© Crown Copyright
Produced by Department of Health

22692 1p 2.5k Nov 00 (ESP)

CHLORINE FREE PAPER

Further copies of this document are available free from:
Department of Health, PO Box 777,
London SE1 6XH.

Or you could call the NHS Response Line
on: 0541 555 455

It is also on our website on: www.doh.gov.uk/mentalhealth.htm

DH Department of Health

Summary of consultation responses

Introduction

1. In November 1999, the Government published **Reform of the Mental Health Act 1983** *Proposals for Consultation*, in print and on the Department of Health's web-site. The report of an Expert Committee[1] established by the Government to advise on reform was published at the same time.

2. 13,000 printed copies of *Proposals for Consultation* were issued and over 12,000 visits made to the web-site document. The consultation period ended on 31 March 2000. Over 1,000 individuals, local statutory and other organisations, and national bodies in England and Wales made separate responses. A table summarising the source of responses is at Annex A.

3. The *Proposals for Consultation* set out 21 consultation points. The responses to each point are summarised below. Some other issues raised in the consultation are also covered at the end of this document. As a summary, it cannot reflect all the views of all respondents, although, where the respondent has granted permission, a copy of each individual response has been placed in the Libraries of the House of Commons and the House of Lords.

4. The responses to the *Proposals for Consultation* will be taken into account when the Government publishes its proposals for legislation in a White Paper later this year.

[1] *Report of the Expert Committee: Review of the Mental Health Act 1983*, Department of Health 1999

Responses to consultation points

Consultation point A: The Government would welcome views on whether the inclusion of principles would aid the interpretation of a new Mental Health Act and on the list of principles proposed[2].

5. 441 (97%) of the 460 people and organisations who responded to this point were in favour of the inclusion of principles within a new Mental Health Act.

6. The list of principles set out in the Green Paper received explicit support from some national bodies and criticism from others – some were against the inclusion of particular principles, for example on safety.

7. Many national bodies suggested the inclusion of additional principles, some previously proposed by the Expert Committee, including:

- reciprocity
- non-discrimination
- consensual care
- patient autonomy
- the carer's role
- least restrictive alternative
- respect for diversity
- patients' health or welfare
- participation
- equality
- informal care
- effective communication
- effective treatment
- the provision of information to patients.

[2] The principles proposed in the Green Paper were:
- Informal care and treatment should always be considered before recourse to compulsory powers;
- Patients should be involved as far as possible in the process of developing and reviewing their own care and treatment plans;
- The safety of both the individual patient and the public are of key importance in determining the question of whether compulsory powers should be imposed;
- Where compulsory powers are used, care and treatment should be located in the least restrictive setting consistent with the patient's best interests and safety and the safety of the public.

Consultation point B: The Government accepts the Committee's recommendation[3] in principle, but would welcome comments. In particular, what are the advantages and disadvantages of including a more specific definition of mental disorder:

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

[3] ie for a broad definition of mental disorder to be included in a new Mental Health Act

8. 298 (72%) of the 415 people and organisations who responded to this point supported a broad definition of mental disorder within a new Act However, some national bodies wanted specific exclusions – for example, personality disorder and learning disabilities – or a much narrower and explicit definition.

9. Many national bodies thought a broad definition would require well defined criteria in application in order to avoid a substantial increase in the use of compulsory powers. The view was also expressed that the terms 'nature' and 'degree' should be retained so that the threshold for the use of compulsory powers could be made clear.

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

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

10. 364 (75%) of the 487 people and organisations who responded to this point considered that the applicant for admission should be an Approved Social Worker (ASW) or that ASWs should provide one of the recommendations for the use of compulsory powers. Most national bodies responding disagreed, some suggesting that another mental health professional with similar specialist training would be as appropriate.

11. 150 (86%) of 174 people and organisations responding on the issue wanted any application to continue to have two other supporting opinions. Some national bodies considered that there should be two medical recommendations, one of which should be from the patient's GP, wherever possible.

12. A statutory right to assessment had support from some national bodies, including such a right for prisoners. The view was expressed that this should extend to a statutory right to *treatment*. It was also suggested that the existing provision[4] for the nearest relative (or the patient's carer) to be able to require a patient's assessment should be retained, together with an obligation for the relevant person to be made aware of it.

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

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

13. 156 (47%) of the 330 people and organisations who responded to this point thought a period of 24 hours sufficient to ensure assessment, including most NHS organisations responding. There were mixed views from national bodies responding on the appropriate period of time, ranging from 24 hours to the current 72 hours. 81 (84%) of the 96 people and organisations responding on the issue were in favour of the involvement of two professionals in emergency situations outside a hospital mental health unit.

14. 230 (91%) of the 253 people and organisations responding on the issue wanted the ward manager's (nurse's) holding power of six hours to be retained.

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

15. 212 (53%) of the 399 people and organisations who responded to this point thought there should be an independent review within 7 days of the commencement of assessment, though most NHS bodies and psychiatrists responding differed. The view was expressed by some national bodies that any such review should be carried out by the psychiatric or other mental health professional, rather than legal, member of the tribunal.

16. Suggested alternative measures included the proposed expedited tribunal hearing, although there was a view that this should only consider whether or not the assessment was necessary. This would then

4 Section 13(4), Mental Health Act 1983

avoid the disincentive of bringing forward possible imposition of a compulsory care and treatment order.

Consultation point F: The Government would welcome comments on the three models proposed by the Committee[5]. We would also welcome views on the alternative model proposed in paragraph 40 above[6].

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

17. 223 (69%) of the 324 people and organisations who responded to this point favoured tribunal model 2 or variations of it. Some national bodies supported other models.

18. Only 42 (17%) of the 241 people and organisations responding on the issue thought a one-person tribunal sufficient to take decisions in respect of uncontested cases. Some national bodies were concerned at the suggestion that oral hearings might be considered unnecessary in such cases.

19. Some national bodies were concerned at the possibility of the same tribunal being able both to confirm the use of compulsory powers and also be responsible for authorising discharge from them.

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

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

[5] The Committee suggested three models for the structure of the new tribunal:
Model 1
1 legal Chair
1 psychiatrist, who does not conduct assessment
1 member with experience of mental health services
Independent doctor with specialist qualification in psychiatry drawn from approved pool to assess patient and report to the tribunal
Model 2
1 legal Chair
2 members with experience of mental health services
Reference to a panel of doctors, and access where necessary to a panel of people with social care expertise.
Model 3
Single person panel likely to be specialist lawyer
Reference to a panel of doctors, and access where necessary to a panel of people with social care expertise.

[6] ie a single person tribunal

20. There were mixed views from the 376 people and organisations who responded on the advantages and disadvantages of models with and without a capacity test, with 195 (52%) in favour of a capacity-based model. Most patient organisations responding were in favour.

21. Only 44 people and organisations said whether taking capacity into consideration would lead to a change in the number made subject to formal compulsion, but 32 (73%) thought the number would increase.

22. Of 85 people and organisations responding on the issue, 48 (56%) were in favour of dealing with issues of capacity in the Act itself, although most national bodies responding were against.

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

23. 192 (41%) of the 467 people and organisations who responded to this point considered that the proposals outlined in the Green Paper for compulsory care and treatment in a community setting were practical.

24. Most national bodies responding believed proposals for compulsory care and treatment in the community could be made to work if certain conditions were met. Conditions suggested included:

- sufficient resources for community services
- compulsory medication only to be given in appropriate clinical settings
- arrangements to be in place for a patient's non-compliance with the care plan to result in rapid compulsory admission to hospital
- powers to be available for avoidance of unnecessary hospital admission as well as post-discharge
- clarification of the role of GPs
- the views of the patient and carers so far as possible to be taken into account in determining the arrangements under the order
- sufficient availability of suitably trained paramedics.

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

25. 130 (42%) of the 311 people and organisations who responded to this point considered tribunals should have exclusive power to discharge

compulsory orders unless they chose to leave this responsibility to the clinical supervisor. Other views expressed by national bodies included that delegation should be to the care co-ordinator rather than clinical supervisor; that GPs should be involved in discharge planning; that the right of discharge by nearest relatives (or nominated representative) should be maintained; and that there should be an appeal procedure available to those responsible for after care.

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

26. 197 (83%) of the 236 people and organisations who responded to this point were in favour of a single power to order assessment and treatment. Some national bodies felt that this power should be extended to magistrates. The view was expressed that the current power of the Crown Court to make the patient subject to an order where there has been no trial should be removed.

27. Some national bodies expressed the view that there should be a separate comprehensive review of all provisions relating to mentally disordered offenders.

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

28. 186 (81%) of the 231 people and organisations who responded to this point were in favour of the court having power to grant leave of absence to a patient remanded for assessment and treatment. The view was expressed that this should only be done with the agreement of the patient's usual clinical supervisor.

29. Provision for the court to decide, when the remand order is made, whether or not the power to grant leave of absence should be delegated to the patient's clinical supervisor received support from several national bodies.

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

30. 171 (93%) of the 184 people and organisations who responded to this point supported the existing legal arrangements for transferring prisoners to hospital for compulsory care and treatment for mental disorder, although some national bodies expressed concern about current implementation. Some expressed the view that prison governors should be empowered to direct transfer to hospital of prisoners who on the evidence of three professionals met the requirements for compulsory assessment.

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

31. 240 (72%) of the 333 people and organisations who responded to this point supported the extension of police powers to cover cases where a person who appears to be in need of medical treatment is found by the police when they have legitimately entered private property.

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

32. 257 (87%) of the 295 people and organisations who responded to this point were in favour of an early gatekeeping assessment where necessary for people in police custody. There were mixed views on whether this assessment needed to take place in a clinical setting.

33. The view was expressed that the police should be encouraged to pursue charges against mentally disordered offenders.

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

- **Should the use of ECT be controlled as the Committee suggest[7]?**
- **Should it ever be imposed on any patient who retains capacity and is not consenting?**
- **Must the express approval of the tribunal through its medical member be obtained before ECT is administered to patients without capacity, whether under a compulsory order or not?**
- **Should ECT be available under provisions covering urgent treatment?**

34. 220 (67%) of the 327 people and organisations responding on the issue were against imposition of ECT (Electro-Convulsive Therapy) on patients with capacity who refuse consent, although most local NHS organisations, and some national bodies, responding thought this should be an option in some circumstances, for example in emergencies.

35. 201 (69%) of 291 people and organisations responding on the issue supported the need for the tribunal's medical member – or the full tribunal – to give express approval in all cases before ECT was administered to all patients without capacity. Most NHS and local government organisations responding thought this unnecessary.

36. 164 (55%) of 297 people and organisations responding on the issue considered ECT should be available under provisions covering urgent treatments, with most NHS and local government organisations in favour.

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

37. Criteria for treatments to have special safeguards imposed suggested by national bodies included:

- invasiveness or intrusiveness
- potential harmful effects and their permanence
- evidence-based guidance
- public controversy.

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

38. There was support for special safeguards for:

- polypharmacy (172 people and organisations)
- doses above the BNF (British National Formulary) recommendation (147)
- ECT (134)
- long term medication (107)
- feeding against a patient's will (95)
- neurosurgery
- hormone treatment.

There was also some *opposition* to special safeguards for ECT (39 people and organisations) and long term medication (53).

39. Some national bodies thought that safeguards for ECT and other specified treatments should apply to informal patients as well as those subject to compulsory powers.

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

40. There were mixed views on the appropriate time to bring in a second opinion doctor. The largest proportion, 95 (45%), of the 209 people and organisations who responded to this point, favoured the existing three month period.

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

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

41. 160 (62%) of the 259 people and organisations who responded to this point thought only emergency treatment should be used during the initial assessment phase for patients who were not previously known. However, some national bodies thought that all treatments should always be available.

42. 139 (75%) of 185 people and organisations responding on the issue wanted the care team to be able to go beyond emergency treatment as soon as an interim care plan had been drawn up. Some national bodies thought the plan should first be approved by an independent reviewer or the tribunal.

Consultation point S: The Government would welcome views on how this recommendation[8] might be implemented:

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

43. Provision for the identification of a 'nominated person' received substantial support.

44. Suggestions from national bodies for the criteria the tribunal should use to appoint a nominated person for an incapable patient included:

- the capability of the nominated person
- the best interests of the patient
- Section 26 of the 1983 Act (which defines 'relative' and 'nearest relative')
- the views of the patient's carers, and care team
- absence of a professional role in relation to the patient
- prior knowledge of the patient
- the applicant's status.

45. There was support from some national bodies for the provision of – or statutory right to – independent advocacy for patients subject to compulsion. Some national bodies supported the use of advance agreements or wanted them to be given specific statutory recognition.

Consultation Point T: The Government would welcome views on whether the principles outlined by the Committee[9] are the best way to achieve the right balance between confidentiality, the patient's health and welfare and the protection of others?

46. 275 (97%) of the 283 people and organisations who responded to this point supported the application of the principles outlined by the Expert Committee in relation to sharing information.

---

[8] ie for a new Act to make provision for the identification of a 'nominated person'

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

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

47. 239 (90%) of the 266 people and organisations who responded to this point wanted victims and their families to be given information in line with the Victims' Charter in relation to restricted patients who had committed serious, violent or sexual offences. There were concerns from some national bodies about possible witch-hunts or misuse of information and that a review of decisions to release information should be available to all patients.

Other issues

Children

48. Some national bodies drew attention to confusion caused by, and the need to dovetail with, overlapping provisions of the Children Act 1989. Views were also expressed that there was a need for separate statutory provisions for children, encompassing the appointment of a *guardian ad litem* in all cases where compulsion was under consideration; that the relationship between parents and the nominated person should be taken into account; and that links to the youth justice system should be made.

Patients with long-term mental incapacity

49. Some national bodies expressed the view that the needs of so-called "Bournewood" patients needed to be properly addressed, including separate incapacity legislation, as soon as possible.

Mental Health Act Commission

50. Views were expressed by some national bodies that the Mental Health Act Commission's role should be extended to cover informal patients, to those who lack capacity, and to prisoners referred to and awaiting transfer. Scotland's Mental Welfare Commission was also put forward as a model.

Annex A
Summary of consultation respondents

individuals	**411**
user/carer/support	190
psychiatry	60
other medical professional	8
social worker	49
other professional	38
legal	25
criminal justice	1
other	40
local organisations	**487**
user/carer/support	93
Community Health Councils	57
psychiatry	19
other medical professional	2
social worker	37
other professional	26
legal	11
criminal justice	4
NHS (Trusts/Health Authorities/PCGs)	140
local government (LAs/SSDs/District Councils)	85
other	13
national bodies	**77**
user/carer/support	17
psychiatry	1
other medical professional	5
other professional	13
legal	6
criminal justice	5
other	30

nb. a further 50 respondents have not been included within the analysis in this summary document as they did not address the specific consultation points