementia, Acquired Brain Disorders and other similar Enduring Disabilities*

12In making recommendations concerning people with long term incapacity the Committee faced considerable difficulties. The Committee does not consider that a mental health act is the appropriate framework for such people. There is an urgent need to provide a comprehensive statutory framework specifically designed for people with longterm incapacity, and the Committee urges the government to make the necessary provision. However, because the Committee considers there will be some people with learning disability who will require care and treatment under a mental health act, it does not recommend that learning disability be expressly excluded from the scope of the new Mental Health Act.

## **THE STRUCTURE OF COMPULSORY POWERS**

### *Assessment*

13The Committee accepts that there will be a need for compulsory assessment powers when attempts to provide informal care and treatment have failed. Accordingly it recommends that authority to impose compulsory assessment lies, as at present, in the hands of three mental health professionals. For the time being it accepts that an ASW should continue to be the applicant, but it recommends that thought be given to extending the role to include other mental health professionals who are not psychiatrists.

14The criteria for admission to assessment should reflect those required for the eventual imposition of a compulsory order and the application should be based on objective grounds. The order should last for a maximum of 7 days, during which time a series of assessments would have to be conducted. 'Formal' rather than 'compulsory' assessment would be available in the community. Compulsory treatment for mental disorder would be permitted in defined circumstances.

### *Emergency Powers*

15The Committee is recommending a simplification of the existing emergency powers of containment.

### *The Imposition of Longer Term Compulsion*

16The Committee has endeavoured to recommend a structure which

- i. will encourage good practice and consensual care,
- ii. promote public safety,
- iii. provide sufficient independent oversight to protect patients, both those who are able to challenge and those who are not, and
- iv. does not impose unreasonable demands on professional time and resources.

In doing so the Committee has recommended an enhanced role for independent decision making. In a society which now places a high value on the protection of human rights it is essential that decisions which involve significant deprivations of liberty and physical integrity be taken openly and accountably by an independent body.

17In essence the Committee recommends a structure which would require the care team to apply in writing for a provisional order within seven days of the commencement of compulsory assessment. This order would last for 21 days and would have to be confirmed by an independent reviewer. If the care team wished to extend compulsion beyond 28 days, a compulsory order would have to be confirmed by a full tribunal at an oral hearing. If a patient wished to challenge his or her compulsion in advance of the 28 day tribunal, he or she would have the right to request an expedited tribunal.

### *The Constitution of the Independent Decision Makers*

18The Committee recommends the creation of a new multi-disciplinary tribunal appointed by the Lord Chancellor. While the Committee appreciates the importance of providing access to medical expertise, it does not wish to retain the practice of the medical member of the tribunal conducting a prior examination of the patient. It describes a number of possible models of tribunal decision-making and recommends further consultation on the details.

19The Committee recommends that the role of independent reviewer be performed by a legal member of the new tribunal.

### *The Compulsory Order*

20The compulsory order would have to be confirmed by the tribunal and could last for any period up to 6 months. The criteria have been devised so as to reflect the Committee's underlying principles and draw a distinction between those patients who lack the capacity to consent to care and treatment for mental disorder and those who retain such capacity. For patients who retain the necessary capacity the grounds for the imposition of compulsion would be significantly more restricted and would relate *primarily* to public safety.

21The care team would be required to specify whether the proposed care and treatment was to be provided in hospital or in the community and there would be provision for variation, with the approval of the tribunal, during the course of the order. In the case of an order designed to take effect in the community the order would specify the obligations on all parties. Persistent non-compliance with any condition on the part of the patient which led to a deterioration in his or her mental health would lead to conveyance to and/or re/admission to hospital. Until safe and adequately staffed non-hospital settings are available, medication could only be forcibly administered in a hospital environment.

### *The Ending of Compulsion*

22If the entry criteria ceased to be met, the clinical supervisor would be obliged to discharge the patient. Renewals could be confirmed by the tribunal on the application of the clinical supervisor. If the order was to last for more than three months the patient would have the right to apply to the tribunal for discharge once during the course of the order.

23The criteria for discharge should reflect the criteria for admission to compulsion and the tribunal should be required to discharge unless satisfied that the criteria for admission continue to be met.

## **TREATMENT**

24The Committee recommends that the term treatment be left undefined, but that certain forms of treatment should attract specific safeguards. These treatments include:

Neurosurgery for mental disorder and other specially invasive treatments;

Long-term medication;

Electro Convulsive Therapy ;

Other controlled treatments, including polypharmacy;

Feeding contrary to the will of the patient;

Emergency treatments.

25The Committee recommends that certain of these safeguards should apply in the case of informal patients as well as in the case of those under a compulsory order.

## **INCAPACITY**

26The Committee appreciates that the notion of incapacity will require careful definition and recommends a definition in line with that proposed by the Law Commission in its Report *Mental Incapacity*, Law Commission Cm 231, 1995. The Committee emphasises that there should be a presumption in favour of capacity and that the final decision should rest with the tribunal.

27Examples are given to illustrate how the definition might be applied in practice and in Chapter 7 the Committee considers some of the more difficult applications of the concept. 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.

## **BEST INTERESTS**

28According to the Committee's recommendations approved care and treatment should be in the patient's best interests. The Committee favours a definition of best interests which gives priority to the assumed wishes of the patient as far as they are ascertainable.

## **COMMON LAW/STATUTE**

29In framing its recommendations the Committee has tried to make the statutory framework as comprehensive as possible, although it still envisages the 'informal' provision of care and treatment for mental disorder in the case of those patients who offer no objection, however expressed. Nonetheless, until there is a statutory framework to cover substitute decision making generally for those people who lack capacity, the Committee considers that treatment for physical disorder must continue to be authorised by the common law where the patient lacks the capacity to consent.

## **INFORMATION SHARING**

30The Committee is aware that the failure to share information between agencies is frequently referred to in independent homicide inquiries. It recommends that the Code of Practice be expressly required by any new act to provide guidance about the sharing of information in relation to mental health care.

## **CARERS**

31Throughout the report the Committee emphasises the important role played by carers and the need both to involve them in planning care and treatment and to offer them all necessary support.

## **SAFEGUARDS**

### ***Hospital Managers***

32While paying tribute to the work of hospital managers the Committee considers that under its proposed scheme they would have no proper role. It therefore recommends the removal of the managers' right to discharge.

### ***Second Opinion Appointed Doctors***

33The Committee recommends that the role currently performed by SOADs be transferred to the medical members of the tribunal or to the panel of independent doctors appointed to advise the tribunal.

### ***Training and Approval***

34The Committee makes recommendations for enhancing the scheme for the training, approval and accreditation of those professionals empowered to act under the new legislation.

### ***The Mental Health Act Commission***

35The Committee recommends the continuation of a body such as the MHAC but recommends that it be reconstituted as a body independent of the Secretary of State, reporting directly to Parliament through the select committee structure. Its role should be expanded in a number of respects including an extension of its remit to cover all patients under compulsion, whether in hospital or community settings, and the care and treatment of informal in-patients.

### ***Advance Agreements about Care***

36The Committee is convinced that the creation and recognition of advance agreements about care would greatly assist in the

promotion of informal and consensual care. It therefore recommends that an obligation be placed on care teams to provide all patients prior to discharge from compulsion with information about and assistance with the creation of such agreements.

### *Nearest Relatives and Advocacy*

37The Committee recommends that future legislation make no reference to the nearest relative. Instead the new act should make provision for the identification, by the patient if possible, of a nominated person and should accord that figure certain rights and responsibilities.

38The Committee is satisfied that access to independent advocacy will be vital if the fundamental principles which underlie its recommendations are to be achieved. The Committee thus recommends:

- i. that a duty be imposed on the Secretary of State to ensure the provision of advocacy,
- ii. that advocates be given specific rights of access to patients under compulsion,
- iii. that relevant authorities have a duty to respond to a patient's advocate, and
- iv. that a statutory right to advocacy be created at the earliest opportunity.

## **CHILDREN**

39The Committee recommends that children continue to be covered by the provisions of mental health legislation. It favours sixteen as the threshold for capacity to make treatment decisions, with a rebuttable presumption of capacity in children from the age of ten or twelve. It further recommends that children subject to compulsion under the new act be entitled to accommodation within an environment which is appropriate to their age.

## **BOURNEWOOD**

40The Committee emphasises throughout its report the need to create a statutory framework specifically designed to meet the needs of those who suffer from longterm incapacity, for whatever reason, and thereby to fill the legislative gap revealed by the **Bournewood** case. It is a considerable task which must be addressed with some urgency, not least because the absence of adequate safeguards renders the government vulnerable under the provisions of the ECHR and thus the Human Rights Act.

41The Committee makes recommendations concerning the principles which should be reflected within the new framework.

## **OFFENDERS**

42The Committee is convinced that a thorough review of Part III of the present Act is essential and recommends that it be conducted in the light of the Committee's own recommendations, before any new legislative provisions are introduced. The Committee identifies issues of principle which, in its view, should underpin any such review and makes certain recommendations concerning the content of future legislation.

43The Committee is satisfied that a health disposal must remain available to a sentencing court on the basis of the admission criteria recommended in the context of civil compulsion, but the Committee recommends greater use of interim health orders. The Committee is also satisfied that the power to impose restrictions must be retained but recommends that the power to grant leave and to authorise transfer between hospitals in the case of restricted patients be extended to the tribunal. The Committee anticipates that the need for conditional discharge will be reduced in the light of the power to apply a compulsory order outside hospital, but it accepts that there will still be a need to retain a mechanism for supervision and ultimate recall to hospital based primarily on considerations of public safety.

## **PRISONERS**

44The Committee is convinced that it would be quite inappropriate to permit compulsory treatment for mental disorder in prison. The priority must be to ensure that all those with mental disorder of a severity which would attract compulsion outside prison are transferred to a suitable hospital facility.

45The Committee therefore recommends the introduction of a right of prisoners to an assessment of their mental health needs. It further recommends a power in the Secretary of State to direct the transfer of a prisoner to hospital for compulsory assessment. If long term compulsory care and treatment was required it would then be provided in hospital, under restrictions if necessary, on the authority of the tribunal.

The full text of the Expert Committee's report is available at

[www.doh.gov.uk/mentalhealth.htm](http://www.doh.gov.uk/mentalhealth.htm)



## Annex C

# Managing Dangerous People with Severe Personality Disorder Proposals for Consultation

### *Executive Summary*

The challenge to public safety presented by the minority of people with severe personality disorder, who because of their disorder pose a risk of serious offending, has been recognised by successive administrations. Dealing with this problem brings together criminal justice and health and social policy and raises complex and sensitive ethical questions. The paper sets out the Government's policy objectives for tackling these issues. It describes the range of service and legislative options that we are considering.

Personality disorder is a term used to describe a number of different conditions. The great majority of people with personality disorder cause at most some distress to themselves or to their family or friends for example by their obsessive or compulsive behaviour. But at the other end of the spectrum is a small group of people who are very seriously disordered and who pose a very high risk to the public. This paper is concerned with the problems presented by this small group.

There are estimated to be just over 2000 people who would fall into this group in England and Wales. Over 98% of these people are men, and at any time most are in prison or in secure hospitals. But the law as it stands fails to protect the public from the danger these people represent because in many cases they have to be allowed to return to the community even though they remain dangerous. Under existing arrangements, although there are pockets of good practice, the kind of therapeutic treatment needed to ensure that they are not released back into society whilst they still present a significant risk is not generally available. Research into the causes of severe personality disorder, and into how best to address the associated risks, has been inconclusive. New research has been commissioned but will take time to complete. Decisions on the direction of policy development for managing this group cannot be delayed until the outcomes of the research are known.

The Government intends to develop a co-ordinated package of arrangements to address these challenges, that achieves better protection for the public, is consistent with human rights law and:

- strikes the right balance between the interests of individuals and of society;
- meets the needs of this group of people better than the present patchy provision;
- is firmly grounded in evidence from research, and capable of adapting over time as new research evidence comes forward;
- provides better value for money than the present arrangements;
- leads in time to a reduction in the level of the most serious offending by people with severe personality disorder, as better preventive measures are identified and implemented, and through the early identification and detention of those who are dangerous.

The paper sets out proposals for change designed to achieve the objective of providing better protection for the public from dangerous severely personality disordered people. There are two components to this. First, ensuring that dangerous severely personality disordered people are kept in detention for as long as they pose a high risk. Second, managing them in a way that provides better opportunities to deal with the consequences of their disorder.

The proposals are based on the results of extensive informal discussions over the past two years involving managers and practitioners from the criminal justice system, health and social services, and the voluntary sector.

Two options are put forward for discussion and comment. Both rely on the development of new, more rigorous, procedures for

assessing risk associated with presence of severe personality disorder. Under either option a specific aim would be to ensure that the arrangements for detention and management focus on reducing such risks.

The first option would rely on introducing measures within the present framework of criminal and mental health law and is based on improving arrangements in both prisons and the health service. It would strengthen existing legislation so that dangerous, severely personality disordered people would not be released from prison or hospital whilst they continued to present a risk to the public. Any individual who had been convicted of a criminal offence and who was subject to a sentence of imprisonment would be held in prison. Anyone else would be held in a health service facility. Although services would continue to be managed separately, commissioning could be centrally co-ordinated.

Under the second option a new legal framework would be introduced to provide powers for the indeterminate detention of dangerous, severely personality disordered people in both criminal and civil proceedings. Those detained under the new orders would be managed in facilities run separately from prison and health service provision. The location for detention would be based on the risk that the person represented and their therapeutic needs rather than whether they had been convicted of an offence.

Changes in legislation and organisation of services will need to be accompanied by initiatives to develop a better trained and supervised workforce, better communication and close working arrangements across criminal justice, health and social services, national standards for managing services, and new monitoring arrangements. These will build on developments that have already begun in the prison and health services. A crucial task for the Government is to work with, and support, those dealing with dangerous, severely personality disordered people in prisons, hospitals and the community to ensure that the services they provide are as safe and effective as possible. This will be particularly important during the preliminary phases of developing and implementing a new strategy.

The Government welcomes views on the analysis in this document, and in particular the options it sets out for the future shape of legislation and service delivery in this area.

The full text of the consultation paper is available on the Department of Health and Home Office websites at:

<http://www.doh.gov.uk/mentalhealth.htm>

<http://www.homeoffice.gov.uk>

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