Reforming
The Mental Health Act

Part I

The new legal framework

Presented to Parliament by the Secretary of State for Health and the Home Secretary by Command of Her Majesty December 2000

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Contents

Foreword

Millions of people face a mental illness at some point in their lives. That is why improving mental health services is a priority for the Government.

First we have made investment a priority. More staff, more beds and more services are being made available particularly for those with the most serious mental health problems. The *NHS Plan*, published in July, outlined further new resources and the development of further new services over the next few years including for those who are dangerous and severely personality disordered.

Second, we have made reform a priority. For the first time mental health services in all parts of England are having to operate to new national standards and similar measures will be introduced in Wales. While there are very real problems and pressures, progress is being made towards plugging gaps in provision and modernising services.

This White Paper details how we will now underpin these improvements in mental health services with reforms to mental health laws.

The current 1983 Mental Health Act is largely based on a review of mental health legislation which took place in the 1950s. Since then the way services are provided has dramatically changed. The current laws have failed properly to protect the public, patients or staff.

Under existing mental health laws, the only powers compulsorily to treat patients are if they are in hospital. The majority of patients today are treated in the community. But public confidence in care in the community has been undermined by failures in services and failures in the law. Too often, severely ill patients have been allowed to drift out of contact with mental health services. They have been able to refuse treatment. Sometimes, as the tragic toll of homicides and suicides involving such patients makes clear, lives have been put at risk. In particular existing legislation has also failed to provide adequate public protection from those whose risk to others arises from severe personality disorder. We are determined to remedy this.

Of course the vast majority of people with mental illness represents no threat to anyone. Many mentally ill patients are among the most vulnerable members of society. But the Government has a duty to protect individual patients and the public if a person poses a serious risk to themselves or to others.

Part One of this White Paper sets out a new legal framework for when and how care and treatment should be provided without the consent of a person with a mental disorder in their interests or in the interests of public safety. Removing an individual's liberty against their will is a very serious step to take so the White Paper outlines how safeguards will be improved.

Part Two of this White Paper sets out how laws and services will be strengthened to safeguard the public against those who pose the greatest risk, including dangerous people with severe personality disorder.

These changes amount to the biggest shake up in mental health legislation in four decades. They will strengthen the current laws. They will introduce new safeguards for patients. They will improve protection for the public. The safety of the public and of patients will be enhanced as a result.

Alan Milburn

Jack Straw

Executive Summary

1 Improving the quality and consistency of health and social care services for the many people who suffer from mental health problems is one of this Government's main priorities. The vast majority of patients with mental illness pose no threat to other people and in many cases are among the most vulnerable in our society.

Extra investment in services and national standards of care

2 Reforming mental health legislation is the third element in the Government's strategy for modernisation of mental health services. **First, we have made investment a priority**. Extra investment already committed will create, by April 2001, almost 500 extra secure beds, over 320 24-hour staffed beds, 170 assertive outreach teams and access to services 24 hours a day, seven days a week, for all those with complex mental health needs. The *NHS Plan* announced a further £300m investment to provide better and faster care to people with mental health problems who need treatment and support, including new services for children and adolescents.

3 **Second, we have made reform a priority.** We have established for the first time new national standards for the care and treatment of mental illness in the *Mental Health National Service Framework*. The *NHS Plan* has set out further initiatives to improve mental health services, to close any remaining gaps in services and to provide more effective and accessible community based support.

A new landscape

4 **Third, we now make law reform a priority in order to provide mental health services with an up to date legal framework.** The last full review of mental health legislation took place in the 1950s. The Mental Health Act 1983 is largely based on the outcome of that review. Since then there have been major changes in mental health services. New drug treatments, different patterns of care which now see more people treated in the community rather than in institutions, and a wider role for other therapeutic approaches, have all made for a markedly different landscape. Modern mental health legislation needs to reflect that landscape.

The scope of new mental health legislation

5 The vast majority of people receive care and treatment on a voluntary basis. However there will always be some people with mental disorder who are either unable or unwilling to seek care and treatment. They may not realise, or not accept, that such care and treatment will be in their best interests if it helps prevent their condition from getting worse or makes it less likely that they will harm themselves or pose a risk to other people.

6 The principles of common law do not always provide the sort of robust framework that is needed to protect people from the effects of serious mental disorder and to enable action necessary to prevent serious harm. The Government has a duty to set out a clear framework in mental health legislation for determining when and how care and treatment for mental disorder may be provided without consent in the best interests of a patient or to prevent serious harm to other people.

Safeguarding human rights

7 Mental health legislation necessarily includes powers to place significant restrictions on the personal liberty of patients, in particular the freedom to refuse care and treatment. Any new mental health legislation must be fully compatible with the Human Rights Act 1998. This White Paper outlines a new framework for mental health legislation that will include a broad definition of mental disorder covering any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning. This wide definition of mental disorder will be matched by criteria that set clear limits to the circumstances in which compulsory powers may be used. A diagnosis of mental disorder alone would never be sufficient to justify use of compulsory powers.

8 Use of compulsory powers will generally only be appropriate if a person is resisting care and treatment needed either in their best interests or because without care and treatment they will pose a significant risk of serious harm to other people. The new legislation will set out the matters that the clinical team should take into account in determining whether care and treatment from specialist mental health services is in a patient's best interests and what should be covered in the care and treatment plan.

9 The new legislative framework will include a significant range of new safeguards. New legislation will introduce:

- a new independent tribunal to determine all longer-term use of compulsory powers;
- a new right to independent advocacy;
- new safeguards for people with long-term mental incapacity;
- a new Commission for Mental Health;
- statutary requirement to develop care plans.

Patient focus

10 Fundamental principles to underpin the new legislation will be set out in a way that provides a clear context for decisions about when and how its powers should be used. New legislation will focus on meeting the needs of individual patients and addressing any risk that they pose to themselves or to other people in a way that is fair and equitable and fully protects their rights and those of others. It will encourage a new patient focus to take account of the characteristics, abilities and diverse backgrounds of individual patients.

New procedures for use of compulsory powers

11 Where people with mental health problems may need compulsory care and treatment, there will be a new three-stage process that applies in all cases (except for offenders, for whom assessment will be ordered by the Court, and for prisoners, by the Home Secretary):

Stage 1 preliminary examination

- Decisions to begin assessment and initial treatment of a patient under compulsory powers will be based on a preliminary examination by two doctors and a social worker or another suitably trained mental health professional that a patient needs further assessment or urgent treatment by specialist mental health services and, without this, might be at risk of serious harm or pose a risk of serious harm to other people.

Stage 2 formal assessment and initial treatment under compulsory powers

- A patient will be given a full assessment of his or her health and social care needs and receive treatment set out in a formal care plan; the initial period of assessment and treatment under compulsory powers will be limited to a maximum of 28 days; after that continuing use of compulsory powers must be authorised by a new independent decision making body, the Mental Health Tribunal, which will obtain advice from independent experts as well as taking evidence from the clinical team, the patient and his or her representatives, and other agencies, where appropriate.

Stage 3 care and treatment order

- The Tribunal or the Court in the case of mentally disordered offenders will be able to make a care and treatment order which will authorise the care and treatment specified in a care plan recommended by the clinical team. This must be

designed to give therapeutic benefit to the patient or to manage behaviour associated with mental disorder that might lead to serious harm to other people. The first two orders will be for up to 6 months each; subsequent orders may be for periods of up to 12 months.

Care and treatment in the community

12 Under the 1983 Act powers to require compliance with treatment are linked to detention in hospital. This does not allow the flexibility for compulsory powers to be used in a way that fits with a patient's changing needs. Nor does it support the processes of individual care planning that are needed to ensure that compulsory treatment will result in good health outcomes for patients and reduced risk. At the moment clinicians have to wait until patients in the community become ill enough to need admission to hospital before compulsory treatment can be given. This prevents early intervention to reduce risk to both patients and the public.

13 We will therefore introduce new provisions so that care and treatment orders may apply to patients outside hospital. This will mean that patients need not be in hospital unnecessarily and need not suffer the possible distress of repeated unplanned admissions to acute wards. There will be no powers for patients to be given medication forcibly except in a clinical setting. But steps will be specified in community orders to prevent patients, if they do not comply with their order, becoming a risk to themselves, their carers, or the public. Both patients and the public interest will be better served as a result.

Better information and advice

14 Patients who are subject to care and treatment under compulsory powers may need help to understand how those powers work. We will take measures to help to ensure that every patient will be informed about the particular powers that apply in his or her case. Patients who want to challenge the use of compulsory powers will continue to have the right to free legal representation. But we will also give them a new right of access to advice and support from independent specialist advocacy services. The new Patient Advocacy Liaison Service will provide access to these specialist schemes.

15 According to independent inquiries a significant factor in many of the homicides and suicides that have taken place over the last decade has been a breakdown in communication and exchange of information between the local services charged with caring for and treating mentally ill patients. New mental health legislation will also introduce a new duty covering the disclosure of information about patients suffering from mental disorder between health and social services agencies and other agencies, for example housing agencies or criminal justice agencies.

New safeguards for children and young people

16 We will introduce additional measures where existing safeguards for patients are not sufficiently robust. We believe it is essential that there are special measures to safeguard and promote the welfare of children and young people with mental health problems. Under new legislation the Mental Health Tribunal will be required to obtain specialist expert advice on both health and social care aspects of the proposed care plan and to consider, in particular, whether the location of care is appropriate. Decisions taken in respect of children will be subject to a clear principle that the interests of the child must be paramount. There will be changes in the provisions regarding the right of a young person between the ages of 16 and 18 to refuse consent to care and treatment for mental disorder.

New safeguards for people with long-term mental incapacity

17 We will also introduce provisions to protect the rights of people with long-term mental incapacity who need care and treatment for serious mental disorder. In many cases such patients do not resist care and treatment but are unable to consent to it. They are, potentially, particularly vulnerable to abuse or neglect and we must ensure that their best interests are properly considered and protected. This can only be achieved through an independent consideration of the care that they receive for their mental disorder. We will place a duty on the clinical supervisor responsible for the care and treatment of a patient with long-term mental incapacity to carry out an assessment and obtain an independent second opinion.

A new Commission for Mental Health

18 We will establish a new Commission for Mental Health to look after the interests of all people who are subject to care

and treatment under powers in the Act. The Commission will carry specific responsibilities for monitoring the use of formal powers, providing guidance on the operation of those powers, and assuring the quality of statutory training provided for practitioners with key responsibilities under the new legislation and for specialist advocacy services.

Chapter 1

Introduction

1.1 Promoting and supporting good mental health services in England and Wales is a key responsibility of Government.

1.2 For too long mental health services have been at the margins of the NHS and social care. Successive governments have failed to give sufficient priority or resources to services for people with mental health problems and other vulnerable groups of patients who have ended up being treated by so-called "Cinderella" services. Services which neither met the needs of patients for good quality care and treatment nor the expectations of the public for adequate safeguards to be in place. That is why the Government has taken action since coming into office to improve the quality and consistency of health and social care services for people who suffer from mental health problems.

1.3 We are already making significant extra investment available to the NHS and local councils to enable them to provide better and faster care to those who need treatment and support. In England, the *Mental Health National Service Framework*1 (NSF) has established for the first time, new national standards for the care and treatment of mental illness and significant funding to provide additional services. In Wales, the emerging All Wales Strategy and associated NSF for Wales will provide a similar framework for improvement.

1.4 In England extra Government investment will create, by April next year, almost 500 extra secure beds, over 320 24-hour staffed beds, 170 assertive outreach teams and access to services 24 hours a day, seven days a week, for all those with complex mental health needs. The priority is to ensure that people with severe and enduring mental illness receive services that are more responsive to their needs and that the safety of patients, their carers, and the public, is protected. In the last two years we have already recruited 3,000 new staff in mental health services, including over 350 more consultant psychiatrists and nearly 2,000 nurses.

1.5 The Government's plans to accelerate the modernisation of the NHS and social care include services for those with mental health problems as one of the three key clinical priorities. The *NHS Plan* announced a further £330m investment over the next three years to fast forward the National Service Framework. Much of it will be focused on providing comprehensive specialist community mental health services. 335 crisis resolution teams will be appointed so that all people with severe mental health problems will have 24 hour access to home support. A further 50 early intervention teams will be appointed to ensure that all young people who develop a first episode of psychosis will receive intensive support during the early critical years. And a further 50 assertive outreach teams will be appointed, bringing the total to 220, so that all patients who need continuing intensive support will be in receipt of assertive outreach services.

1.6 In primary care, 1,000 new graduate primary care mental health workers, trained in brief therapy techniques of proven effectiveness, will be employed to help GPs manage and treat common mental health problems in all age groups, including children. In addition, 500 more community mental health staff will be employed to work with general practitioners and primary care teams, with NHS Direct, and in each accident and emergency department to respond to people who need immediate help.

1.7 In Wales the National Assembly has invested major capital to modernise facilities and to increase secure provision, and has allocated extra funding to health authorities to strengthen community mental health services. In the last 6 months, £35m has been made available for new mental health capital projects while substantial extra funds have been allocated to strengthen community mental health teams and to improve services for the elderly mentally ill.

1.8 The Health Act 1999 has removed legal obstacles to health and local authorities working more closely together so that patients and those using social care services can receive more integrated care that is easier to access and more efficiently delivered. This Act, together with the Care Standards Act 2000 will help raise the quality of health and social services through new independent inspection arrangements through the Commission for Health Improvement and the National Care

Standards Commission. And the establishment of the National Institute for Clinical Excellence and the proposed Social Care Institute for Excellence will ensure the latest advances in clinical and social care practice are spread widely and more quickly. These changes will help to tackle the inconsistencies that have characterised both health and social care services for so long.

1.9 All of these developments will help improve specialist mental health services, currently being provided to about 630,000 people at any one time. The *Mental Health National Service Framework* will introduce significant changes in the way mental health services are delivered. Our aim is to develop services that people will value and use and which will help them to seek help earlier. The NSF standards are set out below.

Standard one

Health and social services should:

- promote mental health for all, working with individuals and communities;

- combat discrimination against individuals and groups with mental health problems and promote their social inclusion.

Standard two

Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed;

- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

Standard three

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care;

- be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services.

Standard four

All mental health service users on the Care Programme Approach (CPA) should:

- receive care which optimises engagement, prevents or anticipates crisis, and reduces risk;

- have a copy of a written care plan which:

  includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators,

  advises the GP how they should respond if the service user needs additional help,

  is regularly reviewed by the care co-ordinator;

- be able to access services 24 hours a day, 365 days a year.

Standard five

Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place, which is:

  in the least restrictive environment consistent with the need to protect them and the public,

  as close to home as possible;

- a copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

Standard six

All individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;

- have their own written care plan, which is given to them and implemented in discussion with them.

Standard seven

Local health and social care communities should prevent suicides by:

- promoting mental health for all, working with individuals and communities (Standard one);

- delivering high quality primary mental health care (Standard two);

- ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an A&E department (Standard three);

- ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard four);

- providing safe hospital accommodation for individuals who need it (Standard five);

- enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard six).

And in addition:

- supporting local prison staff in preventing suicide among prisoners;

- ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk;

- developing local systems for suicide audit to learn lessons and take any necessary action.

1.10 The Government will also continue to support initiatives which combat the social exclusion and discrimination faced by many people with a mental illness. A key milestone that we set in S*aving Lives: Our Healthier Nation* is the reduction of the mortality rate from suicide and undetermined injury by 20% by 2010.2 The Department of Health will be disseminating

standards for the prevention of suicide and self-harm, ensure that staff are competent to assess the risk of suicide and develop local systems for suicide audit to learn lessons and take any necessary action.

1.11 The Department and the National Assembly also funds the *National Confidential Inquiry into Suicides and Homicide by People with Mental Illness* to ensure that everyone involved with mental health services learns and implements lessons from the factors associated with serious incidents. We are committed to taking appropriate action in response to the findings of this Inquiry.

1.12 The Government is also committed to reducing the stigma associated with mental illness. Mental disorders are common surveys have shown that at any one time at least one in six people suffers from some kind of mental disorder. Yet people who have had a mental disorder have to face discrimination and prejudice, even after recovery. We will therefore continue to work in partnership with all those who share our determination to challenge the distorted image of mental disorder and to combat the social exclusion that can result from it.

1.13 The particular problems associated with acute mental disorder have, however, required a framework of legislation that has sought to ensure two aims. First, that those who are seriously ill get appropriate health care to meet their particular needs; and second, that the public is protected from the behaviour of the small minority of people with mental disorder who may pose a risk to their safety.

1.14 The last full review of mental health legislation took place in the 1950s under the chairmanship of Lord Eustace Percy. The Mental Health Act 1983 is largely based on that review. Since the time of the Percy review there have been major changes in mental health services. New drug treatments, different patterns of care which now see more people treated in the community rather than in institutions and a wider role for other therapeutic approaches have all contributed to a markedly different landscape. The 1983 Act, however, remains based on treatment within hospitals. Concerns are also being expressed about the way decisions relating to compulsory treatment are made under the Act. The Act itself is complex and in places, confusing, and its basic underlying principles have not been clearly set out.

1.15 The 1983 Act also fails to fully address the challenge posed by a minority of people with mental disorder who pose a significant risk to others as a result of their disorder. It has failed to properly protect the public, patients or staff. Severely mentally ill patients have been allowed to lose contact with services once they have been discharged into the community. Such patients have been able to refuse treatment in the community. And it is the community as well as those patients which has paid a heavy price. We also need to move away from the narrow concept of "treatability" which applies to certain categories of mental disorder in the 1983 Act. New legislation must be clearly framed to allow all those who pose a significant risk of serious harm to others as a result of their mental disorder to be detained in a therapeutic environment where they can be offered care and treatment to manage their behaviour.

1.16 The Government commissioned a number of research projects into the working of the current Mental Health Act to help to inform us of weaknesses that new legislation should address. These research projects reported earlier this year and a summary of all of the projects was published in March.3

1.17 We also commissioned a review of the existing legislation in 1998 led by Professor Genevra Richardson. The Government broadly accepted the framework for new legislation recommended by the Richardson Committee. Professor Richardson's report was published alongside a Green Paper last year where the Government began a process of consultation on a number of proposed changes to the Act.4

1.18 The changes we intend to make to the Mental Health Act 1983 are described in some detail in the following chapters. In proposing these changes we are determined to make sure that the new legislation fully protects the rights of patients and the public, enhances the principles of fairness and equity, ensures consistency and supports the wider changes we are making to mental health services in England and Wales.

1.19 Finally, new mental health legislation will apply, as does the Mental Health Act 1983, to people with learning disabilities. However, we will be publishing a separate White Paper on the Government's wider approach to improving the life chances for this client group and the application of the legislation will be finalised in the context of that wider policy.

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[1] Department of Health September 1999.Back

[2] TSO July 1999 Cm 4386.Back

[3] *Shaping the New Mental Health Act: Key Messages from the Department of Health Research*

Programme (Department of Health 2000). Back

[4] TSO November 1999 Cm 4480; *Review of the Expert Committee: Review of the Mental Health Act 1983* (Department of Health 1999). Back

Previous Contents Next Official Documents

Chapter 2

Key changes

2.1 The previous chapter sets out our strategy for improving services for the 630,000 people who, at any time, receive care and treatment from specialist mental health services. Good quality care and treatment is the key to making sure that most people with mental health problems will never need to fall within the scope of mental health legislation. This chapter explains why we need a modern framework of mental health legislation, why we need to reform the 1983 Act and the key changes we intend to introduce.

What are the objectives of mental health legislation?

2.2 People with mental illness or other mental disorders should as far as possible 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, met on an informal basis with full agreement between the patient and the care team. However there will always be some people with mental disorder who are either unable or unwilling to seek care and treatment. They may not realise, or not accept, that such care and treatment will be in their best interests if it helps prevent their condition from getting worse or makes it less likely that they will harm themselves or take their own lives. In a small minority of cases, this may mean that not only will a patient pose a significant risk to him or herself but also to other people in their family or in the community.

2.3 In most other areas of health and social care, decisions are made under common law about whether to treat a person without their consent if they are unable to, or do not, seek necessary care and treatment voluntarily. But the principles of common law do not provide the sort of robust framework that is needed to protect people from the effects of mental disorder and to enable action necessary to prevent serious harm. The Government has a duty to set out a clear framework for determining when and how care and treatment for mental disorder must be provided, if necessary against the will of the patient, either in his or her best interest or to prevent serious harm to other people. The same framework should put in place safeguards to protect a patient's rights where care and treatment is given without consent.

What has gone before and what needs to change?

2.4 Legislation to address care of people with mental disorder in a comprehensive way was first introduced in England in the late eighteenth century and during the nineteenth century the issue was frequently reviewed by Parliament. There were over 20 Acts of Parliament passed between 1808 and 1891 dealing with the care of mentally disordered patients in public or private institutions. In 1959, legislation based on the recommendations of a Royal Commission chaired by Lord Eustace Percy5, brought together for the first time in one Act a comprehensive framework of mental health law for England and Wales. That Act was amended and updated to become the Mental Health Act 1983.

2.5 Compulsory powers to detain patients in hospital for assessment and treatment for mental disorder under the 1983 Act are used on about 44,000 occasions each year. At any one time over 12,000 patients are detained for treatment in hospital. It is essential that legislation affecting the lives and liberty of so many people should reflect the values and priorities of society today.

2.6 Care and treatment for mental disorder has moved on a long way in the last 20 years and in many ways the 1983 Act falls short of what is needed. It does not command the confidence of patients and their carers or of the public. The procedures do not always support, and at worst, can frustrate good clinical practice. The processes of the 1983 Act are complex and have become more complex to apply as a result of amendments and development of case law over the past 20 years. Research shows lack of consistency about decisions made on use of powers in the Act between different groups of practitioners, and between hospitals in different parts of the country. The Act has failed to protect the public or patients, as the tragic toll of

homicides and suicides by mentally ill people shows. That failure has undermined public confidence in mental health services.

Principles

2.7 One of our key aims is to ensure that the purpose and scope of new legislation are readily understood. This is important for patients, their carers, and the public. It is essential for the health and social care professionals and other practitioners who will use the new powers.

2.8 The fundamental principles that underpin new legislation will be set out in a way that provides a clear context for decisions about when and how the powers should be used. The areas that will be covered are described below.

2.9 New legislation will be fully compatible with the Human Rights Act 1998 and the emphasis throughout will be on ensuring that decisions taken are appropriate to each patient as an individual. An important aspect of this approach is that in deciding matters relating to the care and treatment of patients with mental disorder those responsible must act openly and fairly. This means that they must take account of the characteristics, abilities and diverse backgrounds of individual patients, including matters such as age, gender, sexual orientation, social, ethnic, cultural and religious background. They must not make general assumptions about how any one of those factors will impact on a particular patient's health and social care needs, or about the way that care and treatment should be provided.

2.10 Formal powers should not be used as an alternative to securing the agreement of people whose disabilities result in difficulties with communication. Formal powers should only involve imposition of such conditions as are necessary to ensure the patient's health or safety or the safety of other people. When decisions under mental health legislation affect a child the child's welfare should be paramount.

2.11 People with mental disorder should be treated in such a way as to promote to the greatest practicable degree their self-determination and personal responsibility. Steps should be taken to ensure that, so far as possible, patients are able to participate in decisions relating to their care and treatment. In some cases this will mean discussing with a patient when he or she is well what care and treatment they would prefer if the mental disorder deteriorates and they become acutely ill. Where a patient is required to comply with particular aspects of his or her care and treatment plan, services must be provided in a way that enables them to do so. Care and treatment should involve the least degree of compulsion that is consistent with ensuring that the objectives of the plan are met.

2.12 Mental health legislation makes provision for very significant curtailment of the freedom of individuals to refuse care and treatment and to determine how they live their lives. Formal powers should only be used with good cause and after alternatives have been considered.

Need for a new focus on the individual

2.13 Development of new therapies and drug treatments now means that the majority of people with serious mental disorder do not need long periods of hospital treatment. Most can, with appropriate supervision, be successfully and safely treated in the community. But successful treatment in the community will, for many, depend on compliance with treatment. All too often patients who have been discharged from hospital fail to comply with treatment and their condition relapses frequently resulting in unplanned readmission to hospital and, sometimes, serious harm to the patient or to other people. Over recent years there have been over 1,000 suicides each year by people with mental health problems, and about 40 homicides by people known to have been in recent contact with mental health services.6

2.14 Under the 1983 Act powers to require compliance with treatment are linked to detention in hospital. This does not allow the flexibility for compulsory powers to be used in a way that fits with a patient's changing needs. Nor does it support the processes of individual care planning that are needed to ensure that compulsory treatment will result in good health outcomes for patients and reduced risk. At the moment clinicians have to wait until patients in the community become ill enough to need admission to hospital before compulsory treatment can be given. This prevents early intervention to reduce risk to both patients and the public.

2.15 New legislation will introduce statutory requirements that all patients treated under formal powers will be given a full assessment of their health and social care needs in accordance with the *Care Programme Approach*7 and the 1996 Welsh Office *Guidance on the Care of People in the Community with a Mental Illness*. Any proposals for compulsory care and treatment after the formal assessment period must be based on individual care and treatment plans.

2.16 Concerns of risk will always take precedence, but care and treatment provided under formal powers should otherwise reflect the best interests of the patient. Clinical teams will need to account for the steps they have taken to consider the needs and wishes of the patient in putting together a care and treatment plan.

2.17 Formal care and treatment of a patient with mental disorder will inevitably restrict his or her personal freedoms but should only do so to the extent justified by any risk that they pose to themselves or to other people. The possibility of informal, consensual care and treatment should always be considered before recourse to compulsory powers. Proposed plans for use of formal powers will be tested against the principle that necessary care and treatment should be provided in the least restrictive environment consistent with ensuring the safety of the patient and of other people. Government policy for people with learning disability or other disabilities is to promote independence, choice and inclusion. It is not intended that care and treatment under compulsory powers should be used as a means to prevent people taking the normal risks associated with daily life.

2.18 The new provisions will mean that compulsory care and treatment can, if appropriate, take place in the community rather than through detention in hospital. This would not be contemplated at a time when a patient was assessed as posing a significant risk of serious harm to him or herself or to other people in these cases detention for treatment in hospital will be required. But otherwise if care in the community under compulsory powers offers the best prospect of a good therapeutic outcome it should be considered. Compliance with treatment and contact with services will both be enforced under the new legislation in a way that was never possible under the 1983 Act. That will help prevent patients relapsing and becoming subject to the distress of repeated unplanned admissions to acute wards and should achieve better outcomes for patients while minimising any risk they may pose to themselves or to other people. It will also help ensure that patients whose care, with proper supervision, can be well managed outside hospital without risk are not unnecessarily kept in hospital simply to ensure compliance with medication.

Need for better information for patients and their carers

2.19 Good information will often help ensure that patients get early access to care, sometimes avoiding the need for compulsory treatment. For patients who are subject to compulsory powers good information will help overcome misunderstandings between them and the clinicians who are responsible for their care. Misunderstandings that can sometimes get in the way of good health outcomes. The 1983 Act does not cover provision of information to patients and their carers outside use of compulsory powers. For patients who are subject to compulsory powers it requires that information is given but does not go beyond that to ensure that they get help in understanding the implications of that information or in communicating their views.

2.20 New legislation will include measures to ensure that patients and their carers get the information and support they need, when they need it. For some this may simply involve help in understanding how to access specialist mental health services. Primary Care Trusts, Primary Care Groups, and health and social services authorities will be required to make available advice and information about the services they commission for people with mental disorder, and about how patients and their carers can access those services. The information should be made available in an appropriate format, as required, for all patients. This will be backed up by the developments that are already taking place in England through implementation of the *Mental Health National Service Framework* and *NHS Plan* and which will be taken forward in Wales through the *All Wales Strategy* and the NSF for Wales.

2.21 In some circumstances, a family member or another person who knows a patient well, is better placed than the patient to recognise that he or she may need treatment for serious mental disorder. Patients suffering from first episode psychosis, for example, often fail to seek help before they become acutely ill. The Code of Practice on new legislation8 will include guidance for health and social care practitioners on the circumstances in which it may be appropriate to discuss a patient's care and treatment with a member of his or her family, or another person. This will include information about the action that a patient's GP should consider taking if he or she is asked by a relative or another person to assess the patient's mental state.

2.22 Patients who are subject to care and treatment under formal powers may also need help to understand how the legislation works including how to appeal against use of compulsory powers, and how to ensure that their views and wishes are properly represented.

2.23 New legislation will place a duty on those responsible for the care and treatment of patients under formal powers to ensure that, as far as possible, every patient is fully informed about the particular powers that apply in his or her case, and rights under the law. This will include the nomination of a person to represent him or her in discussions with their clinical team and in other matters relating to their care. This person, to be known as the "nominated person", will replace the "nearest relative" under the 1983 Act and take on some of the same functions. The patient may identify such a person in an advance

agreement and it is likely that in most cases the nominated person will be a relative of the patient or their main carer.

Advocacy

2.24 As now, patients who want to challenge the use of compulsory powers will have the right to free legal representation and, if appropriate, to seek an independent medical opinion. But it is important that they have a right of access to advice and support from independent specialist advocacy services at other times. Access to independent specialist advocacy is already available in some areas; the Government is currently considering how best to extend the provision of such services, building on existing good practice. The aim is to ensure that patients who are subject to compulsory powers, and their carers, are better able to understand the purpose and scope of the legal powers that affect them. Specialist advocates will also be able to help represent any concerns that the patient has about his or her care and treatment.

2.25 The new Commission for Mental Health (see paragraph 2.33) will be responsible for monitoring the quality and overseeing the operation of these specialist advocacy services. The Patient Advocacy Liaison Service announced in the *NHS Plan* will be the gateway to specialist advocacy schemes.

Need for better decision-making

2.26 For mental health legislation to achieve its purpose patients, their carers and the public must be confident that the powers are used in a way that is equitable and consistent. The 1983 Act is complex. As a consequence, the reasons that patients are brought under, and discharged from, compulsory powers sometimes appear to reflect differences in practice between clinical teams rather than a consistent approach to decision-making under the Act. In addition, for most of the people who exercise key responsibilities the Act does not require any special training in the use of the powers it contains. Doctors are given responsibility for use of powers that allow patients to be detained for treatment for long periods of time with no provision for automatic independent scrutiny of their decisions.

2.27 The Mental Health Act Commission has responsibility for monitoring the operation of the Act but its remit is not clearly defined and nor is the interface between its responsibilities and those of the recently established Commission for Health Improvement and new National Commission for Care Standards. This lack of clarity is unhelpful for both patients and service providers.

2.28 A key aim in reviewing the 1983 Act has been to identify ways of improving the quality, openness and consistency of decisions that are made about use of compulsory powers. New legislation will significantly tighten up the procedures for assessment of patient needs and development of plans for continuing care and treatment. The same basic procedures will have to be followed for all patients who are subject to care and treatment under compulsory powers a single pathway will replace the many different routes through the current Act. The aim is to require all practitioners to do what is already accepted as good professional practice. The new provisions will mean that there is a better record of why decisions are taken and what they entail.

2.29 Except for people before the Courts,9 proposals for use of compulsory powers beyond 28 days will require authorisation by a new independent Mental Health Tribunal. This will create greater openness and clearer accountability for decisions to use powers in the new legislation. It will also ensure that patient interests and the public interest are properly taken into account. The Tribunal will be required to seek advice from independent experts as well as taking evidence from the clinical team and the patient.

2.30 Practitioners who are responsible for using the powers in mental health legislation need to have a thorough understanding of its scope and purpose. They also need to know how their roles and responsibilities fit with the roles and responsibilities of others. Specialist training will be provided for all professional staff authorised to undertake specific functions under new legislation. Training and regular updating will be statutory requirements for those who are responsible for taking key decisions.

2.31 Professionals and agencies that have responsibility for patients who are subject to compulsory powers need to share relevant information to ensure that all those involved in a patient's care and treatment are properly informed. This is often important to ensuring the patient's best interests are met. It may sometimes be necessary in the public interest. According to independent inquiries a significant factor in many of the homicides and suicides that have taken place over the last decade has been a breakdown in communication and exchange of information between the local services charged with caring for and treating mentally ill patients. In the new legislation there will be a new duty covering the disclosure of information about patients suffering from mental disorder between health and social services agencies and other agencies, for example housing agencies or criminal justice agencies.

2.32 The new procedures to improve the process of making and recording decisions, including the procedures associated with presenting cases to the Tribunal, are important elements in providing high quality care and treatment for patients who are subject to formal powers. Managers of mental health services will be expected to ensure that this is recognised in the job descriptions for practitioners with key responsibilities under new legislation and that clinical teams get any necessary administrative support.

Commission for Mental Health

2.33 A new Commission for Mental Health will be established to look after the interests of people who are subject to care and treatment under powers in the new legislation. The new Commission, which will replace the Mental Health Act Commission, will, amongst other things, carry specific responsibilities for monitoring the use of formal powers, providing guidance on the operation of those powers, and assuring the quality of training provided for practitioners with key responsibilities under the legislation and for specialist advocacy services. The responsibility for inspecting and monitoring facilities in which detained patients are treated will in future rest with the Commission for Health Improvement and the National Care Standards Commission, allowing the Commission for Mental Health to focus more effectively on reviewing the use of the legislation. The Commission for Health Improvement or the National Care Standards Commission will however be able to ask the Commission for Mental Health to perform inspection and monitoring on its behalf.

Need for additional safeguards

2.34 In two areas the provisions of the 1983 Act do not sufficiently protect the interests of some of the most vulnerable patients who need treatment for mental disorder.

Children and young people

2.35 The provisions in new legislation, like the 1983 Act, will potentially apply to people of any age. In view of the special needs and status of children and young people, it is essential that special steps can be taken to safeguard and promote their welfare. But under the 1983 Act there are no special provisions about how the powers should be applied to children and young people. The new care and treatment order10 will provide flexibility, where the criteria for compulsory care and treatment are met, to ensure that the needs of a child or young person are reflected in a way that is consistent with his or her best interests.

2.36 Under new legislation the Tribunal will be required, in considering an application for a compulsory order for care and treatment of a child or young person, to obtain expert advice on both health and social care aspects of the proposed care plan. It will also be required to consider in particular whether the location of care is appropriate to his or her needs.

2.37 There will be changes in the provisions regarding the right of young people between the ages of 16 and 18 to refuse consent to care and treatment for mental disorder. This will clarify the circumstances in which use of compulsory powers under mental health legislation may be appropriate for this age group.

2.38 The Government will consider ways to further safeguard the rights of children and young people with serious mental disorder, including those who are treated informally.

Adult patients with long-term mental incapacity11

2.39 New legislation will include provisions to protect the rights of people with long-term mental incapacity who need care and treatment for serious mental disorder. In many cases such patients do not resist care and treatment but nor are they able to consent to it. They are sometimes described as "not uncompliant" and it is inappropriate to suggest that they should be subject to compulsory powers. But a patient with long-term mental incapacity who needs treatment for serious mental disorder is, potentially, particularly liable to abuse or neglect. This is an area where the human rights of a very vulnerable group of people have never been given sufficient consideration in mental health statute.12

2.40 It is essential to ensure that the best interests of these patients are properly considered and protected and this can only be achieved through independent scrutiny. New legislation will place a duty on the clinical supervisor responsible for the care and treatment of a patient with long-term mental incapacity to refer the care plan to a member of the expert panel for a second opinion when the care and treatment for a mental disorder continues for longer than 28 days. These cases will come within the remit of the Commission for Mental Health and there will be a right to apply to the Tribunal to challenge detention and for a review where there are concerns about the quality and nature of the patient's care and treatment.

2.41 The following chapters describe in detail how the new legislation will work. The second part of the paper explains what the changes mean for the management of people who pose a serious risk to the public. There is a glossary of terms used in the Annex.

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[5] *Royal Commission on the Law relating to Mental Illness and Mental Deficiency* (HMSO 1957). Back

[6] *Safer Services* report of the National Confidential Inquiry into suicide and homicide by people with mental illness (Department of Health 1999). Back

[7] See *Effective care co-ordination in mental health services: Modernising the Care Programme Approach* (Department of Health October 1999). Back

[8] See chapter 7 Back

[9] In some cases care and treatment for mental disorder under compulsory powers will need to be considered when a person is charged with an offence and comes before the Courts see chapter 4. Back

[10] See chapter 3 paragraphs 3.43 ff. Back

[11] For an explanation see the Glossary of Terms. Back

[12] The need to introduce better safeguards in this area was highlighted by the House of Lords judgement in the case of *R v Bournewood Community and Mental Health NHS Trust ex parte L* (1998). Back

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Chapter 3

Scope of new mental health legislation

3.1 Mental health legislation establishes the framework for provision of care and treatment for mental disorder under formal powers. Within this framework, responsibility for decisions on what care and treatment a particular patient needs, and in what conditions it is provided, will generally rest with the clinicians concerned with his or her care. In the case of patients subject to compulsory care and treatment the responsibilities of the clinical team will, under new legislation, be subject to the jurisdiction of the new Mental Health Tribunal.

3.2 The provisions in new legislation will potentially apply to people of any age, but there will be special safeguards for children and young people under the age of 18. These safeguards are described in paragraphs 3.673.72.

Definition of mental disorder

3.3 Powers in new legislation will be based on a broad definition of mental disorder covering any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning. This definition is consistent with the approach recommended by the Law Commission in considering legislation relating to mental incapacity.13 It is intended to ensure that the presence, or absence, of any one particular clinical condition does not limit the discretion of clinicians to consider whether a patient with mental disorder should be treated under compulsory powers.

3.4 In contrast to the 1983 Act, new legislation will not define particular categories of mental disorder. This means that no particular clinical diagnosis will have the effect of limiting the way that the powers are used. The same criteria will be used to determine whether an individual falls within the scope of the legislation whatever their diagnosis. These criteria are described in paragraphs 3.143.18 below.

3.5 This change in approach will ensure the flexibility for compulsory powers to be used in whatever way best meets a particular patient's needs and is consistent with any risk that they pose to themselves or to other people. It will also help to ensure that patients who require care and treatment under mental health legislation are not excluded because of too narrow a definition of mental disorder. One of the effects of the change will be to move away from the narrow concept of "treatability" that applies to certain categories of mental disorder in the 1983 Act. This will mean that new legislation will more clearly apply to any individual who has a personality disorder who poses a serious risk of significant harm to others as a result of their mental disorder (see Part Two of the White Paper). Under the present Act we know that a significant number of people with a primary diagnosis of personality disorder who pose a risk to others are not detained in hospital because of uncertainty about whether their personality disorder can be "treated" or not. The new criteria with specific references to risk will provide clarity. These powers will be matched by new services to provide assessment of patients' needs and care programmes designed to manage behaviours that lead to serious harm to other people.

3.6 But it is equally important that only those patients who need to be covered by the provisions of the legislation come within its scope. The wide definition of mental disorder will therefore be matched by criteria that set clear limits to the circumstances in which compulsory powers may be used (see paragraphs 3.143.18 below). A diagnosis of mental disorder alone would never be sufficient to justify use of compulsory powers.

3.7 The introduction of a new definition of mental disorder and new criteria for use of compulsory powers will have an impact on who comes within the scope of the new legislation and what provisions apply to them. Alongside the changes that are being introduced through the *Mental Health National Service Framework* and *NHS Plan* and their Welsh counterparts, this will mean more effective care and treatment for patients. The Government's objective is to reduce, wherever possible, the number of individuals who are subject to the use of powers for compulsory care and treatment in a way that is consistent

with the objectives set out in the previous chapter.

Procedures for use of compulsory powers

3.8 A key aim of new legislation is to develop a framework that is fully compatible with the Human Rights Act 1998. The complexity of the matters that need to be covered make it essential that new legislation is straightforward for practitioners to use, and for patients and their carers to understand. It will be based on a common framework that will apply in all cases where there is a decision to use compulsory powers.14 New legislation will require those responsible for taking decisions about use of compulsory powers to make a written record, following a standard format,15 of what they decide and why.

3.9 The framework will set out a single pathway for compulsory care and treatment based on three distinct stages. The period of time that each stage takes will vary according to the needs of each patient, but all three stages will have to be followed consecutively in every case. If a patient is well known to the service the first and second stages of formal assessment and development of a care plan may be completed within a matter of days. But a patient will never be made subject to a care and treatment order beyond 28 days without first going through an initial period of formal assessment by specialist mental health services, either as an inpatient or in the community. Nor will any patient, other than a convicted prisoner, be subject to long-term compulsory care and treatment without authorisation by an independent Tribunal or the Court. The procedures in respect of those before the Courts are described in the next chapter.

3.10 The three main stages of the framework are set out below:

Stage 1 decisions on use of compulsory powers

- Decisions to begin assessment and initial treatment of a patient under compulsory powers will need to be supported by objective evidence and based on preliminary examination by appropriately qualified professionals.

Stage 2 formal assessment and initial treatment under compulsory powers

- A patient will be given a full assessment of his or her health and social care needs and receive treatment based on a preliminary care plan;

- the period of formal assessment and initial treatment under compulsory powers will be limited to a maximum of 28 days; there will be a fast-track procedure for a patient to refer his or her case to the Tribunal for review during that time; after 28 days continuing use of compulsory powers must be authorised by an independent decision making body the new Mental Health Tribunal.

Stage 3 care and treatment order

- The Tribunal will be able to make a first care and treatment order for up to 6 months; after that the next order may be for up to 6 months and subsequent orders may be for periods of up to 12 months. The care and treatment order will authorise the care and treatment specified in a care plan recommended by the clinical team.

3.11 A patient will be discharged from compulsory care and treatment under the new legislation when the conditions for continued use of compulsory powers are no longer met. For many patients this will be possible during the formal assessment and initial treatment period; for patients subject to a care and treatment order authorised by the Tribunal, discharge may take place at any time during the duration of the order. Discharge from compulsory care and treatment does not mean that a patient no longer needs specialist care. Some patients will not need continuing care but in many cases care and treatment will continue without the use of compulsory powers.

3.12 The clinical supervisor16 will generally decide when to discharge a patient from compulsory care and treatment. But a

patient will be entitled to request the Tribunal to review the need for continuing care and treatment under compulsory powers once during the formal assessment and initial treatment period, and then once during the period of any subsequent care and treatment order longer than three months. The Tribunal will order discharge from care and treatment under compulsory powers if it decides that the conditions for continued use of compulsory powers are no longer met.

3.13 These procedures are discussed in detail in paragraphs 3.283.64. The procedures that apply in emergencies are set out at the end of this chapter. The following section sets out the conditions in which compulsory powers may be used.

Criteria for use of compulsory powers17

3.14 A decision that a patient should be assessed under the new legislation will, generally, be made by two doctors and a social worker or another mental health professional with specific training in the application of the new legislation. They must all agree that the conditions for application of compulsory powers are met. This process and the alternatives, and applications in respect of people who are before the Courts, are described in detail later in this chapter and in chapter 4.

3.15 Unless a patient is referred by the Courts as an alternative to a remand in custody, the people responsible for making the decision to use compulsory powers will be able to do so only if, on examination of the patient, they consider that two preliminary conditions are met. The first is whether the patient is suffering from a mental disorder that is sufficiently serious to warrant further assessment or urgent treatment by specialist mental health services. The second consideration is whether, without such intervention the patient is likely to be at risk of serious harm, including deterioration in health, or to pose a significant risk of serious harm to other people.

3.16 Use of compulsory powers under new legislation will generally be appropriate only if the patient is resisting, or is considered likely to resist, proposals for assessment and treatment or is not complying with an existing treatment programme.

3.17 Once the decision to use compulsory powers has been made the patient will be given a full assessment to establish what his or her health and social care needs are, and whether there is a need for continuing care and treatment under formal powers. For some patients this process may be completed within a matter of hours, for others it will take several days. New legislation will place a requirement on the clinical team to prepare a preliminary written care plan within 3 days unless there are exceptional circumstances that mean this is impractical. During that first 3 day period the clinical supervisor will be required to discharge the patient from care and treatment under compulsory powers if he or she considers that the patient no longer meets the two conditions for initial use of compulsory powers.

3.18 During the remainder of the period of assessment and initial treatment continued use of compulsory powers will be justifiable only if in the opinion of the clinical supervisor the conditions for the Tribunal to make a care and treatment order would be met. The conditions to be considered by the Tribunal cover three related issues:

- the patient must be diagnosed as suffering from a mental disorder within the meaning of the new legislation;

- the mental disorder must be of such a nature or degree as to warrant specialist care and treatment. This may be necessary in the best interests18 of the patient and/or because without care and treatment there is a significant risk of serious harm to other people;

- a plan of care and treatment must be available to address the mental disorder. In cases where the use of compulsory powers arises primarily in the patient's own best interests that plan must be anticipated to be of direct therapeutic benefit (defined in paragraph 3.21) to the individual concerned. In cases where compulsory powers are sought primarily because of the risk that the patient poses to others, the plan must be considered necessary directly to treat the underlying mental disorder and/or to manage behaviours arising from the disorder.

3.19 The plan of care and treatment may in the initial stages be quite simple. In some cases it will consist of continuing assessment of the patient's care and treatment needs by the clinical team, with or without medical treatment. But once the full assessment is completed the care and treatment plan will need to set out in detail what care and treatment is to be provided, in accordance with the Care Programme Approach or the Care Plan guidance issued in Wales (see box). An important aspect of the Care Programme Approach is that the clinical team is required regularly to review the patient's care and treatment needs and to adjust the plan of care and treatment accordingly. The Code of Practice on the new legislation will include

guidance on how this process should operate when a patient is subject to care and treatment under compulsory powers.

The written care plan for individuals on enhanced CPA should include:

- arrangements for mental health care including medication;
- an assessment of the nature of any risk posed; and the arrangements for the management of this risk to the service user and to others, carers and the public including the circumstances in which defined contingency action should be taken;
- arrangements for physical health care: how and what will be provided usually by the GP, but also by social services when help with meals and personal hygiene may be offered;
- action needed to secure accommodation, appropriate to the service user's needs;
- arrangements to provide domestic support;
- action needed for employment, education, or training or another occupation;
- arrangements needed for an adequate income;
- action to provide for cultural and faith needs;
- arrangements to promote independence and sustain social contact, including therapeutic leisure activity;
- date of next planned review.

3.20 The scope of care and treatment for mental disorder under compulsory powers will not be defined in the new legislation. In each case the plan of care and treatment must indicate what symptoms or behaviours arising from mental disorder it is intended to address. This will ensure that the Tribunal considers any issues regarding the limits of care and treatment for mental disorder.

3.21 The concept of therapeutic benefit will cover improvement in the symptoms of mental disorder or slowing down deterioration and the management of behaviours arising from the mental disorder. This would include behaviours that may lead to significant adverse consequences for the patient such as suicide or serious self-harm, or serious deterioration in physical health.

3.22 Compulsory care and treatment may also be necessary to manage behaviours arising from the mental disorder that may lead to serious harm to other people. In such cases, where a person is subject to compulsory care and treatment on the basis of the risk they pose to others, the care plan must include the provision of interventions that are specifically designed to ameliorate the behaviours that cause them to be a risk to others.

3.23 New legislation will set out certain considerations that must be taken into account by the clinical team in deciding whether it is in the patient's best interests to receive continuing care and treatment, including under powers in legislation, and in deciding what the contents of the care plan should be.

3.24 The first consideration will be the nature and degree of the disorder what and how severe the symptoms are, how the disorder is likely to develop and what interventions are appropriate. The clinical team should take account of any information that is available about how the patient has responded to treatment for mental disorder in the past, whether they have complied with care and treatment provided and what are the risks of not treating them. This will include consideration of whether the mental disorder may affect the patient's capacity to make decisions about proposed care and treatment or about

particular aspects of care and treatment.

3.25 Second, the clinical team should take account of the patient's expressed wishes and preferences in respect of the care and treatment proposed. They should ensure that all patients, including those with disabilities giving rise to communication difficulties, are enabled to express their views, supported, where appropriate, by an advocate. They also need to consider whether overriding the patient's wishes may make it more difficult to deliver effective care and treatment.

3.26 Some patients, because of mental disorder or other disabilities, or for other reasons, will not be able to decide or to communicate their wishes and preferences. For these patients the clinical team must consider any information that is available about the patient's past and present wishes and feelings, including information in any advance agreement he or she has made regarding care and treatment for mental disorder.19 If it is practicable to do so, they should also seek the views of the nominated person20 and any other person the patient has named as someone to consult, other close relatives and carers, and the patient's GP.

3.27 If a patient is assessed as presenting a significant risk of serious harm to other people the care and treatment plan should, as a first consideration, include measures to manage the assessed risk (see discussion in chapter 4 also).

Preliminary examination and decision to use compulsory powers

3.28 Under new legislation the first stage of formal procedures will be triggered by a request which will normally be from a patient, a patient's carer or GP, or from criminal justice agencies21 for a preliminary examination and consideration of use of compulsory powers. This request will go to the NHS Trust or Primary Care Trust that is responsible for providing specialist mental health services in the area where a patient is at the time that the request is made. Under the 1983 Act the responsibility for dealing with such requests rests with local authorities. But the move to new partnership arrangements for provision of health and social care between NHS Trusts and local authorities and the creation of Care Trusts providing both health and social care aspects of mental health services make it unnecessary and impractical to require local authorities alone to deal with referrals for examination under new legislation. The change is not intended to diminish the contribution that good social care can make in addressing the needs of patients with serious mental disorder and their carers.

3.29 There will be a duty on the relevant Trust to arrange a preliminary examination within a maximum time period in response to a reasonable request from a patient, a patient's carer or GP, or from criminal justice agencies. In some circumstances it will be appropriate to refer the request for preliminary examination to particular specialist services, if for example the person to be examined is elderly, a child, someone with learning disability, or known to have a history of serious offending. There will be an expectation that Trusts will develop local service agreements with specialist services so that the process of referral takes place as quickly as possible.

3.30 The purpose of a preliminary examination under new mental health legislation is to establish whether there is objective evidence that a patient meets the conditions for initial use of compulsory powers and whether use of compulsory powers is required. Two doctors and a social worker or another approved mental health professional will visit the patient to carry out the preliminary examination.

3.31 One of the doctors will, where practicable, be someone who works in the mental health service that will be responsible for providing care and treatment for the patient. He or she will have to be approved under the new legislation as someone who has the appropriate level of professional expertise and has received training in the use of powers under the legislation. The other will be someone who is independent of that service that is, a person who works in another specialist mental health service22, another doctor approved under the new legislation, or the patient's GP.

3.32 The third person will be a social worker or another approved mental health professional with special expertise in the care of people with serious mental disorder, and where relevant learning disability, who will be responsible under the new legislation for co-ordinating the preliminary examination process. Their role will, in particular, be to consider with their medical colleagues whether the needs of the patient might be met, and any risk that they pose to themselves or to other people be addressed, through alternatives to compulsory treatment from specialist mental health services. For some patients addressing housing needs, providing additional social care support at home, or access to day care may be a more appropriate approach.

3.33 Once the preliminary examination is complete, if both doctors and the social worker/mental health professional decide that the conditions for assessment and initial treatment under compulsory powers are met, the social worker/mental health professional will be responsible for co-ordinating and managing the next steps. This means formally confirming in writing the decision that assessment and initial treatment under powers in the legislation are needed, collating reports from each of

the three people involved, and registering the decision with the Trust or other agency23 that will be responsible for continuing care and treatment of the patient. The decision must be registered as soon as possible and not later than 7 days after being made. The period of assessment and initial treatment under compulsory powers will not start until the decision is registered. Once the decision has been registered and accepted by the service provider, the managers of that service will take formal responsibility for provision of care and treatment under the new legislation.

3.34 The social worker/mental health professional will also be responsible for nominating a person to be consulted by the clinical team (see chapter 5 paragraphs 5.6ff). The patient may have identified such a person in an advance agreement (see chapter 5 paragraphs 5.14 and 5.15).

3.35 The social worker/mental health professional will formally arrange with the relevant consultant for the patient to be admitted to hospital, if necessary. In cases where a patient is admitted to hospital the decision will be registered when the admission takes place, and the compulsory assessment and initial treatment period will run from that time.

3.36 In most cases formal assessment and initial treatment will take place under compulsory powers in hospital. But in some circumstances, for example if the patient is a child, elderly or has a learning disability, it may be in his or her best interests to arrange for initial assessment and treatment by specialist services to take place outside hospital. In other cases a patient who is well known to services and already receiving treatment in the community may require formal assessment and initial treatment because his or her condition is deteriorating. In a case where detention in hospital is not thought to be a necessary pre-condition for effective assessment and initial treatment the new legislation will allow for formal assessment and initial treatment to take place in the community.

Formal assessment and initial treatment under compulsory powers

3.37 The provisions for initial assessment and treatment under the new legislation will be designed to ensure that care and treatment decisions are based on proper consideration both of a patient's best interests, including consideration of any risk he or she poses to him or herself or other people. This means taking steps to find out what the patient's present and previous wishes and preferences are and what plan of care and treatment will best meet his or her health and social care needs. The process of assessment leading to development of a care and treatment plan should be open and fully recorded.

3.38 Under the new legislation formal assessment and initial treatment in the community or under compulsory powers may apply for up to 28 days from the time that the decision is registered. During this period no treatment without the consent of the patient, other than urgent treatment, can take place before a written care plan has been completed. Unless there are exceptional circumstances, a written care plan must be drawn up according to a standard pro-forma and formally recorded in the patient's notes within 3 days. In most cases the care plan will not be fully developed at that stage but a preliminary care plan may be implemented during the formal assessment period as soon as it is agreed.

3.39 For a patient treated under compulsory powers for more than a few days the care plan should be based on a full assessment of his or her needs carried out in accordance with the enhanced Care Programme Approach or the Care Plan guidance issued in Wales (see box above). For the purposes of assessments under the new legislation the Care Programme Approach will be applicable to patients of any age. Any changes in the preliminary care plan must be recorded in writing and kept with the patient's notes.

3.40 The patient's clinical supervisor will be under a duty to keep his or her care and treatment needs under review. Where relevant the clinical supervisor should have access to sources of expert advice on the care and treatment of people with learning disabilities or physical disabilities and in some cases shared care may be appropriate.

3.41 During the period of formal assessment and initial treatment the clinical supervisor will be required to stop using compulsory powers if he considers that the conditions on which the Tribunal would make a care and treatment order are no longer met. This would usually happen when a patient's symptoms improve to the extent that he or she is able to consent to the care and treatment plan or when continuing care and treatment is no longer needed. Many patients with serious mental disorder will respond to treatment and be discharged from compulsory powers within the first 28 days, although, as now, many will continue to receive care and treatment on a voluntary basis.

3.42 A patient will be able to apply to the Mental Health Tribunal for review of the continued application of compulsory powers under new legislation at any time during the period of formal assessment and initial treatment. The nominated person or specialist advocate may assist him or her to do so. The Tribunal hearing will take place within 7 days of receipt of the application for review. If the Tribunal decides that the conditions for continued use of compulsory powers are not met, the patient will be discharged from compulsory care and treatment straight away. If the Tribunal decides that the conditions are met, it will have the power to make a care and treatment order for up to 6 months (as described below). But it may consider

that a longer period of assessment and treatment is needed or that the condition of the patient would have changed significantly if the hearing had taken place at the end of the full 28 day period. The evidence from the use of the Mental Health Act 1983 is that around half of those treated under formal powers make sufficient progress to enable them to revert to informal care after about 28 days care and treatment. It is therefore sensible to allow for this period to pass before holding tribunals routinely. In these circumstances it will have the power to make an order extending the original period of assessment and treatment for a further 28 days. The constitution and procedure for a Tribunal hearing at an initial review will be similar to that described below for hearing an application from the clinical supervisor for making a longer term care and treatment order.

Longer term care and treatment

3.43 A key change in the new legislation will be the introduction of procedures for independent scrutiny of all proposals to continue care and treatment under compulsory powers for longer than 28 days. Continuing care and treatment will be based on recommendations from the patient's clinical supervisor. Where the new Mental Health Tribunal consider that the criteria (set out in paragraphs 3.143.18 above) are met and the care and treatment plan is appropriate it will make a Care and Treatment Order. At this stage all aspects of the case for use of compulsory powers will be taken into account. The order will provide the authority for the clinical team to continue care and treatment under compulsory powers.

3.44 The new Tribunal will have a legally qualified chair24 and two other members with experience of mental health services. One of the members will be a person with a clinical background and the other will usually have a background in community or voluntary sector service provision. All members of the Tribunal will be required to undergo training on the application of compulsory powers under the new legislation.

3.45 When the clinical supervisor applies to the Tribunal for authority to continue compulsory care and treatment beyond 28 days, arrangements will be made for the patient to be seen by an independent doctor drawn from a panel of people appointed to provide expert evidence to the Tribunal. The panel will include doctors drawn from a variety of backgrounds including general, old age, learning disability, child and forensic psychiatry and clinical psychology; and from black and ethnic minority backgrounds. Wherever possible the person who sees the patient will have expertise in the particular type of mental disorder that he or she is suffering from.

3.46 The expert panel will also include people with experience in ethnic minority issues, social care, learning disability nursing, mental health nursing, and the probation service. The Tribunal will, as necessary, be able to seek an opinion from these members of the panel in addition to the report from the medical expert.

3.47 The Commission for Mental Health25 will appoint people to the panel, in consultation, where appropriate, with the relevant professional bodies. Medical members of the panel will be clinicians of consultant grade; other members will be practitioners with appropriate seniority and experience.

3.48 The task of the Tribunal will be to decide, on the basis of the evidence put to it, whether the conditions for continuing care and treatment under compulsory powers are met. It will be required to consider the care and treatment plan proposed for the patient by the clinical supervisor in consultation with other members of the clinical team. It will also consider the report from the panel medical expert and any evidence put forward by the patient and his or her representative, including any independent medical opinion commissioned on his or her behalf.

3.49 If the Tribunal is satisfied that the conditions for compulsory care and treatment are met it will have the power to approve a care and treatment order. If it decides that the conditions are not met, the patient will be discharged from compulsory care and treatment under the new legislation.

3.50 The Tribunal will be required to make a care and treatment order if the care and treatment plan proposed by the patient's clinical supervisor meets the criteria set out in the new legislation, and is appropriate in all the circumstances. The legislation will include provisions to cover circumstances where the Tribunal considers that a patient should be treated under compulsory powers but is not satisfied that the care and treatment plan is appropriate.

3.51 It will be open to the Tribunal to make flexible orders covering compulsory care and treatment in the community as well as in hospital. When the Tribunal makes a care and treatment order, it will attach a copy of the care and treatment plan on which the order is based, and specify a number of matters relating to the application of compulsory powers. These will include:

- the length of time the order is to last;

- whether the patient is to be detained for care and treatment in a particular location;

- if the patient is not detained, the consequences of non-compliance with the plan; and,

- if the patient is detained, whether he or she may be granted leave, transferred to another location or discharged from compulsory care at the discretion of the clinical supervisor.

Length of the care and treatment order

3.52 On the first two occasions that the Tribunal hears an application from the clinical supervisor to continue compulsory care and treatment, it will be able to make a care and treatment order that lasts for up to 6 months. When considering subsequent applications, it will be able to make orders for up to 12 months at a time.

Location of care and treatment

3.53 One of the major changes in new legislation will be the flexibility for care and treatment under compulsory powers to take place in a range of settings. This means that a patient who meets the criteria for the use of compulsory powers need not necessarily be detained in hospital, but any patient who is actively resisting treatment will only be given medication in hospital.

3.54 Many patients will need care and treatment in hospital in their best interests or because they pose a significant risk of serious harm to other people. For these patients, detention in hospital will be specified as a condition of the care and treatment order.

3.55 But care and treatment in hospital is not always in a patient's best interests. Under new legislation the Tribunal will be required to consider what location is most appropriate to each patient's needs, taking particular account of the degree of security that is required to manage any risk that they pose to themselves or to other people. This new flexibility is essential to delivering the principle that care and treatment under compulsory powers only involves imposition of such conditions as are necessary to ensure the patient's health and/or safety or the safety of other people.

Compulsory care and treatment outside hospital

3.56 If the Tribunal makes an order specifying care and treatment other than on the basis of detention in hospital, it will be required to state in the order what elements of the care and treatment plan are compulsory.

3.57 The care and treatment order might, for example, require the patient to allow access by staff from the specialist mental health team; attend day care; or comply with specified medication. Against each requirement, the order will specify what action the clinical supervisor is empowered to take if the patient fails to comply. The order might provide for health or social services staff to have access to the patient at home, to arrange for the patient to be taken for care or treatment to hospital or another location, or to be admitted to hospital for further assessment of his or her care and treatment needs.

3.58 When a patient is subject to a care and treatment order outside hospital, those responsible will be required to ensure that services are provided in a way that enables the patient to comply. Patients will not be charged for provision of any service that is specified in the order as something that they must comply with.

Discretion to discharge, grant leave or vary the conditions of the care and treatment order

3.59 In most cases a patient's care and treatment needs will change during the course of an order, as he or she responds to treatment or as the mental disorder worsens or goes into remission over time. In these circumstances it may be appropriate to discharge the patient from the order, or vary the conditions for example by granting a period of leave at home. The clinical supervisor is best placed to judge what action is appropriate. If a patient is detained for care and treatment in hospital the Tribunal will generally give discretion to the clinical supervisor to discharge him or her from compulsory care and treatment, grant leave, or arrange transfer to another hospital.

3.60 Exceptionally, the Tribunal will be able to require that, other than in cases of emergency, decisions on discharge, leave and transfer should be referred to it for prior approval. This would usually only be appropriate in cases where, because the patient poses a significant risk of serious harm to other people, detention in conditions of security is a condition of the care and treatment order. In such cases, if the Tribunal does not accept the recommendation of the clinical supervisor it may

suggest that the care and treatment plan is revised, for example to specify care and treatment outside hospital subject to continued supervision by specialist mental health services.

Right to request a review by the Tribunal

3.61 Where a patient is not liable to detention following a Court order he or she will have the right, where appropriate through his or her advocate, to request that the Tribunal reviews any order for compulsory care and treatment lasting longer than 3 months. A patient will be able only to request one review during the period of any order. The purpose of the review will be to determine whether the current arrangements for care and treatment under compulsory powers are appropriate. The review will not constitute an appeal against the original decision to impose compulsory powers.

Tribunal hearings

3.62 Tribunal hearings will normally take place at the hospital where a patient is detained for care and treatment, or in the case of a patient subject to a care and treatment order in the community at a suitable place in the local area. A patient will be entitled to an oral hearing on any occasion when the Tribunal is considering his or her case. The Tribunal will follow an inquisitorial process. Patients will have the opportunity either personally, or through a representative, to present objections to any element of the care and treatment plan that would form part of an order.

3.63 An initial care and treatment order or a review will always require an oral hearing if the patient wishes to make representations in person or there is a difference of opinion between the clinical supervisor and the expert panellist. No renewal or review of an order will take place without the patient or his or her representative having the opportunity to make representations to the Tribunal. In cases where there is no oral hearing the Tribunal will review the patient's case on the papers, which must include an opinion from the expert panel. If the Tribunal has requested changes to the care plan, it will not always be necessary for an oral hearing to take place. The essential principle is that the patient will always be given the opportunity to make any objections or other representations but if there are none it will be open to the Tribunal to make decisions without a hearing. Any decisions will of course be communicated to the patient, his or her representative, and the clinical team.

Appeal to the higher courts

3.64 Where a Tribunal makes an order for care and treatment under compulsory powers, there will be a right of appeal from the Tribunal to the Higher Court on a point of law. Patients will also be able to challenge decisions by way of judicial review.

Aftercare following discharge from a care and treatment order

3.65 Most patients will need some form of continuing care from health and social services after they have been discharged from a care and treatment order. A patient's clinical supervisor will have the power to discharge him or her from a care and treatment order only on the basis of an agreed written plan, setting out what, if any, continuing care and treatment is to be provided, and when the plan will be reviewed. The clinical supervisor will be required to notify the Commission for Mental Health that the patient has been discharged and given a copy of the agreed continuing care plan as required by the legislation.

3.66 If the Tribunal orders discharge from compulsory care and treatment it should be satisfied that appropriate aftercare arrangements are in place, or will be in place, when the discharge takes effect.

Special provisions for children and young people

3.67 Determining whether care and treatment provided under compulsory powers will be in the best interests of a child or young person with serious mental disorder is often difficult. Parents or others with parental authority may consent to treatment for mental disorder on behalf of a child or young person. But even if parental consent is given, the clinical team must consider the wishes and feelings of the child. The issues are complicated by the need to take account of the child's educational as well as health and social care needs. If the child's parents oppose care and treatment proper account must be taken of their views, and of the impact of any decision to impose care and treatment on relationships within the family.

Requirements to consult

3.68 Under new legislation those responsible for deciding whether a child or young person of any age, including those aged 16-18 should be subject to assessment and initial treatment under compulsory powers will be required to consult his or

her parents, or any other person with parental responsibility. The only exception to this would be where emergency procedures apply (see paragraphs 3.73 and 3.74).

3.69 The clinical team responsible for assessment and initial treatment of a child or young person under compulsory powers will be expected to follow the Care Programme Approach or the Care Plan guidance issued in Wales. There will be a presumption that assessment will be carried out on a multi-disciplinary basis and include consideration of education and social care as well as health needs. In making decisions on the longer-term care and treatment of a child or young person, the Tribunal will be required to seek advice from people with expertise in the care and treatment of children and adolescents. This would usually include at least one specialist in child and adolescent psychiatry.

Young people aged 16-18

3.70 The current legal position is that a young person over the age of 16 may consent to treatment for mental disorder but refusal to consent can be overruled by a parent. This means that he or she can consent to treatment against the wishes of his or her parents in which case compulsory powers need not be considered. But if the parents consent, treatment can be given against the young person's wishes without use of compulsory powers.

3.71 In the case of a young person, care and treatment for mental disorder, without his or her consent, can raise complex ethical problems for the clinical team and be stressful for all concerned. There is a particular problem if that care, sometimes over a sustained period of time, requires restraint or seclusion or the administration of medication against the young person's wishes. In these circumstances it may well be in the best interests of the young person for care and treatment to be provided within the framework of mental health legislation. But the correct interpretation of the law in these circumstances is often difficult. There is no requirement, if the young person's parents agree to treatment, to treat him or her under compulsory powers in the 1983 Act.

3.72 Over recent years there has been increasing recognition of the capacity of a developing young person to take decisions on his or her own behalf. In line with this and for the other reasons outlined above, in new legislation a 16-18 year old person who does not consent, and who meets the conditions for care and treatment under compulsory powers, will only be treated under compulsory powers and will thereby be protected by the safeguards described in chapter 5.

Procedures that apply in emergencies

3.73 In some cases the need to deal with an emergency situation will mean that the usual procedures for assessment and treatment under compulsory powers are not appropriate. Sometimes it will be in the best interests of the patient or will avert an unacceptable risk if care and treatment under compulsory powers is started, or other action is taken, before a full preliminary examination has been carried out.

3.74 But it is important that the provisions are only used in emergencies and not as a way of avoiding following the proper procedures. The circumstances in which emergency procedures are used and the length of time they apply will be carefully regulated through performance monitoring and by the Commission for Mental Health. If a patient is held under emergency powers, that time will be counted as part of any subsequent period of assessment and initial treatment under compulsory powers.

Emergency admission to hospital

3.75 In cases where there is an urgent need to admit a patient to hospital for assessment and initial treatment under compulsory powers, the procedures described earlier in this chapter will apply. But in an emergency the decision may be made by the social worker/mental health professional and one of the two doctors who would otherwise be involved. A decision to continue the period of assessment and initial treatment would require the agreement of a second doctor as soon as possible and always within a maximum of 72 hours.

Holding powers when a patient is in hospital

3.76 If there is an urgent need to use compulsory powers in the case of a patient who is already in a unit run by specialist mental health services the decision may be made by one doctor who is employed at that unit. If the patient is in a hospital other than a specialist mental health unit, a decision to apply compulsory powers will require the agreement of two people, who may be any two of the people (two doctors and a social worker/mental health professional) who would otherwise be involved in deciding to apply assessment and treatment under compulsory powers.

3.77 In either case a decision to continue assessment and treatment under compulsory powers will require the agreement of

all three people who would otherwise be involved as soon as possible and always within a maximum of 72 hours.

3.78 In addition to these provisions new legislation will, like the 1983 Act, allow for a nurse with appropriate seniority and experience26 to authorise the detention of a patient in hospital for a period of up to 6 hours. This holding power will be available only if there is an urgent need to arrange for the patient to be referred for a decision on assessment and initial treatment under compulsory powers.

Police powers to remove a person to a place of safety and seek assessment in an emergency

3.79 The police are often the first resort when individuals with mental disorder need care and treatment in an emergency. They have experience of taking people into a place of safety from public places and of arranging assessment of their need for admission to hospital. New legislation will retain the flexibility of existing arrangements, building on the best features of what people are already implementing through local protocols. It will clarify the respective rights and responsibilities of patients, police and health and social services agencies.

Power to remove from public places

3.80 New legislation will include provisions, as in the 1983 Act, for the police to remove a person from a place to which the public have access if he or she appears to be suffering from mental disorder and in immediate need of care and control.

Power to remove from private property

3.81 Where a person who appears to be suffering from mental disorder and in immediate need of care and control is on private property, possibly in his or her own home, a number of different issues have to be considered. There may be a need to intervene in the patient's best interests or to protect others from serious harm but these factors must be balanced against his or her right to privacy. If the situation permits, that balance is best assessed judicially by a local magistrate with advice from a social worker.

3.82 In some circumstances, if there is an urgent need for action, it may not be practical to seek a magistrate's warrant. New legislation will provide for the police to intervene in an extreme emergency where a mentally disordered person is on private premises. But they will be able to do so only on the advice of a mental health practitioner with appropriate seniority and experience27 that the person appears to be in immediate need of care and control, for example, to prevent serious harm to him or herself or to other people. In these circumstances, the police will have the power to enter private premises and remove the person to a place of safety. Where practicable the police will be accompanied by a mental health practitioner.

Place of Safety

3.83 Police cells are not generally appropriate places for assessing whether a person needs medical treatment. But if the person is violent, or if it is unclear whether the appearance of mental disorder is due to the temporary effects of alcohol or drug misuse, it may be inappropriate to take him or her straight to hospital. A flexible response to developing circumstances is needed. Provisions in new legislation will allow for a person who is detained in a place of safety for assessment for use of compulsory powers, to be taken to another place of safety. This provision should be used only if it is in the person's best interests or necessary for the protection of others to do so.

3.84 The maximum overall detention period in a place of safety will remain at 72 hours. But where a police cell is the place of safety there will be a duty on the local Trust to arrange a preliminary examination within six hours if requested to do so by a Forensic Medical Examiner, or to transfer the person to hospital for examination within that period.

3.85 Liability to detention in a place of safety will end after 72 hours, or when one of the three people responsible for carrying out the preliminary examination concludes that compulsory care and treatment is unnecessary, or when a decision to apply compulsory powers is made.

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[13] *Making Decisions* (TSO October 1999) Cm 4465. Back

[14] For prisoners and people before the Courts the framework will be similar but the procedures will be different see chapter 4. Back

[15] Following procedures set out in regulations. Back

[16] See definition in the Glossary of Terms. Back

[17] There is also a need to ensure safeguards through legislation for patients with long-term mental incapacity who require treatment for mental disorders without the use of compulsory powers. The safeguards and procedures that will apply are discussed in chapter 6. Back

[18] See paragraphs 3.37 ff. Back

[19] See discussion in chapter 5, paragraphs 5.14 and 5.15. Back

[20] See chapter 5, paragraphs 5.6 ff. Back

[21] i.e. Police, Probation Service, Courts, or Prison Service. Back

[22] This could include a doctor who works in a separate specialist mental health service run by the same Trust. Back

[23] For example, a service provider in the independent sector. Back

[24] In the case of patients subject to special restrictions the Tribunal will be chaired by a judge or QC see chapter 4. Back

[25] See chapter 7. Back

[26] The Mental Health (Nurses) Order 1998 sets out which nurses may exercise the powers under section 5(4) of the Mental Health Act 1983. Similar arrangements will be made under the new legislation. Back

[27] Guidance on this will be in the Code of Practice on the new Act. Back

Chapter 4

Compulsory care and treatment of mentally disordered offenders

4.1 In some cases care and treatment for mental disorder under compulsory powers will need to be considered when a person is charged with an offence and comes before the Courts, or whilst they are in prison on remand or following conviction for an offence.

4.2 The causes of offending behaviour are complex. In some cases even where a person has a mental disorder there will be no clear link between the offence and the mental disorder. But whatever the circumstances of the individual case, people who are before the Courts or in prison should be assessed and if appropriate receive treatment from specialist mental health services at the earliest opportunity. In the majority of cases, this will be in the best interests of the individual. Where there is a recognised link between the offending behaviour and the person's mental disorder, compulsory care and treatment aimed at managing high risk behaviour resulting from the disorder will also be in the interests of the public. For those before the Courts early assessment will enable the Court to make a fully informed decision on the appropriate sentence.

4.3 Under new legislation the conditions that need to be met for use of compulsory powers will be the same for mentally disordered offenders as for other people, but different procedures will apply. This chapter sets out what those procedures are. The second part of this paper describes in more detail how they will apply in practice to offenders who are assessed as presenting a significant risk of serious harm to others.

Offenders before the Courts

4.4 The Court will have a range of disposal options, depending on the nature of the offending, the risk to others from possible repeat offending and the assessment of the offender's treatment needs. Where medical assessment indicates that there is a need for treatment for mental disorder, the traditional response has been that this should override considerations of punishment in the criminal justice system. This has proved an effective as well as a humane response to offending behaviour where there is a clear link between the mental disorder and the offence. But at the time of sentencing it will often not be possible to establish such a link. It is therefore important that a Court, in considering what disposal should apply to a person with mental disorder, has access to a comprehensive assessment of his or her treatment needs.

A single power of remand for assessment and treatment

4.5 Provisions in new legislation will simplify procedures for the Courts to obtain a medical assessment and order treatment at any stage of the trial when mental disorder becomes an issue. A balance must be struck between the need to obtain an assessment urgently and if care and treatment is an issue to obtain appropriate medical evidence to justify treatment under compulsory powers. Obtaining a second medical opinion may unnecessarily delay the process of ordering a full assessment.

4.6 New legislation will provide for the Courts to remand a person for assessment by specialist mental health services on the basis of a single medical opinion from an appropriately qualified doctor that a care and treatment order may be an appropriate disposal. The provisions will allow for the order to be reinforced immediately, or later, by a second medical opinion that initial treatment under compulsory powers is necessary. The second medical opinion will be notified to the Court at the next review. This power will apply both in the magistrates and the higher Courts.

4.7 The Court remand for assessment will be based on the medical recommendation and could be for detention in hospital

or for assessment in the community on bail. The Court will have the discretion, in any case, to remand to hospital, subject to a suitable place being available. The order will be renewable by the Court at 28-day intervals for up to a maximum period of 12 months, on the recommendation of the clinical supervisor. But the Court will be expected to make a disposal if the person is convicted, as soon as there is sufficient information to make an effective sentencing disposal. The offender will have the right to legal representation at any hearing where renewal of the remand order or sentencing is considered.

Moving between assessment facilities

4.8 In the course of a remand, it may prove necessary to alter the basis of the assessment arrangements. For example, initial assessment by specialist mental health services may indicate that a person has a mental disorder that is not amenable to conventional treatment in hospital, but should be assessed for possible admission to a specialist facility. It might be appropriate, for example, for a patient on remand to be transferred to a unit that specialises in the treatment of people with learning disability, forensic patients, or people with severe personality disorder. Under new legislation it will be possible for such a change to be ordered and reviewed by the Court on the basis of care and treatment plans submitted by the clinical supervisor. The offender would have the right to legal representation to contest such a change.

Agreeing leave

4.9 During a remand to detention in hospital, the remanding Court will have a power to agree to the offender being given leave from hospital on the recommendation of the clinical supervisor. The Court will have discretion when it makes the order, if it is satisfied that public safety will not be compromised, to allow the clinical supervisor to grant leave.

Sentencing

4.10 On receipt of the completed clinical assessment, if the person is convicted, the Court will have a number of options:

- *A criminal justice disposal*. This will be at the discretion of the Court to decide in the light of the offence, the medical evidence, any history of offending and the implications of a particular disposal for the offender's future management, both in terms of his or her treatment needs and any risk to other people.

  A life sentence will be mandatory in the case of a conviction for murder; automatic in the circumstances of section 2 of the Crime Sentences Act 1997; or discretionary in the event that the offence and the evidence of the offender's dangerousness justifies it.

  An appropriate determinate prison sentence or other criminal justice disposal could be passed.

  Any of these disposals would signal the end of detention under mental health legislation unless the Court makes a hospital and limitation direction or the person is transferred to hospital on the direction of the Home Secretary (see paragraph 4.11).

- *A care and treatment order.* This option will be available only if on the basis of a full assessment by specialist mental health services the clinical supervisor recommends continuing care and treatment and the Court consider the criteria for making a care and treatment order under the new legislation are met. The Court in considering the evidence for making a care and treatment order will apply similar processes to those described in relation to the Tribunal in the previous chapter (see paragraphs 3.43ff). Unless a restriction order applies the procedures for discharge of the order would be the same as for an order made by a Mental Health Tribunal. A care and treatment order made by the Court would be for a maximum of 6 months. Any extension of liability to compulsory treatment after that would be through the procedures for a Tribunal order described in chapter 3.

- *A restriction order.* Where the clinical assessment indicates that the offender poses a significant risk of serious harm to others, or because of the nature of the current offence or previous convictions, the Court will be able to add a restriction order to a care and treatment order. This will only be applicable when the care and treatment order is based on detention in hospital. Patients who are subject to restrictions will be managed under the supervision of the Home Secretary, as in the 1983 Act.29

- *A hospital and limitation direction*.30 The Court will retain the option of combining a criminal justice tariff with an

order for care and treatment under mental health legislation by adding a hospital and limitation direction to a prison sentence. A hospital and limitation direction has the effect of requiring the offender's detention for medical treatment in hospital until such time as the clinical supervisor advises that treatment in hospital is no longer necessary. The offender can then be transferred to prison, by direction of the Home Secretary, to complete his or her sentence. Time spent during detention for medical treatment will count towards completion of the offender's criminal justice tariff. Under new legislation this option will be available for a patient diagnosed with any mental disorder within the meaning given to it in new legislation.

Prisoners

Referral for assessment and treatment under compulsory powers

4.11 Some offenders already serving a prison sentence develop severe mental health problems whilst in prison. Others will have been given a prison sentence, for example a mandatory life sentence, but have had recognised mental health needs at the time of sentencing. Some prisoners with mental disorder need treatment from specialist mental health services and there is no power in statute to treat a prisoner in prison without his or her consent. Under the 1983 Act the Home Secretary has the power to transfer a prisoner to hospital for treatment, but does not have a power that would allow for a period of specialist assessment without treatment.

4.12 New legislation will provide for the Home Secretary to direct a prisoner to undergo a specialist assessment for mental disorder, in addition to powers to direct transfer to hospital for treatment. Such a specialist assessment will take place in an appropriate environment, which could be in a hospital, or a dedicated section of a prison. In particular this will allow for specialist assessment of prisoners who pose a high risk before decisions on possible transfer to a specialist mental health unit are considered.

4.13 A transfer direction will generally specify that a prisoner is detained in hospital for treatment, and carry restrictions as described above.

4.14 Under the 1983 Act, when a transferred prisoner reaches the date on which he or she would have been released from prison, liability to detention for treatment is deemed to continue as though the Court had made an unrestricted hospital order. Under new legislation, authorisation for continuing care and treatment will be subject to the clinical supervisor submitting an application for approval by the Mental Health Tribunal as described in chapter 3.

Role of the Tribunal for patients subject to restrictions

4.15 For patients subject to restrictions, the role of the new Mental Health Tribunal will be similar to that of the Mental Health Review Tribunal under the 1983 Act. The Tribunal will be required to review the offender's liability to detention in hospital for treatment rather than considering an application for making or renewing a care and treatment order as described in chapter 3.

Role of Parole Board for prisoners serving a life sentence

4.16 The Parole Board will continue to have responsibility for release of a life sentence prisoner who is subject to a hospital and limitation direction or is transferred to hospital from prison. Whilst detained under powers in the new legislation, a patient who is subject to a life sentence will be able to apply to the Tribunal for a review of his or her liability to compulsory care and treatment. If a Tribunal decides that the criteria for compulsory care and treatment are no longer met, the patient will be returned to prison. A patient who had served the tariff imposed by the Court would be eligible on return to prison to apply to the Parole Board for release.

Discharge of restricted patients from hospital and provisions for recall

4.17 The Tribunal hearing an application from a restricted patient will be able to make a discharge subject to conditions, as in the 1983 Act. If the Tribunal concludes that it is no longer appropriate for the patient to be liable to compulsory care and treatment, it will be required to order absolute discharge.

4.18 The Tribunal might conclude, on the basis of a proposed care plan, that the criteria for continuing liability to care and treatment under compulsory powers are met, but that detention for treatment in hospital is not appropriate. In these circumstances the Tribunal could order discharge from hospital conditional on compliance with the care plan. The issues to be considered by the Tribunal would be similar to those for making a care and treatment order in the community. The order

can only be made if the necessary services are available and no conditional discharge will be deferred indefinitely without review. Conditions of discharge will include supervision by social and psychiatric supervisors, who will be required to report regularly to the Home Secretary. The Home Secretary will retain the power of recall to hospital as in the 1983 Act (see second part of White Paper, which deals with this in more detail).

4.19 A patient who is subject to conditional discharge will have the right to apply to the Tribunal for review of liability to continuing compulsory care and treatment or liability to compulsory recall under the legislation. Both the Home Secretary and the Tribunal will be able to discharge the patient absolutely from compulsory powers.

4.20 A lawyer with experience of sentencing in the higher Courts will chair a Mental Health Tribunal hearing an application or reference of a restricted patient. This is essential to preserving the confidence of the sentencing Court in the efficacy of powers for compulsory care and treatment as an alternative to a prison sentence.

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[29] See chapter 4 in Part Two of this White Paper. Back

[30] See explanation in the Glossary of Terms. Back

Chapter 5

Safeguards to protect patients

5.1 New legislation will be fully compliant with the Human Rights Act 1998. The previous chapters describe a number of significant safeguards that will protect the rights of patients who are subject to compulsory care and treatment under new legislation. In particular, the key principles that will underpin the new legislation emphasise the importance of care and treatment that is appropriate to the needs of individual patients. The introduction of a requirement that all longer-term care and treatment orders are authorised by a body independent of the clinical team, is another key way in which the new legislation will protect patient rights.

5.2 The provisions of new legislation will place a clear duty on those responsible for providing health and social care services for patients subject to compulsory powers to ensure that care and treatment plans are properly implemented, and kept under review.

5.3 A Code of Practice on the new legislation will set out detailed guidance on what the provisions mean and how they should be applied. And the Commission for Mental Health, whose role and responsibilities are set out in chapter 7, will have a specific remit to look after the interests of patients who are subject to formal powers. This includes patients who are subject to compulsory powers and those with long-term mental incapacity who are subject to the special safeguards described in chapter 6.

5.4 In addition to these general measures, there will be specific provisions in new legislation to safeguard the rights of patients. This chapter describes provisions to ensure that patients are better able to represent their wishes in respect of care and treatment provided under compulsory powers, procedures for treatment for mental disorder without consent, and provisions covering the role of carers.

Patient representation

5.5 Patients with serious mental disorder often need the help of someone who knows them well to represent their views and wishes in discussions with the clinical team. This is important if, particularly in the initial stages of assessment and treatment under compulsory powers, a patient is too ill to participate fully in decisions about his or her care. Under the 1983 Act, the approved social worker is required to consult the person designated as the patient's nearest relative.

5.6 New legislation will preserve this approach through provisions for nomination of a person to be consulted by the clinical team in all cases where a patient is subject to care and treatment under compulsory powers.31 The process of nomination will, in the first instance, be the responsibility of the social worker/other mental health professional responsible for co-ordination of action following the decision to apply compulsory powers. In deciding who should be nominated, he or she will be required to consult that patient's close relative or main carer. They should also take into account any views about who should be nominated that the patient has expressed in a recent advance agreement (see below).

5.7 The legislation will include provisions for an alternative nominated person to be appointed by the Tribunal where, for example, it is impractical or inappropriate for the person nominated to act on the patient's behalf.

5.8 New legislation will require the clinical team to consult the nominated person during the period of assessment and initial treatment of a patient, and subsequently at any time when a substantial variation in a compulsory care and treatment order is proposed. There will also be a requirement to consult the nominated person before the patient is discharged from compulsory powers. But the clinical team will also be able to seek the views of the nominated person at other times. The nominated person will have the right to seek a meeting with any doctor appointed to provide an independent opinion on the patient's care and treatment.

5.9 The nominated person will be able to attend any Tribunal hearing and apply to the Tribunal on behalf of the patient for review of the use of compulsory powers, within the time-scales set out in chapter 3. If the patient is not able, because of mental incapacity or for other reasons, to instruct a lawyer to represent him or her at the Tribunal hearing, the nominated person will have the power to do so on his or her behalf.

Access to specialist advocacy services

5.10 Admission to specialist mental health services under compulsory powers is inevitably stressful for a patient and his or her family or other carers. It is important that all those concerned have access to advice and support to help them understand how the powers in the legislation work, who is responsible for taking decisions, how those decisions may impact on the patient, and what rights he or she has to seek a review.

5.11 New legislation will place a duty on the clinical supervisor to inform the patient about these matters. But patients and their carers may, understandably, also want advice or help from an independent person. Under new legislation providers of health and social care services will be required to ensure that patients who are subject to care and treatment under compulsory powers have access to independent specialist advocacy services. This right of access to specialist advocacy will be available to children and young people, as well as to adult patients. For patients cared for in NHS Trusts in England, the Patient Advocacy Liaison Service announced in the *NHS Plan*32 will provide the gateway into, but not be the provider of, independent specialist advocacy services. Health Authorities will ensure suitable independent advocacy is made available. The Patients' Forum, to be established in every NHS Trust and Primary Care Trust to provide direct input from patients into how services are run, will monitor these arrangements locally. In Wales, the emerging All Wales Strategy has proposals on access to advocacy which will guide provision there.

5.12 The role of specialist advocates will be to provide information and, if appropriate, help the patient represent his or her views in discussions with the clinical team about his or her care and treatment under formal powers. Specialist advocates may also advise the nominated person. Access to specialist advocacy will not replace the right of patients to be legally represented at a Tribunal hearing.

5.13 The Commission for Mental Health will be responsible for drawing up and administering standards of training and practice for specialist independent advocacy services, for monitoring and reviewing the provision of advocacy to patients who are subject to compulsory care and treatment under the new legislation. The Department of Health has commissioned Durham University to provide a report on principles and good practice in the provision of advocacy for people with mental disorder. This study, which is due to report early next year, will inform the development of standards for specialist advocacy services.

Advance agreements

5.14 Many patients with serious mental disorder are well for much of the time. A patient who has had experience of different types of care and treatment for mental disorder may wish to put on record, when well, what sort of treatment he or she would prefer if the mental disorder deteriorates. Advance agreements of this sort may be an important factor in determining what care and treatment is in a patient's best interests.

5.15 Clinical teams will be expected to help patients develop such advance agreements. When a patient is subject to assessment and initial treatment under compulsory powers, the clinical team will be expected to take account of any recent advance agreement developed in consultation with specialist mental health services. Guidance on advance agreements will be included in the Code of Practice on the new legislation.

Consent to treatment

5.16 New legislation, like the 1983 Act, will include provisions covering the use of certain specified treatments for mental disorder, and all long-term treatment without consent. The Code of Practice will include general guidance on care and treatment for mental disorder under the new legislation, including the interface between treatment of mental disorder and physical disorder.

Treatments subject to special requirements on consent

5.17 Powers in mental health legislation to require a patient to comply with care and treatment for mental disorder will not allow the clinical team complete freedom to impose care and treatment without the patient's consent. As in the 1983 Act there will be special safeguards for patients covering the procedures for use of certain treatments that are irreversible,

particularly invasive or likely to have serious side effects, or where there is no clear evidence of effectiveness. The provisions covering special safeguards on consent will provide flexibility to change the list of treatments covered, in the light of new research evidence, or if new treatments are developed. As in the 1983 Act they will cover informal patients as well as patients who are subject to compulsory care and treatment.

Treatments requiring consent and a second opinion

5.18 The 1983 Act sets out stringent safeguards in respect of psychosurgery for mental disorder. Such psychosurgery cannot be undertaken without the express permission of the patient and three people appointed by the Mental Health Act Commission, of whom one 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 not capable of consenting, or does not consent, the psychosurgery may not be undertaken.

5.19 Similar provisions will apply under new legislation, with the independent opinions provided by people from the panel of people appointed to provide expert evidence to the Tribunal. But there will be provision for the case of a patient who, because of permanent or potentially long-standing incapacity, is not able to consent to be referred to the High Court for approval if there is clear evidence that he or she might benefit from psychosurgery. Such cases are likely to be very rare.

Treatments requiring consent or a second opinion

5.20 New legislation will also make provision for certain treatments to require either the consent of the patient or the agreement of a doctor from the expert panel appointed to advise the Tribunal before the treatment is undertaken. The list of treatments covered will include electro-convulsive therapy (ECT) provided as part of a care and treatment plan.

5.21 But the Government is satisfied that ECT is a vital treatment that can save lives, particularly in cases of very severe depression. As now, clinical teams will be able to provide ECT to a patient without consent if there is an urgent need to do so in his or her best interests and it is not practicable to arrange for a second opinion. The Department of Health has asked the National Institute for Clinical Excellence to develop guidance on the treatment of resistant depression and as part of this to clarify the role of ECT and other treatment choices. The policy for safeguards in legislation will be reviewed in the light of the new guidance.

Other treatments

5.22 The Code of Practice on the new legislation will contain specific guidance on the use of certain other treatments for mental disorder. The list will include treatment with more than one drug from the same class (polypharmacy), treatments above the levels recommended in the British National Formulary,33 and certain physical treatments which may be needed as a consequence of behaviours arising from mental disorder such as procedures following serious self-harm and feeding contrary to the will of the patient.

5.23 The Tribunal, as part of its consideration of whether a care and treatment plan proposed for a patient is in his or her best interests, will consider how and to what extent the care and treatment plan takes account of any guidance in the Code of Practice on the legislation.

Requirement to seek a second opinion on long-term treatment without consent

5.24 Under the new legislation, as in the 1983 Act, there will be a limit to the length of time that a patient who is subject to care and treatment under compulsory powers may be given treatment without consent. If the plan of care and treatment includes treatment without consent the clinical supervisor will be required to arrange for a second opinion to be obtained within 3 months of the start of the care and treatment order unless the Tribunal has stipulated a shorter, or longer period.

5.25 Doctors appointed to the panel of expert advisers to the Tribunal will also undertake the function of providing second opinions under the new legislation. The function of the second opinion doctor will be to consider whether the treatment is consistent with acceptable practice in the treatment of patients with mental disorder. They will also be expected to consider whether it is consistent with the criteria for application of care and treatment under compulsory powers. The clinical supervisor will be expected to revise the care and treatment plan in the light of the second opinion doctor's advice and to make a written record of the action he or she takes.

Carers

5.26 Carers play a very important role in supporting and helping look after people with serious mental disorders. This is

recognised in the *Mental Health National Service Framework,* and standard 6 sets out clear expectations regarding their needs.34

5.27 People who are closely involved in the care of a patient with mental disorder will often be able to help a clinical team decide what care and treatment will be in his or her best interests. Carers will be defined in new legislation in a way that does not exclude a person who may play a significant role in a patient's care even though, because of the nature of his or her symptoms, this is not on a regular basis.

5.28 New legislation will place a duty on Trusts to arrange a preliminary assessment for use of compulsory powers in response to a reasonable request from a carer. Carers will have a similar right to request an assessment for those with long-term mental incapacity under procedures set out in chapter 6.

5.29 Those responsible for deciding that assessment and initial treatment under compulsory powers will be required should consult anyone who is known to be closely involved in a patient's care. The only exception would be in circumstances where emergency powers are used (see chapter 3 paragraphs 3.73ff).

5.30 The same provisions will apply during the period of assessment and initial treatment and any care and treatment order particularly if a substantial change in care and treatment provided outside hospital, or discharge from compulsory powers, is proposed. In deciding whom to consult the clinical team will be required to take account of the views of the patient, or the nominated person. Unless not to consult would pose an unacceptable risk, they will be barred from consulting anyone whom the patient has expressly stated, including in an advance agreement, should not be consulted35,36. But this would not prevent that person from offering information to the clinical team.

Information sharing

5.31 Professionals and agencies that have responsibility for patients who are subject to compulsory powers will need to share relevant information to ensure that all those involved in the patient's care and treatment are properly informed. This is particularly important where the patient is at risk of self-harm or suicide or of harming others.

5.32 It is clear that the sharing of information between agencies is greatly facilitated by the presence of a local multi-agency information sharing protocol. But in many cases these do not exist. There is a continuing reluctance on the part of health and social services agencies to share information, particularly with criminal justice agencies, notwithstanding the fact that this may be in the patient's best interest and sometimes in the public interest. This reluctance is often because of a fear of breaking professional codes of practice and the threat of litigation for breach of confidentiality.

5.33 New legislation will therefore include provisions designed to increase the confidence of relevant agencies to share information where it is necessary to do so, and to ensure that where information is shared the patient's rights and best interests are properly safeguarded. There will be a new duty covering the disclosure of information about patients suffering from mental disorder between health and social services agencies and other agencies (for example housing and criminal justice). Such a duty will be framed to ensure that information is exchanged only in certain specified circumstances and provided certain conditions are met, for example that disclosure is necessary in the best interests of the patient or to prevent a significant risk of serious harm to others.

5.34 New legislation will also place a duty on health and social services agencies to ensure that appropriate arrangements for storing and exchanging confidential patient information with other agencies are in place. Guidance in the Code of Practice on the new legislation will set out general principles that should be followed.

The following principles will be set out 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 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 risk of serious 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.

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[31] Similar provisions will apply to those patients who are subject to the special safeguards described in Chapter 6.Back

[32] *The NHS Plan* July 2000 Cm 4818-I, see paragraphs 10.17 ff.Back

[33] *British National Formulary* (British Medical Association and the Royal Pharmaceutical Society of Great Britain). The BNF provides doctors, pharmacists and other professionals with sound and up-to-date information about the use of medicines.Back

[34] All individuals who provide regular and substantial care for a person on CPA should:
* have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
* have their own written care plan which is given to them and implemented in discussion with them.Back

[35] A patient aged 16-18 would not be able to bar consultation with his or her parents.Back

[36] *The Protection and Use of Patient Information* (Department of Health March 1996).Back

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Chapter 6

Safeguards for patients treated without use of compulsory powers

6.1 Under the 1983 Act the large majority of patients who are subject to formal powers are people who resist care or treatment. But some patients who need treatment for serious mental disorder are not able, because of long-term mental incapacity, to consent to care or treatment, although they do not resist it. It is estimated that at any time there may be as many as 44,000 people37 in this category who are being cared for by specialist mental health services.

6.2 The need to consider safeguards for this group of patients was highlighted in a recent case38 concerning the care of a patient with severe learning disability.

6.3 It is neither appropriate nor necessary to make a patient with long-term mental incapacity subject to care and treatment under compulsory powers unless he or she poses a risk of serious harm to other people or resists necessary care and treatment. But, under the 1983 Act, without the use of compulsory powers, these patients do not have access to the safeguards that are available to patients who are subject to compulsory care and treatment.

6.4 New legislation will introduce a separate framework of safeguards for this group of patients to ensure that care and treatment is provided in a way that is consistent with their best interests and to bring them within the remit of the Commission for Mental Health. There will be a right to apply to the Tribunal to challenge any detention and for a review where there are concerns about the quality or nature of the patient's care and treatment.

6.5 The aim is to protect the interests of patients who, because of the nature of their mental disorder or because of other disabilities, are not able fully to express their wishes. In many cases such patients are not capable of giving voice to concerns about care and treatment through the normal complaints procedures. The focus of the safeguards will, therefore, be on the quality of care and treatment the patient receives, in particular to ensure that it is provided in an appropriate setting and without unnecessary coercion or deprivation of liberty.

6.6 The new framework of safeguards will potentially apply to any patient with long-term mental incapacity who is assessed as needing long-term care and/or treatment for serious mental disorder from specialist mental health services in his or her best interests. This might include, for example, patients with dementia, severe learning disability or brain injury. The new framework will apply to patients admitted to a hospital, or resident in a care home39 or similar establishment but not to a patient who is living independently in his or her own home, with or without the support of carers and others. The considerations that a clinical team needs to take into account in deciding what care and treatment may be in a patient's best interests will be as described in chapter 3.

6.7 Under the new legislation, where a patient appears to meet the criteria set out above, his or her clinical supervisor will be required to arrange a full assessment and develop a care plan on the basis of the Care Programme Approach and the Care Plan guidance in Wales. The plan would need to cover all aspects of care and treatment including any steps taken to restrict the patient's freedom involving locking doors or the routine administration of sedatives. Such steps will only be justifiable if they are in the patient's best interests. The assessment may be carried out in a hospital or any other appropriate establishment or facility, for example a nursing home or care home,40 where the patient is resident at the time. The clinical supervisor will be required to arrange for a doctor drawn from the panel set up to provide expert evidence to the Tribunal to examine the patient. The second opinion doctor will discuss the proposed care and treatment plan with the clinical supervisor, and if appropriate, suggest changes to it. Before finalising the plan, the clinical supervisor will be under a duty to ensure that the patient's carers and close relatives are also consulted. He or she will also be required to consult with a social care

representative who will nominate a person to represent the patient.

6.8 The clinical supervisor will be required to notify the Commission for Mental Health that a plan is being drawn up and, unless there are exceptional circumstances, finalise it within 28 days.

6.9 The clinical supervisor will be required to place on record with the care and treatment plan a note certifying that, in his or her opinion:

- the care and treatment plan is in the patient's best interests;
- that the patient is not actively resisting care and treatment; and,
- does not pose a significant risk of serious harm to other people.

6.10 He or she must also provide copies of the agreed care and treatment plan for the patient and the nominated person, and register it with the hospital or care home responsible for the patient's care and treatment. The clinical supervisor will be expected to keep the care and treatment plan under review in accordance with normal procedures under the Care Programme Approach. In the case of a patient with a learning disability and long-term mental incapacity there may be occasions when he or she is better able to understand the nature of the choices they are being asked to make in a particular situation and this should be taken into account by the clinical team. It is therefore essential that patients' needs are regularly assessed, including their capacity to make choices and decisions, so that care and treatment plans can be reviewed and updated accordingly.

6.11 At any stage, the patient or his or her representative will be able to apply to the Tribunal either to challenge detention or for a review of the care and treatment plan. This might be appropriate, where for example there were concerns about the content or whether it was being delivered in accordance with the patient's best interests. In such a case the Tribunal will be expected to commission an up to date report from a doctor drawn from the expert panel as well as considering evidence from the clinical team, the nominated person and, if appropriate, the patient's carers or close relatives. The clinical supervisor will be required to take account of any changes to the care plan suggested by the Tribunal and, if necessary, to submit a revised care plan for formal approval. However, the expectation is that any dispute would normally be resolved informally through discussion with the clinical team without recourse to the Tribunal. The patient and the nominated person will have access to support and advice from specialist independent advocates who may assist in this process (see chapter 5 paragraphs 5.105.13).

6.12 Carers will have the right to ask the patient's clinical supervisor or doctor responsible for the patient's care to undertake a formal assessment under these procedures. If the clinical supervisor accepts, then the processes outlined above will apply. If the clinical supervisor rejects the request he or she will be required to provide a written reply setting out the reasons for the decision.

6.13 Because of the potentially large number of patients who may need to be assessed under the procedures at the time new legislation comes into force, transitional arrangements will be included to enable this to take place over a period of time.

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[37] This figure which covers England and Wales is based on the information the Department of Health has been able to access from a number of sources.Back

[38] *R v Bournewood Community and Mental Health NHS Trust ex parte L* (1998) All ER319.Back

[39] "Care home" is used here to describe nursing homes and residential care homes as defined in the Registered Homes Act 1984. The Care Standards Act 2000 will, when implemented, introduce new definitions for "independent hospitals" and "care homes". Future legislation will take account of these new definitions.Back

[40] See the Care Standards Act 2000 for changes to the names and definitions of these establishments.Back

Chapter 7

Guidance on the new Act and oversight of the way it is applied

7.1 The new legislation will affect the lives of some of the potentially most vulnerable people in our society. Responsibility for applying the powers in the legislation will fall to managers of services and practitioners from many different professions working in different locations and with different levels of experience. In many cases the people who apply the powers in the legislation will have frequent experience of doing so and most will have a good understanding of what the legislation is about. In other cases the people who apply the powers will do so only infrequently.

7.2 Providers of care and treatment41 will be accountable for the quality of activity undertaken by their staff in relation to patients who are subject to care and treatment under the legislation. They will be subject to routine monitoring in certain key areas, for example compliance with the provisions of the Code of Practice, through the normal performance management arrangements that apply to all health and social care providers. This will be overseen by the Commission for Health Improvement and the National Care Standards Commission, and will usually provide an appropriate level of general quality assurance. But this type of monitoring is not sufficient to ensure protection of individual patient rights and it does not enable an appropriate level of scrutiny of activity under the legislation at a national level.

Code of Practice

7.3 The Government has a duty to provide guidance on the operation of the new legislation. This will be done, as now, through the publication of a Code of Practice covering key areas of good practice in the operation of the new law. The new Code will be an important source of information for practitioners, patients and their advisers. It will also be a key tool for those responsible for monitoring the performance of the services that provide care and treatment to patients under the new legislation the Commissions for Health Improvement and Care Standards42, the Regional Offices of the NHS Executive, and the Social Care Regions in England and Wales.

7.4 New legislation will place a duty on the Secretary of State to publish a Code of Practice and to keep it under review. It is important that the Code takes account of the views of those with a significant interest. There will, therefore, be specific requirements in new legislation covering arrangements for consultation on the content of the Code including with the Commission for Mental Health. The Code will be prepared for consultation before any new legislation comes into force.

Commission for Mental Health

7.5 The Government also has a responsibility to ensure proper oversight of the way that powers in the new legislation are used and that the people who apply the powers, or have an advisory role under the legislation, are appropriately trained. This is important in the interests of patients and their carers, and of the public.

7.6 The new legislation will make provision for the Secretary of State, in consultation with the National Assembly, to establish a Commission for Mental Health. The Commission will consist of a primarily non-executive Board with a non-executive Chairman and members representative of users, carers and the key professional bodies. Key executive staff of the Commission will also be members of the Board. The Commission will be required to provide the Secretary of State with an annual report on its work to be laid before Parliament and the National Assembly.

7.7 The Commission will be supported by full-time professional and administrative staff, based in a central office but working regionally as well as nationally. It will also be empowered to appoint people on a part-time basis working

regionally. This flexibility will provide opportunities to make best use of the experience and expertise of people who currently fulfil the role of lay managers, and Mental Health Act Commissioners under the 1983 Act. The Commission and its staff will be fully independent of the NHS Executive and its regional offices, and the NHS Directorate in Wales.

7.8 The remit of the Commission for Mental Health will be similar to that of the existing Mental Health Act Commission but without its current responsibilities for regular visiting. Instead there will be a fresh emphasis on monitoring the implementation of the safeguards which ensure that compulsory powers are properly used. It will have significant new responsibilities for collecting and analysing information, and overseeing standards of specialist advocacy and training for practitioners with key roles under the new legislation. It will also have an important role in overseeing the arrangements for care of patients with long-term mental incapacity under the new legislation.

7.9 Issues of the quality and consistency of services provided, such as the nature of the environment, access to fresh air and activities, and visiting arrangements will fall within the remit of the Commission for Health Improvement or the National Care Standards Commission. The role that the current Mental Health Act Commissioners play in alerting patients to their rights and responding to the many matters of general concern raised by patients will be taken on by the new independent specialist advocacy services. The Commission for Mental Health will, however, have an important role to play in relation to both of the other Commissions and the specialist advocacy services.

Monitoring the operation of new legislation

7.10 Effective monitoring of all aspects of the care and treatment of patients with mental disorder is essential but there is a special need to ensure that the safeguards relating to use of formal powers are properly implemented. Most activity relating to decisions under the new legislation will take place outside the formal setting of a Tribunal hearing and much of it will not be subject to routine scrutiny by anyone independent of the body responsible for providing care and treatment. Independent monitoring is essential to ensure that the objectives for mental health legislation are being met, that the impact of particular safeguards on service delivery and professional practice is properly understood, and the interface with other areas of policy is taken into account.

7.11 The Commission will have a particular remit to advise the Secretary of State on matters relating to whether the powers in the Act are being used in a way that is consistent with the key principles set out in chapter 2. The Commission will be expected to keep under review matters relating to the use of the Act in respect particularly of minority groups, children and people with long-term mental incapacity.

7.12 It will be essential that the Commission for Health Improvement, the National Care Standards Commission and the Commission for Mental Health work closely together so that they can each contribute to the others' objectives. Representatives of the Commission for Mental Health may accompany or advise performance managers, the Commission for Health Improvement or National Care Standards Commission on an inspection visit to a facility responsible for care and treatment of patients who are subject to formal powers under the new legislation. The Commission for Health Improvement or National Care Standards Commission may alert the Commission for Mental Health to any concerns of special significance to patients subject to formal powers, while the Commission for Mental Health may draw their attention to issues of quality that the specialised monitoring may have highlighted.

Guidance and support

7.13 The current Mental Health Act Commission plays a valuable role in providing general and specific guidance on the operation of powers in the 1983 Act. The Commission for Mental Health will take on overall responsibility for this function.

7.14 Patients and their carers will be able to contact the Commission but the first line of independent advice will be through contact with local specialist advocacy services (see chapter 5 paragraphs 5.10ff). The Commission will be responsible for assuring the quality of local specialist advocacy, and will provide support and advice to specialist advocates. This will ensure that the Commission is aware of issues that are being raised with advocates locally. It will also enable the Commission to bring to the attention of local advocacy services matters of concern that arise from analysis of routine data or through validation processes.

7.15 The Commission for Mental Health will not have a specific remit to investigate complaints from patients subject to formal powers but may be requested to become involved by those with responsibility for the normal complaints procedures if there are exceptional reasons for requiring a specialist independent input. Complaints raised directly with the Commission would generally be referred to the relevant specialist advocacy service so that they may be pursued through the normal channels. The specialist advocacy service will be able, if necessary, to provide the complainant with support and advice on how to proceed.

7.16 Service providers will be required to report to the Commission the death of any patient who is subject to care and treatment under compulsory powers, and the Commission will have the discretion to undertake a detailed investigation if there are particular concerns.

7.17 The Commission will publish and keep under review guidance on good practice relating to the operation of powers under new legislation on the lines of the Practice Notes published by the Mental Health Act Commission for example on use of seclusion, and treatment of people with eating disorders. The Commission will have an important role in advising the Secretary of State and the National Assembly on the content of the Code of Practice.

Training

7.18 A good understanding of the provisions and purpose of the legislation by people with key responsibilities is essential to ensuring high quality, consistent decision making. This provides a safeguard for patients and is an important element in assuring Government that the legislation is properly administered.

7.19 Under the new legislation people responsible for key decisions will be required, as a condition of appointment, to undergo initial training and regular updating on the provisions. This will include, for example, the doctors, social workers, and other mental health professionals who take responsibility for deciding on assessment and initial treatment under compulsory powers, those who act as clinical supervisors, and those responsible for authorising use of emergency holding powers. Training on the new legislation will also be a condition of appointment to the expert panel of advisers to the Tribunal, and for appointment to the Tribunal itself.

7.20 The Commission for Mental Health will be responsible for assuring the quality of training for key practitioners and people who provide specialist independent advocacy. The Commission will also be responsible, in consultation with the relevant professional bodies, for making appointments to the panel of experts appointed to advise the Tribunal and carry out the second opinion doctor function.

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[41] Including in the independent and voluntary sectors.Back

[42] See Glossary of terms.Back

Chapter 8

Conclusion

8.1 The first part of this paper has set out the Government's plans for a modern framework of mental health legislation. A framework that will enhance patient rights, assist in the delivery of high quality services, and provide the necessary support for the small number of people with mental health problems who may pose a risk of serious harm to others.

8.2 Our plans have benefited from an extensive process of formal and informal consultation. This process will continue as a draft Mental Health Bill is prepared and further definition is added to the framework we have set out here.

8.3 When Parliamentary time allows, we will introduce a new Bill consistent with the necessary resources to implement the new legislation being available. Following Royal Assent, there will need to be an appropriate period before it comes into force in order to allow for a full programme of training and other preparation to be implemented.

8.4 But we will not delay the improvements we plan in our mental health services. The Government is committed to new services, fast access to quality treatment, timely support, reduced discrimination, help for families and communities, a modern workforce, together with new patient focused legislation, as the future for mental health.

8.5 The second part of this paper sets out how changes in service provision, together with the new legislation, will impact on the management of people with mental disorder who present a high risk of serious harm.

Annex

Glossary of terms

Advance agreements

An advance agreement sets out a patient's instructions concerning his or her care or treatment. It will usually be made out when the patient has proper ability to make such decisions and is intended to be used to influence treatment when his or her judgment is impaired by mental disorder. Health professionals are not bound to follow such instructions if they conflict with their professional judgment about the most appropriate form of care and treatment, but they should give them serious consideration.

Care and Treatment Order

The care and treatment order will authorise the care and treatment specified in a care plan recommended by the clinical team. The order will be made by the Mental Health Tribunal.

Care Plan

A comprehensive care plan is prepared by a patient's clinical team following a detailed assessment of the patient's needs carried out in accordance with the Care Programme Approach and the corresponding guidance in Wales. The written care plan will address the patient's identified health and social needs.

Care Programme Approach (CPA)

The CPA provides a framework for care co-ordination of service users under specialist mental health services. The main elements are a care co-ordinator, a written care plan, and at the higher level regular reviews by the multi-disciplinary health team and integration with the social services care management.

Carers

Professional carers, relatives or friends who look after individuals who are mentally disordered. This will normally be the main carer or carers.

Civil powers

Legal powers of compulsory care and treatment authorised by the Mental Health Tribunal in civil proceedings.

Clinical supervisor

The consultant with lead responsibility for the care of a patient with a mental disorder. Normally a consultant psychiatrist, but may also include a consultant psychologist. The clinical supervisor replaces the current "Responsible Medical Officer".

Clinical Team

A multi-disciplinary team, under the leadership of the clinical supervisor, which is responsible for the assessment, care and treatment and supervision of patients.

Code of Practice

A statutory Code of Practice will provide guidance on the operation of the new legislation, and will cover the key areas of good practice. It will be an important source of information for practitioners, patients and their advisers.

Commission for Health Improvement (CHI)

CHI was set up under the Health Act 1999 to inspect all NHS organisations in a rolling programme to help drive up standards and the quality of care, and began work in April 2000. CHI is the first ever independent, external body to scrutinise standards in the NHS. CHI also has a developmental role in helping the NHS to address weaknesses through providing advice and spreading good practice more quickly and effectively than before.

Commission for Mental Health

The Mental Health Act Commission will be replaced by a new Commission for Mental Health which will look after the interests of people who are subject to the provisions of the new legislation.

Compulsory powers

The legal powers of compulsion which empower the clinical supervisor to provide care and treatment for a mental disorder in the absence of a patient's consent.

Conditional discharge

When a restricted patient is discharged from hospital subject to specified conditions and liability to be recalled to hospital by the Home Secretary.

Criminal justice disposal

A period of imprisonment or a community punishment imposed by a Court.

Criminal justice system

All the agencies responsible for the detection and prosecution of breaches of the criminal law and for the execution of the sentences of Courts. These include the police, the Crown Prosecution Service, the Courts and the probation and prison services.

Discharge

A patient will be discharged from compulsory care and treatment under the new legislation when the conditions for continued use of compulsory powers are no longer met. Discharge from compulsory care and treatment does not mean that a patient will not need continuing care but in many cases care and treatment will continue without the use of compulsory powers.

Emergency powers

Powers to detain a patient pending a preliminary examination to determine whether the use of compulsory powers is appropriate.

Expert panel

Local panels of experts from a wide variety of disciplines including general, old age, child and learning disability psychiatry and psychology. The panel will also include those with social care and mental health nursing backgrounds. Members of the panel will be of consultant grade, or, in the case of social workers or nurses, will have appropriate seniority and experience. Appointments will be made by the Commission for Mental Health.

Forensic Medical Examiner

Also known as forensic physician or police surgeon. These are doctors who attend police stations (under the provisions of the Codes of Practice issued under the Police and Criminal Evidence Act 1984) to provide medical care to detainees, victims and police officers and to carry out forensic assessments, eg to give an opinion on fitness for interview or to advise on the need to obtain support for a mentally disordered or otherwise vulnerable person.

Formal assessment

All patients coming within the provisions of the new legislation will undergo a formal assessment in accordance with the Care Programme Approach or the corresponding guidance in Wales.

Formal powers

This term covers both powers of compulsion for the resisting patient and the proposed new legal safeguards for the not-uncompliant patient.

Hospital and limitation direction

Where the court imposes a prison sentence at the same time as a direction of immediate admission to hospital (a hospital direction) together with a limitation direction (which has the same effect as a restriction order). When the offender is discharged from detention in hospital, he will be transferred to prison to serve the remainder of his sentence.

Informal care and treatment

Care and treatment is provided informally if either the patient agrees voluntarily to its provision or, in the case of those suffering from long-term mental incapacity is not actively resisting.

Information sharing

New legislation will place a duty on professionals and agencies that have responsibilities for patients who are subject to compulsory powers to share relevant information to ensure that all those involved in a patient's care and treatment are properly informed. This is often important to ensuring the patient's best interests are met. It may sometimes be necessary in the public interest.

Judicial review

The legal process by which a person may challenge a decision, for example of a Tribunal, on grounds such as unreasonableness, or procedural unfairness.

Local Health Groups

22 Local Health Groups have been set up in Wales. They are co-terminus with local authority areas. As advisory sub-committees of their Health Authority, they play a major part in the development of Health Improvement Programmes, clinical governance in primary care and in informing the commissioning of hospital and community health services.

Long-term mental incapacity

In the new legislation 'long-term mental incapacity' will be used to describe the condition of those who, as a result of a long-term mental disorder or other disability, are consistently unable to make informed choices or decisions about care and treatment for their mental disorder. The mental incapacity may be the result of severe learning disability, degenerative disease or brain injury. It will not, however, cover those whose mental incapacity is fluctuating in the sense they are able, at times, to express their views and preferences.

Mental disorder

Under new legislation this will be defined to cover any disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.

Mental Health Tribunal

A new independent Tribunal will authorise the use of formal powers beyond 28 days. The Tribunal will be required to seek advice from independent experts (from the expert panel) as well as taking advice from the clinical team and hearing the views of patients or their representatives.

Mental Health National Service Framework (NSF)

Published in September 1999, the NSF has established national standards for the care and treatment of mental illness in England. An NSF for Wales is being developed in conjunction with the new All Wales Strategy for adult mental health services.

Mental health practitioner

Qualified practitioner working in the field of mental health.

National Care Standards Commission

Provisions for the Commission were made in the Care Standards Act 2000 and it is expected to take on its regulatory responsibilities from April 2002. The Commission is an independent inspection and regulatory system for independent health and social care services.

Nominated person

A nominated person is someone who is appointed to represent a patient in discussions with his or her clinical supervisor and in other matters related to their care. The nominated person will replace the "nearest relative" under the 1983 Act and will take on some of the same functions. The patient may identify such a person in an advance agreement. In most cases, it is likely that he or she will be a close relative of the patient, or will be the main carer.

Personality disorder

A disorder of the development of personality. It includes a range of mood, feeling and behavioural disorders including anti-social behaviour.

Place of safety

Any suitable place to which a person is taken under the new legislation for the purpose of carrying out a preliminary examination.

Primary Care Trusts (PCTs)

PCTs are free-standing bodies, accountable to their Health Authority for commissioning care and responsible for the provision of community services.

Primary Care Groups (PCGs)

PCGs are groups of family doctors and community nurses with resources for commissioning healthcare. PCGs are a sub-committee of their Health Authority.

Psychiatric supervisor

A psychiatrist who is responsible for supervising an offender on conditional discharge from compulsory care and treatment in hospital. The psychiatric supervisor is currently known as the supervising psychiatrist.

Restriction Order

When, in the case of an offender, a compulsory care and treatment order in hospital is made, the court will be able to impose a restriction order where it appears necessary for the protection of the public from serious harm. The principal effect of the restriction order will be that the patient cannot be discharged from hospital without the consent of the Home Secretary or that of the Mental Health Tribunal in accordance with certain statutory criteria. It also means that the Home Secretary's consent is needed for the patient to be allowed out of hospital either for short periods or to move to another hospital.

Restriction Direction

When transferring a prisoner from prison to hospital for compulsory care and treatment, the Home Secretary may, and in most cases will, also impose a restriction direction, so that the patient cannot be transferred to another hospital, sent on leave or discharged without his consent.

Restricted patient

A patient subject to a restriction order or restriction direction.

Second opinion approved doctor

A psychiatrist appointed by the Commission for Mental Health to provide a second opinion, as required by legislation, on the continued use of medication in the face of a patient's persistent objection or, providing the special safeguards in respect of patients with long-term mental incapacity who do not resist treatment. He or she also provides a second opinion on the use of treatments requiring special safeguards such as psychosurgery or the use of electro-convulsive therapy.

Social supervisor

A social worker (or in some cases, a probation officer) who is responsible for the supervision of an offender on conditional discharge from compulsory care and treatment in hospital.

Specialist mental health service

Care and treatment for a mental disorder which is provided under the management of a clinical supervisor.

Tariff

The period of a life sentence to be served to meet the requirements of retribution and deterrence before a prisoner is eligible for release on life licence.

Therapeutic benefit

The concept of therapeutic benefit will cover improvement in the symptoms of mental disorder or slowing down deterioration and the management of behaviours arising from the mental disorder.

Transfer direction

A warrant issued by the Home Secretary, following medical recommendations, directing that a prisoner be transferred to a named psychiatric hospital for compulsory care and treatment.

Urgent treatment

Any treatment that needs to be provided immediately, in the best interests of the patient and which cannot await the development of a care plan.