Health & Social Services Committee **HSS(2)-12-04(p.3)**

Date: **Thursday 14 October 2004**
Venue: **Committee Rooms 3&4, National Assembly for Wales, Cardiff Bay**
Title: **Draft Mental Health Bill - Response from the Royal College of Psychiatrists**

The Royal College of Psychiatrists:

Evidence submitted to the Joint Committee on the Draft Mental Health Bill

> **"The whole picture (on the provision of care and treatment) is distorted by the use or prospect of compulsion, which deters people from seeking treatment, denies them the right to choose the treatment they want, and prioritises certain kinds of patient in the offer of services."**
> Baroness Hale of Richmond, Sieghart lecture, British Institute of Human Rights 2004

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SUMMARY OF KEY ISSUES

- Reform of mental health law can only play a small part in improving patient care:
    - reducing stigma and discrimination,
    - enhancing awareness within society,
    - ensuring an adequate and well trained workforce and
    - access to a range of psychological and medical treatments

  are all far more important in improving mental health (including issues of safety).

- The legal framework for non-consensual treatment for the mentally ill should:
    - mirror that for the physically ill as closely as possible. There is no place, in the 21st Century, for forcing treatment which they do not want on people who retain full decision-making capacity.
    - ensure the Government's intention not to increase the number of patients subject to compulsion is realised. The proposed definition of Mental Disorder is only workable if the conditions for compulsion are restricted.
    - not be used solely for the control of social, or anti-social, behaviours, in a health service, unless there is a health need and benefit.
    - be consistent between different parts of the United Kingdom.

- A Mental Health Act should not:
    - have an adverse effect on voluntary patients either by making them fear using services or by limiting the services available for such patients due to an increase in resources for those subject to compulsion.
    - have an adverse effect on the safeguards for compelled patients because staff requirements cannot be met.
    - require practitioners to have to balance the ethical principles of their profession against compliance with the law.

- A Mental Health Act should:
    - be understandable to practitioners.
    - in relation to children and young people, involve psychiatrists and other professionals, including lawyers, with expertise in working with children.

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and Ireland. The College is pleased to be afforded the opportunity to present written and oral evidence to the Committee.

The Royal College of Psychiatrists is a member of the Mental Health Alliance.

SUMMARY OF KEY RECOMMENDATIONS

1. The draft Codes of Practice must be made available, along side the draft Bill, in order to fully to understand the provisions of the Bill

Question 1

2. Principles should include: non-discrimination, respect for diversity, respect for personal autonomy, informal care where possible, reciprocity, least restrictive alternative, patient participation and consensual care where possible, respect for carers, patient benefit, child welfare.

Question 2

3. The definition of mental disorder in the draft Mental Health Bill is satisfactory ONLY if combined with extremely tight conditions and limitations. Otherwise either the New Zealand or Australian definitions of mental disorder should be adopted.

4. The Bill should contain the following exclusions: Nothing in the conditions for compulsion shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder solely by reason of: cultural, political or religious beliefs or promiscuity, sexual deviancy or other immoral conduct or dependence on, or misuse of alcohol or drugs or impairment of intelligence or the commission, or threat, of illegal or disorderly acts.

5. Use of the Act should be prohibited in cases where the capacitous patient willingly accepts assessment and treatment as recommended by the medical practitioner.

6. Patients who lack decision-making capacity must not be excluded from receiving treatment because they resist treatment and yet present only moderate risk to their health.

7. There should be two important additional conditions for compulsion in the draft Bill:
    a. Impaired decision-making by reason of their mental disorder.
    b. In relation to a treatment order: Therapeutic benefit for the patient.

8. Community Treatment Orders should be available for patients only on authorisation of the Tribunal after a period of in-patient assessment and whilst the person suffers impaired decision-making by reason of their mental disorder. Leave of absence powers enable assessment and treatment in the community during the assessment period.

Question 3

9. A Tribunal should not be permitted to authorise a treatment order if it is hearing an appeal within the first 14 days of the period of assessment.

Question 4

10. Compulsion should only be possible, other than in an emergency, if two doctors certify that the patient suffers from a mental disorder satisfying the conditions.

11. Clinical supervisors must be qualified to assess if a person meets the conditions for compulsion in order to be able to keep under review if the conditions continue to be met.

12. The Mental Health Tribunal should be permitted to authorise specified medical treatments only if they are agreed as necessary by both the clinical supervisor and medical expert panel member.

13. There should be no limitation of the right to discharge by the Clinical Supervisor for patients detained under civil sections. The College would also wish those rights (and

associated limitations) currently available to the nearest relative to be available to the nominated person.

14. Transfer between hospitals should require consultation, other than in an emergency, but without specific time limits.

Question 5

15. Medical treatment, provided it is not irreversible or hazardous, may be given under the direction of a registered medical practitioner, within the first 5 days, if it is necessary to alleviate, or prevent a deterioration, in the patient's condition.

Question 6

16. Safeguards, both legal and clinical, for persons under 16 years of age must be re-evaluated.

17. Changes to the medication plan after 28 days should be authorised by a medical member of the Expert Panel, with similar requirements to consultation as specified. If a full Tribunal was to be required there is a real danger that either:
    a. necessary changes in medication would be significantly delayed leading to prolonged suffering and increased risks or
    b. the initial treatment plans authorised would be very broad giving limited or no protections to the patient.

18. It should be clear from the legislation, or Code of Practice, that one option for a care plan presented to a Tribunal would include the statement that identified treatments will only be given with the patient's consent (subject to an emergency treatment clause).

19. Electro-convulsive therapy (ECT) should only be prescribed by qualified psychiatrists. There should be no compulsory ECT in the face of the refusal of a capacitous patient. The current provision in relation to surgery for mental disorder (requiring capacitous consent) should not be extended.

Question 7

20. The College believes the principles underpinning the legislation should be on the face of the Bill, as with the Mental Capacity Bill.

Question 8

21. The rights, and safeguards, for patients should be the same under the Mental Capacity and the Mental Health Bills.

Question 9

22. The Mental Health Act for England and Wales must meet the requirements both of Human Rights legislation and the recommendations of the Council of Europe.

Question 10

23. Further research is required to assess the realistic likely impact of the proposals, on the workforce, in relation to numbers, recruitment and morale.

Additional information

24. A review of the of the Bill's workforce and service impact in Wales should be undertaken.

25. The principles and essential provisions of mental health legislation should not differ significantly between different parts of the United Kingdom.

INTRODUCTION

Reform of mental health legislation must be set in context. Improving patient care (including issues of safety) depends on a range of measures. First it must relate to reducing stigma and discrimination. Enabling people to feel able to seek help early, to talk about their fears and difficulties, without fearing scorn, humiliation or loss of status, freedom, job and friends would result in a marked improvement in care. Secondly we cannot escape the need for resources including an adequate, well-trained workforce and access to a range of treatments including psychological therapies and new generation of medications. Patient choice and involvement in their own care and treatment is as important in psychiatry as any other part of the health service. Thirdly all law in relation to healthcare should exist to enable patients to receive treatment, within a clear legal framework, to improve personal health and well-being, to protect against abuse and, through these measures, to increase the health and safety of the nation.

The College has welcomed the many important Government initiatives (including making mental health a priority, the NHS plan, the National Service frameworks, the additional financial investment, the Mental Capacity Bill, the Disability Discrimination Bill and the report on social exclusion report) in mental health

Against this background the College welcomes reform of the Mental Health Act. The provisions of the current Act (based on the recommendations of the Royal Commission which set the framework for both the 1959 and the current Mental Health Act) have fulfilled their functions very well. Nonetheless the practice of psychiatry (new treatments, more multi-disciplinary working, much greater patient and carer involvement) and the expectations and aspirations of patients, their families and staff have changed substantially. Medicine as a whole, of which psychiatry is an integral part, has recognised the central importance of both patient choice and the patient/doctor partnership in decision making. Discrimination and stigma are unacceptable and their elimination must be our goal.

One of the unexpected changes, since the introduction of the 1983 Act, is the doubling in the number of patients detained under the Act. There is no suggestion of an equivalent increase in rates of severe mental illness. Likely explanations include the Nation's reduced tolerance of risk, the climate of blame within which mental health professionals work and the reduction in number of acute psychiatric beds. Psychiatrists are increasingly reluctant to risk their reputation, and perhaps their career, by respecting a patient's choice if there is ANY risk in that decision (this is particularly important in the light of the conditions for compulsion in the draft Bill).

The Royal Commission (Percy Commission) of the 1950s helped frame mental health legislation which led the world in reinforcing enlightened psychiatric practice. New legislation should do the same for the 21st century. Clinical discretion and a Code of Practice cannot rescue a bad Mental Health Act.

A significant question, as described in the report of the Joint Committee on the draft Mental Incapacity Bill, is whether or not it is either necessary or appropriate to have separate legislation for those suffering from mental disorder (given the Government's intention to pursue both bills we acknowledge it is their view that separate legislation is warranted). The Mental Capacity Bill sets out a legal framework for the health and social care of those who are unable to make decisions for themselves. The College believes the principles and provisions of this Bill will significantly aid the care, treatment and safeguards for a vulnerable section of the community. The final provisions of the Mental Capacity Act are not currently decided.

The need for, and content of, a Mental Health Act will clearly depend, in part, on the provisions of the Mental Capacity Act. It is essential therefore that, as has recently taken place in Scotland, the capacity legislation should be passed prior to the introduction of any Mental Health Bill.

It is essential that the proposed Codes of Practice are available if the provisions and likely effects of this Bill are to be fully understood.

Recommendation
The draft Codes of Practice must be made available, along side the draft Bill, in order to fully to understand the provisions of the Bill.

Question 1. IS THE DRAFT MENTAL HEALTH BILL ROOTED IN A SET OF UNAMBIGUOUS BASIC PRINCIPLES? ARE THESE PRINCIPLES APPROPRIATE AND DESIRABLE?

"Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world".
United Nations declaration of Human Rights 1948

"The use of compulsion also raises some more fundamental questions about discrimination between people with mental disorders and everyone else. Why should the conditions for treatment for mental disorder be different from the conditions for treatment for physical disorder? In other words, why should not this too depend upon consent or incapacity? And why should capacitated people be able to make advance directives about treatment for future physical disorder but not about treatment for future mental disorder? If incapacity were the criterion, rather than the severity of symptoms or the prospect of harm to others, then some people might be given the help they need before their situation became too desperate."
Baroness Hale 2004

1) It must be consistent with the Human Rights Act 1998 which embodies the European Convention on Human Rights (ECHR).
2) It must be recognised that legislation in relation to health care may, like medication, do harm as well as good. The Hippocratic Principle of "first do no harm" should apply in the field of legislation as in any other medical intervention. Harm may be done to the patient (in terms of reducing personal autonomy, breaching individual liberty, damaging health, social or employment prospects) or to the population at large (by increasing stigma and discrimination). It may also cause harm by damaging both the professional and public perception of psychiatry, which in turn would impact adversely on recruitment to an already heavily under-recruited specialty
3) The Expert Committee set up to review the Mental Health Act 1983 (Richardson Committee) in its report of November 1999 included the following underlying principles:
    a) Non-discrimination (that wherever possible the principles governing mental health care should be the same as those which govern physical health).
    b) Patient autonomy.
    c) Informal care wherever possible.
    d) Least restrictive alternative.
    e) Consensual care.
    f) Participation by service users.

g) Reciprocity (where society imposes an obligation on an individual to comply with a programme of treatment and care it should impose a parallel obligation on the health and social care authorities to provide appropriate services).
h) Respect for diversity.

Non-discrimination as between those suffering between mental and physical illnesses is a central area of concern (and being addressed in a number of areas such as the proposals in the Disability Discrimination Bill). The Joint Committee on Human Rights when reviewing the draft Mental Health Bill stated, "we have doubts about whether it should be possible to override the wishes of the patient, expressed when capable of making a decision, about treatment. The ECHR permits treatment to keep a person alive against his or her will, if he or she is suffering from a mental disorder at the time, because the state can rely on its positive obligation to preserve life. The same duty would justify the state in compulsorily providing treatment to someone who would otherwise be likely to cause death or serious harm to others. But we have doubts as to whether this duty would justify overriding a direction given with proper capacity where the patient later became ill, but not a threat to himself or others."

If proper regard is given to advance directives by people capable of making them, then it would clearly be nonsense for directions given by a capable person, at the time the decision needs to be made, to be disregarded.

Finally, any new Act must not have an adverse effect on voluntary (consenting) patients e.g. by limiting the amount of resource available for such patients or by directing services and resources in such a way that there will be access to resources without cost for compelled (detained) patients but at a cost for those who willingly accept treatment.

Specified principles should include:

Recommendation
Non-discrimination, respect for diversity, respect for personal autonomy, informal care where possible, reciprocity, least restrictive alternative, patient participation and consensual care where possible, respect for carers, patient benefit, child welfare.

Question 2 IS THE DEFINITION OF MENTAL DISORDER APPROPRIATE AND UNAMBIGUOUS? ARE THE CONDITIONS FOR TREATMENT AND CARE UNDER COMPULSION SUFFICIENTLY STRINGENT? ARE THE PROVISIONS FOR ASSESSMENT AND TREATMENT IN THE COMMUNITY ADEQUATE AND SUFFICIENT?

A) DEFINITION OF MENTAL DISORDER

Current position (Mental Health Act 1983)

Mental disorder is sub-divided into four categories: mental illness, mental impairment, severe mental impairment and psychopathic disorder. The major category (over 80%) of detentions is mental illness and this is undefined. The absence of a definition, along with guidance from the Courts, has enabled a practical and developmental use of the category to ensure that when patients are described as mentally ill it is in line with developing practise.

In relation to learning disability, the definitions in the current Act for mental impairment and severe mental impairment include the requirement for the person to have "abnormally aggressive or seriously irresponsible conduct" in addition to having a learning disability.

The draft Mental Health Bill defines mental disorder as “an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain”. This is the same definition as in the Mental Capacity Bill and includes neurological and other physical causes of brain dysfunction including intellectual impairment, head injury, multiple sclerosis and so on. Whilst it is clear that this would not result in any inappropriate exclusions it undoubtedly gives the potential for serious over inclusion. If such a broad definition is to be used then it is imperative that the conditions for compulsion, including exclusion conditions, which follow this definition, must be extremely strict, a matter overlooked in the 2004 draft Mental Health Bill.

It should be noted that in New Zealand and Australia (countries quoted by the Government because of their use of community treatment orders) there is a much narrower definition of mental disorder.

New Zealand – Definition of Mental Disorder

“An abnormal state of mind shown by delusions or disorders of mood, perception, volition or cognition.

Australia , New South Wales – Definition of Mental Disorder

“Mental illness means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

a) Delusions
b) Hallucinations
c) Serious disorder of thought form
d) A severe disturbance of mood
e) Sustained or repeated irrational behaviour indicating the presence of one or more of the symptoms referred to in paragraphs a-d

RECOMMENDATION
The College believes the draft Mental Health Bill definition to be satisfactory ONLY if combined with extremely tight conditions and limitations, as described below. Otherwise either the New Zealand or Australian definitions of mental disorder should be adopted.

EXCLUSIONS FROM DEFINITION OF MENTAL DISORDER

Most definitions of mental disorder have a number of exclusions. Indeed the College is not aware of any mental health act which has no exclusions from the definition of mental disorder, or required conditions for compulsion, in any other common-law jurisdiction. For example the current Mental Health Act (1983) states that people may not be “dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs”.

The Draft Mental Health Bill has no exclusions.

Scotland ((Mental Health (Care and Treatment) Scotland) Act 2003 – Exclusions

"A person is not mentally disordered by reason only of any of the following;

a) Sexual orientation
b) Sexual deviancy
c) Transexualism
d) Transvestism
e) Dependence on, or use of alcohol or drugs
f) Behaviour which causes, or is likely to cause harassment, alarm or distress to any other person
g) Acting as no prudent person would act

New Zealand – Exclusions

"That persons political, religious, or cultural beliefs; or that persons sexual preferences; or that persons criminal or delinquent behaviour; or substance abuse; or intellectual disability.

Australia, New South Wales – Exclusions

"Certain words or conduct may not indicate mental illness or disorder. A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following;:

a) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief
b) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief
c) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy
d) That the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation
e) That the person engages in or refuses or fails to engage in or has engaged in or refused or failed to engage in a particular political activity
f) That the person engages in or refuses or fails to engage in or has engaged in or refused or failed to engage in a particular religious activity.

RECOMMENDATION
The Bill should contain the following exclusions:

Nothing in the conditions for compulsion shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder solely by reason of: cultural, political or religious beliefs or promiscuity, sexual deviancy or other immoral conduct or dependence on, or misuse of alcohol or drugs or impairment of intelligence or the commission, or threat, of illegal or disorderly acts.

Drug and alcohol misuse

The issue of excluding from compulsion 'solely by reason of misuse of drugs or alcohol' is more contentious than the other exclusions. There is little doubt that in the past there has, at times, been a misunderstanding of this provision. A small number of patients who should have been detained were not on the grounds of their substance misuse despite the presence of serious mental illness. This is a matter for training. It is the College's view that including compulsion solely due to alcohol or drug misuse will have significantly damaging consequences in the following areas:

Clinical: A central tenet for the treatment of people who misuse substances is the acknowledgement of their difficulties and the need to accept responsibility for them. Taking control away and making others responsible for their behaviour may seriously damage the prospect of recovery. Patients with drug and alcohol problems do not generally see themselves as 'mentally ill'. Many, for example, will not attend psychiatric hospitals specifically because of the inferred 'label' of a psychiatric disorder. The addiction services have developed widespread community-based services so as to increase access and the availability of services to those with drug and alcohol problems. Fear of being made subject to compulsion is likely to discourage people coming forward for treatment and to be a major retrograde step in the addiction field. It may also lead to a decrease in patients presenting for help to statutory services, with an increase in the number of complex cases attending non-statutory agencies. This could have implications in terms of management of the more complex problems.

Resources: The mental health resources, including new teams being developed under the National Service Framework such as Crisis Teams, would be overwhelmed by drug and alcohol consumers' emergency assessments and admissions. These individuals may only be intoxicated for one night, but still trigger the proposed new system to detain them. This will have considerable resource implications for Accident and Emergency units and out of hours assessments in police custody suites, as well as mental health on call services. It is not appropriate to apply a Mental Health Act to a person with intoxication.

Inpatient units: In the care of people with substance misuse or dependence, use of the Mental Health Act (and, in the absence of consensual treatment, detention would be necessary) is likely to be detrimental to their care. Individuals with chronic drug and alcohol problems if admitted compulsorily into mental health wards may also pose difficulties for other patients through damaging the therapeutic environment for those with functional mental illness.

Learning Disability

The College proposes that people with a learning disability should only be liable to compulsion under the Act if they have a mental disorder in addition to their learning disability. The use of the 'impairment of intelligence' exclusion condition should enable this. It is Government policy, as set out in 'Valuing People', that people with learning disability should access services in the same way as anyone else, and this proposal would achieve that aim.

If the 'impairment of intelligence' exclusion is not included, then the definition of mental disorder in the draft Bill would include almost all people with learning disability, who would then be liable to compulsion at any time they decline medical treatment (including education and training). Leaving aside the serious ethical issues, this would lead to the inappropriate detention of more people with learning disability, and the growth of institutional care. This would not be in keeping with the aims of 'Valuing People'.

Illegal or disorderly acts

Most people with mental disorder do not commit offences. Most offenders do not suffer from a mental disorder. Diagnosing mental disorder solely on the basis of illegal acts, or for the prevention thereof, would enable this legislation to be used for political purposes. Any possible perception of this would be extremely damaging to psychiatry, the mental health services and the law.

B) CONDITIONS FOR TREATMENT AND CARE UNDER COMPULSION

Current position (MHA 1983)

The current conditions are that it is necessary for the person to be in hospital (this immediately defines the severity of the patient's condition which is necessary prior to compulsion), that they need to be detained in the interest of their own health or safety or with a view to the protection of others, that the treatment cannot be provided unless the patient is detained, and, in those people who are deemed to be suffering from mental impairment or psychopathic disorder, that the treatment is likely to alleviate or prevent a deterioration in the patients condition.

Many people would argue that patients should only be made subject to compulsion if they are unable to make a decision for themselves. Others have argued that doctors would be unable to stand back and see people harm themselves on the basis that the patient retained capacity and would broaden the definition of incapacity until it essentially meant anyone who disagreed with their doctor. However, the inclusion of an incapacity requirement is the only way to ensure lack of discrimination from those suffering from physical illnesses. It is worth repeating the law in relation to those suffering a physical illness. This was most recently spelt out by Dame Elizabeth Butler-Sloss in the case of Ms B (2002):

"A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death". It should be noted that Dame Butler-Sloss had, inadvertently, excluded the mentally ill from her words. A person diagnosed as mentally ill, even though competent, does not have the right to refuse to consent to medical treatment.

It may be that there is a source of confusion here. The vast majority of people with mental illnesses retain fully their ability to make decisions throughout their illness. Most patients with mental illnesses, who require medical intervention are treated by General Practitioners or as informal/voluntary patients by psychiatrists.

Both the current Mental Health Act and the draft Mental Health Bill require psychiatrists to force treatment on patients who are perfectly capable of making decisions for themselves whilst offering no protection, or legal framework, for patients who lack capacity but, because of their illness, do not object to the treatment (this is the so-called Bournewood Gap). The absurdity of both the current position and the proposals may be clarified with two examples.

Example 1: A patient with depression recognises that he is ill. He understands that he is at increased risk of suicide but feels he is safe enough at home, with the support of his family, and does not wish to be admitted to hospital. He wishes to be treated with cognitive therapy. His family support this plan. The doctors believe that because of the suicide risk it would be unsafe to leave him at home. They feel obliged to make the patient subject to compulsion, in hospital (to be on the safe side), and, because of the waiting time for availability of cognitive therapy he is forced to have medication.

Example 2 (the Bournewood Gap): A patient with depression believes he is responsible for all the ills of the world. He wishes to die. He agrees to be admitted to hospital as he believes he will be killed in hospital – which is what he believes he deserves. Such a patient will be admitted to hospital and treated informally, with none of the protections (statutory second medical opinions, Tribunals etc) offered by being subject to a mental health act.

A recognised difficulty is that there are different ways of determining capacity. It is argued that the definition in the Mental Capacity Bill centres around cognitive (thinking) ability without giving weight to the importance of factors such as emotion or delusions. The

Common Law determination of capacity in 'Re C' (the person should be able to understand, remember, believe, weigh in the balance and express a decision) may be a little better. However the College's preferred approach is that taken in Scotland. This is to recognise that patients may have impaired capacity, which damages their ability to make decisions, without losing capacity altogether.

Other issues, which it is important to consider, are whether or not patients should be compelled to accept "treatment" if they cannot benefit from the treatment (the draft Mental Health Bill has no benefit requirement) and whether or not it is necessary for the treatment to be in their best interests (the Mental Capacity Bill requires any treatment to be in the person's best interest, the draft Mental Health Bill has no such requirement).

Conditions in the draft Mental Health Bill

The Bill lists the following conditions:

A) The first condition is that the patient is suffering from mental disorder.

B) The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.

C) The third condition is that it is necessary –

- a) For the protection of the patient from –
  - i) Suicide or serious self-harm, or
  - ii) Serious neglect by him of his health or safety, or
- b) For the protection of other persons, that medical treatment be provided to the patient.

D) The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.

E) The fifth condition is that medical treatment is available which is appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all other circumstances of his case.

(The definition of medical treatment (clause 2(7)) includes:

- a) Nursing
- b) Care
- c) Cognitive therapy, behaviour therapy, counselling or other psychological intervention
- d) Habilitation (including education and training in work, social and independent living skills) and
- e) Rehabilitation)

F) The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons. (It should be noted that this deviates from the 'least restrictive option' principle)

G) For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.

ISSUES

The wording in relation to the third condition presents a problem in that some patients' diagnoses are associated with a significant risk of suicide or self harm at all times. For

example up to 10% of patients with schizophrenia may commit suicide. In the context of the 'blame culture' and society's low tolerance of risk it seems likely that clinicians will err on the side of safety leading to inappropriate detention in hospital (with a significant impact both on the individual who is deprived of his liberty and the resources available for mentally ill people who would benefit from hospital care and yet do not display such behaviours). If the wording were as in the 1983 Act "In the interest of" rather than " for the protection of" it would enable the clinician to weigh up relative risks.

Furthermore, because the conditions now centre on risk it would appear to be unlawful to apply the Bill's provisions for patients with mental illness who have lost capacity (and so refuse effective treatment) if the consequences of the illness cause moderate physical or mental damage to the individual.

The fourth condition would presumably require patients to be treated with the authority of the Mental Capacity Act if they lack capacity and are compliant. It may be, we do not know the final provisions of that legislation, that this will also apply to incapacitated patients who resist treatment. In either case this is likely to lead to confusion.

In relation to point (F),the principle of least restrictive alternative should apply to all categories of patient.

Recommendation
Use of the Act should be prohibited in cases where the capacitous patient willingly accepts assessment and treatment as recommended by the medical practitioner.

The College finds it difficult to understand the meaning of the fifth condition. It does not appear to equate to a condition that treatment should be available which will provide therapeutic benefit to the patient.

In addition the final paragraph, if taken as stated, to apply to all other conditions, may be interpreted as suggesting that a determinations of dangerousness is, of itself, evidence of mental disorder. The two conditions, taken together, suggest that a 'clinically appropriate' determination might be solely to prevent criminal behaviour.

There are no exclusion conditions (see below).

Recommendation
Patients who lack decision-making capacity must not be excluded from receiving treatment because they resist treatment and yet present only moderate risk to their health.

<u>The Conditions in Scotland (Mental Health (Care and Treatment) (Scotland) Act 2003)</u>

The conditions for an assessment order are:

a) The patient has a mental disorder
b) <u>That because of the mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired.</u>
c) That it is necessary to detain the patient in hospital for the purpose of
    I. Determining what medical treatment should be given to the patient or
    II. Giving medical treatment to the patient
d) That if the patient were not detained in hospital there would be significant risk to

  I. The health, safety or welfare of the patient or
  II. To the safety of any other person

e) That the granting of a short-term detention certificate is necessary.

The conditions for a treatment order are:

1) That the patient has a mental disorder.
2) That medical treatment which would be likely to
   a) Prevent the mental disorder worsening
   b) Alleviate any of the symptoms or effects of the disorder is available for the patient
3) That if the patient were not provided with such medical treatment there would be a significant risk
   a) To the health, safety or welfare of the patient
   b) To the safety of any other person
4) <u>That because of the mental disorder the patients ability to make decisions about the provision of such medical treatment is significantly impaired</u>
5) That the making of a compulsory treatment order in respect of the patient is necessary
6) Where the Tribunal does not consider it necessary for the patient to be detained in hospital such other conditions as may be specified in regulations.

The phrases underlined are particularly pertinent here.

<u>RECOMMENDATION</u>
The College believes there are two important required conditions additional to those in the draft Bill.

1. Impaired decision-making by reason of their mental disorder. The concept of impaired decision-making may be easier to use in a clinical setting than lack of capacity whilst still ensuring that there is no compulsion in the face of a fully competent refusal AND no failure to treat an incapacitated person on the grounds that the person does not present sufficient risk.

2. In relation to a treatment order:
Therapeutic benefit for the patient. Therapeutic benefit means medical treatment which is likely to bring about an “improvement in the symptoms, or signs, of mental disorder, or reduce or prevent deterioration in the person's mental or physical health”.

The College preferred conditions would mirror those in the new legislation in Scotland both in relation to short-term detention and compulsory treatment orders. An alternative would be that the conditions for England are left looser than those for Scotland but combined with a tighter definition of mental disorder and stronger exclusion condition (as in New Zealand or Australia). It is recognized that should impaired decision-making be accepted as a necessary requirement for compulsion then particular consideration will need to be given in relation to offenders (see below).

Note: The usual argument against impaired decision-making or incapacity as a condition is that some people might decide that they did not want medical treatment without which they would die. It is worth recalling the case of Ms B (2002). She had become paralysed by a bleed into her brain. She wished the hospital to remove the ventilator which was keeping her alive. The Court determined that, given she retained full decision-making capacity, this was her right as an autonomous individual. Ms B’s condition would fit within the proposed definition of mental disorder. Consequently the provisions of this Bill would have deprived Ms B of this human right.

The College is able to give details in relation to other European countries if this would be helpful to the committee.

C) COMMUNITY TREATMENT ORDERS (REFERRED TO AS 'NON-RESIDENT' ORDERS IN THE DRAFT MENTAL HEALTH BILL)

Current position

It is often, mistakenly, assumed that treatment in the community (under compulsion) is not available under the '83 Act. It occurs under the following circumstances:

a) Patients subject to guardianship under the Mental Health Act. They may be required to live in a particular place, to attend a health or social care facility for treatment or education or training. Patients subject to guardianship must permit access to health or social care professionals. There is no authority to administer medication in the absence of consent or compliance. There is no authority to convey a person.
b) Section 25 of the Mental Health Act. This is similar to guardianship other than it can only be applied once a person has already been detained in hospital under a treatment order (Section 3 or Section37) but does include a power to convey patients including the authority to compel a patient to attend a health care or social facility. Again there is no authority to compel a patient to accept medication.
c) Section 17 leave of absence. Patients detained under Section 2, 3 or 37 of the Mental Health Act may be sent on leave. Whilst they cannot be forced to have medication in the community there may be grounds for recall to hospital if the patient does not comply with their medication. Patients certainly believe they will be returned to hospital if they stop their medication. For practical purposes, therefore, this is a form of community treatment order.
d) Patients detained under Section 37 with a 41 restriction order currently on conditional discharge. Such patients are in the same position as those on Section 17 leave, i.e. they have a right to refuse medication whilst in the community but most patients feel that they would be ill advised so to do given the authority to recall to hospital.

In addition there are patients who lack capacity to consent but who are compliant with the treatment and receive it under the common law (c.f. Bournewood).

Recent history

Prior to 1986 it was established practice that under certain relatively rare circumstances patients coming to the end of their Section would be readmitted overnight in order that their Section might be renewed (under Section 20 of the Mental Health Act) following which they would then again be sent on leave under Section 17. This, as described above, was a form of continuing community treatment order in all but name.

Following a Court Case (Halstrom) in 1986 this was declared unlawful in England and Wales and the practise ceased.

That decision was modified by the Court of Appeal in 1999. The Court held that it was lawful to renew the detention of a patient (Section 20) as long as the patient's medical treatment viewed as a whole involved treatment as an inpatient (the particular patient, at the time of the renewal, had a treatment plan which consisted of five days on leave and two days in hospital each week).

The circumstances in which a renewal of section could take place were further amended in 2002 (D.R.). Here the Court determined that a patient's Section could be renewed (Section 20) if the patient was required to attend a hospital once a week (this patient was required to

attend occupational therapy at the hospital once a week and also to attend a ward round). This has markedly increased the opportunity for the renewal of Section 3 leading to what has been termed a “long leash” arrangement.

It has been argued that there are a small number of patients, well known to the service, whose clinical history includes serious mental illness, repeated compulsory admission to hospital, ceasing medication when discharged from the order and prompt and inevitable relapse.

One model for enabling such patients to be placed directly on a community treatment order is that from Saskatchewan:

1) A person must suffer from a mental disorder, for which he or she is in need of treatment or care that can be provided in the community.
    - In the previous 2 years the person must have

    - Spent at least 60 days as an involuntary in-patient in a psychiatric facility, or
    - Been an involuntary in-patient in a psychiatric facility on 3 or more separate occasions, or
    - Previously been the subject of a community treatment order.
2) There must be a likelihood that if the person were not to receive treatment while residing in the community, he or she would likely cause harm to self or others or suffer substantial mental or physical deterioration as a result of the mental disorder.
3) The services the person requires in order to reside in the community must be available in the community.
4) The person is unable to understand and to make an informed decision regarding his or her need for treatment, care or supervision as a result of the mental disorder.
5) The person must be capable of complying with the requirement for treatment and supervision contained in the CTO.

It should be noted that this requires the patient to lack capacity.

The arguments in favour of community treatment orders are:

a) That if a patient is to be forced to have treatment many would prefer to do so at home rather than in hospital if this were a reasonable option.
b) Some patients who stop their medication against medical advice when informal would continue to take it whilst continuing to be subject to mental health legislation. This might reduce the relapse rate for some of the so called revolving-door patients who are admitted to hospital, take their medication, become well, leave hospital, stop their medication, relapse, have to be readmitted and so on.
c) There is a clear advantage in terms of inpatient resources.

The arguments against community treatment orders are:

a) Patients who are well enough to be in the community are generally well enough to make decisions for themselves even if the decision is not necessarily in the interests of their health (putting them on an equal footing with those suffering from physical illnesses).
b) That the numbers of people subject to compulsion will inevitably rise. Currently all people who are subject to compulsion are ill enough to need to be in hospital therefore if patients are going to be made subject to compulsion who are not ill enough to need to be in hospital they will be in addition to those currently subject to the Mental Health Act.

c) By removing the conditions of needing to be ill enough to warrant admission to hospital patients may become subject to compulsion despite suffering from only very mild illnesses.

Draft Mental Health Bill

The provisions are confusing.

Clause 26 authorises the Clinical Supervisor to make a patient resident for assessment, non-resident if he determines this is appropriate. This appears to conflict with Clause 15 (2) which determines that additional conditions, required if assessment is to be carried out in the community, will be set out in regulations.

Further it is difficult to understand the distinction between the powers set out in Clause 26 (transfer to the community) and those Clause 30, Power to give leave of absence.

RECOMMENDATION
Community Treatment Orders should be available for patients only on authorisation of the Tribunal after a period of in-patient assessment and whilst the person suffers impaired decision-making by reason of their mental disorder. Leave of absence powers enable assessment and treatment in the community during the assessment period.

Question 3 DOES THE DRAFT BILL ACHIEVE THE RIGHT BALANCE BETWEEN PROTECTING THE PERSONAL AND HUMAN RIGHTS OF THE MENTALLY ILL ON ONE HAND, AND CONCERNS FOR PUBLIC AND PERSONAL SAFETY ON THE OTHER?

"In part, the long standing ambiguity between Asylums as places of imprisonment and social control, as opposed to places of protection and individually orientated support and treatment, lives on in the public debate over psychiatry. To the extent that the atmosphere so generated needlessly undermines professional morale and patient confidence it continues to act as a barrier to progress."
The Office of Health Economics 1989

The College confines its answer to clinical rather than legal matters.

The question presupposes that these are opposing requirements. This is, in general, an error. Safety can best be improved by making the service accessible and effective. Public safety in this area of medicine is no different from, for example, in relation to sexually transmitted disease. It is essential that prospective patients are not deterred from seeking help. Indeed, because suicide and other risks are largely assessed from information given by the patient, it is necessary for the person to feel able to talk freely. Fear that being open will lead to loss of liberty does not aid this process. Hence if mental health law is seen to be overly coercive it will lead to patient avoidance of mental health services and, paradoxically, and increase in risk both to the individual and the public.

Nonetheless there are a small number of mentally disordered people who present serious risks to others. If such a person lacks decision-making capacity, medical intervention should not, with the correct safeguards, infringe personal or human rights. This applies also for those who are convicted of serious crimes. For those who fit neither of these categories the central issue is what degree of certainty should be required before determining that such a person is dangerous. For example if a person suffering from tuberculosis, or other notifiable

infectious disease, refuses treatment they will only be detained if the form of TB makes it almost inevitable that other people will become infected. Any lesser standard in relation to the mentally disordered would be inappropriate. Clinically this is particularly difficult to determine, hence, for example, the estimation that, with current knowledge and skills, between 2000 and 5000 people would need to be detained to prevent one homicide (Crawford, Psychiatric Bulletin February 2000).

The Government has rightly stated, in our view, that it has no intention of increasing the number of people subject to compulsion. The proposals in the Bill (the combination of a very broad definition of mental disorder combined with wide conditions for compulsion and the absence of exclusions) will lead to a marked increase in compulsory orders. All patients who meet the current conditions will meet the new conditions along with along with many people who could not currently be detained. For example patients who will be subject to compulsion in the community cannot be ill enough to need to be in hospital and, therefore, could not be detained under the current Act. A new Mental Health Act should ensure that the Government's intention becomes a reality.

It remains the view of the College that safety and human rights are best enhanced by a mental health act which focuses on those people whose decision-making is impaired by reason of their mental disorder.

APPEALS

Current position

A detained patient can appeal once in each period of detention. If appealing during detention for assessment (Section 2) the appeal must be made in the first 14 days. The Tribunal can release the patient from detention immediately, at a time in the future or confirm continuing detention. The Tribunal cannot increase the period of detention.

The Draft Mental Health Bill

The patient, and the nominated person on the patient's behalf, may appeal to a Mental Health Tribunal (MHT) at any time during the first 28 days and again during any period of further assessment. A further appeal may be made during any period when the Tribunal has authorised detention for more than 3 months. There is a mechanism for appealing to a Mental Health Appeal Tribunal (the members of which are all lawyers) against the decision of the MHT on points of law.

The concept of an appeal within the framework of mental health legislation is, of course, rather different from that in the Courts. In the Court an appeal is against the decision of the first Court. In the framework of mental health legislation there is no appeal against the initial detention be it by professional staff or a Mental Health Tribunal (other than judicial review). The appeal is against the continuation of the detention given the patients mental state at the time of the hearing. The College has two concerns:

If the patient appeals within the assessment period the Tribunal could convert the assessment order into a treatment order. This may be seen as a disincentive to appealing during this period.

A concern is that it would be perfectly possible for the patient's appeal to be heard by the same Tribunal as authorised their continuing detention. The College has reservations as to whether this would be seen as sufficiently independent and therefore acceptable to patients. There may be a perception that Tribunals would fear giving the impression that they were

overturning the decision of a previous Tribunal and therefore might be reluctant to discharge the patient from the order.

RECOMMENDATION
A Tribunal should not be permitted to authorise a treatment order if it is hearing an appeal within the first 14 days of the period of assessment.

Question 4 ARE THE PROPOSALS CONTAINED IN THE DRAFT MENTAL HEALTH BILL NECESSARY, WORKABLE, EFFICIENT, AND CLEAR? ARE THERE ANY IMPORTANT OMISSIONS IN THE BILL?

The proposals, as set out in the Bill, are long, extremely complex, confusing and, some would say, incomprehensible. Some of the measures (Mental Health Tribunal, Advocacy, some of the children's and forensic provisions) will rightly enhance patients' rights. The College believes the impact of the proposals overall will damage safety for both the patient and society. The workforce implications are discussed in relation to a later question. The College believes the Bill as now drafted to be unworkable.

Further issues in relation to compulsion/detention

Current position

Detention is authorised by two registered medical practitioners making recommendations, one of whom must be approved under Section 12 of the Mental Health Act (as having special experience in the diagnosis or treatment of mental disorder) and an Approved Social Worker making an application. This applies to both assessment (28 day) and treatment (6 month) orders.

Draft Mental Health Bill

Treatment order

The College welcomes the introduction of Mental Health Tribunals with the role of authorising compulsion and treatment after 28 days. The draft Mental Health Bill proposes that the membership of the Tribunal should consist of a lawyer, a clinical person (who need not be medically qualified) and a layperson. Medical input will be given by an independent psychiatrist appointed from an 'Expert Panel' established for this purpose. This psychiatrist will interview the patient, present his/her findings to the Tribunal and may be cross-examined.

If the Clinical Supervisor is not a registered medical practitioner then the assessment of mental disorder and conditions necessary for continuing compulsion are made by only one registered medical practitioner. The College believes this to be unsafe.

Recommendation
Compulsion should only be possible, other than in an emergency, if two doctors certify that the patient suffers from a mental disorder conditions.

CLINICAL SUPERVISORS

Current position.

All patients subject to the Mental Health Act are under the care of a Responsible Medical Officer (RMO) i.e. a registered medical practitioner who is a Consultant Psychiatrist.

The Draft Mental Health Bill

The RMO is replaced by a Clinical Supervisor who may be a consultant in another mental health profession such as clinical psychology. There are a number of issues:

1. One of the central duties of the person in overall charge of the care of a person subject to mental health legislation is to keep under constant review whether or not the "relevant conditions of compulsion are still satisfied" and to discharge the patient from compulsion if the conditions are not satisfied. This requirement is made clear both in the current Mental Health Act Code of Practise and in the explanatory notes which accompanied the draft Mental Health Bill.

The Government has determined that only registered medical practitioners are deemed to have the necessary training to comply with the need for "objective medical evidence" from the European Convention on Human Rights and so to make the initial recommendation that a patient meets the relevant conditions for compulsion. The draft Bill supports this interpretation. Indeed it is noted that schedule 3 of the draft Mental Health Bill requires a registered medical practitioner to undertake the assessment for the new equivalent of a Section 5(2), (the order which enables an informal inpatient to be detained whilst a proper assessment for detention is undertaken). It is unclear how a psychologist or other person who is not medically qualified is able to satisfy the legal requirement of ensuring that "the relevant conditions are still satisfied" if they are unable to determine the presence or absence of these conditions in the first instance.

2. Currently a Section 3 (the 6 month treatment section) requires two medical recommendations (one from a specially trained doctor, usually a psychiatrist, the other a doctor who should have known the patient previously, ideally the patient's GP) and an Approved Social Worker. The draft Bill proposals (the Clinical Supervisor plus the Tribunal plus a medical member of the Expert Panel) mean that the longer term order would rely on only one medical recommendation if the Clinical Supervisor is not a doctor.

3. The person in charge of a patients care is responsible for their care either directly or via a duty rota consisting of equivalently qualified people for 24 hrs a day, 7 days a week, 365 days of the year. It is unclear whether all other professions who might fulfil the role of clinical supervisor have an infrastructure which would support such a system.

4. The person in charge of the patients' care initiates the prescription of many treatments. The proposals in the draft Mental Health Bill include that one of the roles of the clinical supervisor will be the prescribing of electro-convulsive therapy (subject to the patients consent or the authority of the Tribunal). The College does not consider that, at present, any professional, other than a psychiatrist, is trained to prescribe electro-convulsive therapy. Authority to prescribe medication would continue to be determined by the Medicines Act (there is no equivalent control in relation to electro-convulsive therapy).

5. The College is fully supportive of multi-disciplinary working and respects the strengths of other disciplines working with the mental health field. This has resulted in the College having some difficulty in determining a policy in relation to the issue of Consultants in other disciplines having overall responsibility for patients subject to compulsion. We would welcome further discussion in relation to the issues raised above.

RECOMMENDATION
Clinical supervisors must be qualified to assess if a person meets the conditions for compulsion in order to be able to keep under review if the conditions continue to be met.

EXPERT PANEL MEMBER

It is understood that the expert panel member will advise the Tribunal in relation both to grounds for compulsion and the care plan. However clauses 47 and 49 suggest that the Tribunal can alter a care plan only with the agreement of the clinical supervisor.

The MHA 1983 only permits specified treatments after 3 months if agreed by both the second opinion appointed doctor and the responsible medical officer. It is understood that the Clinical Supervisor cannot be required to give treatment that he thinks is inappropriate for the patient. However it is hard to understand the role of the expert panel member if his findings cannot ensure amendment of the care plan.

Recommendation
The Mental Health Tribunal will be permitted to authorise specified medical treatments only if they are agreed as necessary by both the clinical supervisor and expert panel member.

DISCHARGE FROM COMPULSION

Current position

Patients (other than those on restriction orders) may be discharged by their Responsible Medical Officer, Nearest Relative (subject to limitations), the hospital managers and the Mental Health Review Tribunal.

Draft Mental Health Bill

It is proposed that discharge will be limited to the Mental Health Tribunal and the Clinical Supervisor. Furthermore for some patients, even though detained under a civil section (i.e. they have not been charged with or convicted of any offence) the Mental Health Tribunal may remove from the Clinical Supervisor the right to discharge.

RECOMMENDATION
The College is opposed to any limitation of the right to discharge by the Clinical Supervisor for patients detained under civil sections. The College would also wish those rights (and associated limitations) currently available to the nearest relative to be available to the nominated person. The College supports the removal of the authority of Hospital Managers to discharge a detained patient against medical advice.

TRANSFER BETWEEN HOSPITALS

The proposal to require a minimum the clinical supervisor to give a minimum 7 days notice of transfer, other than in an emergency, is understandable but likely to have a significant adverse impact on patients, services and utilization of resources. Two brief examples are:

Patients may be moved at their request to be nearer home or family.
Patients may be moved, in an emergency, to a hospital with a psychiatric intensive care unit, but would not be able to be moved back as soon as their condition improved. This would harm both the patient whose transfer is delayed and another patient requiring the intensive care bed.

Recommendation
Transfer between hospitals should require consultation, other than in an emergency, but without specific time limits.

OFFENDERS

Whatever amendments are made to the legal provisions in relation to mentally disordered offenders there is a significant shortfall in required resources. The College is keen to play its part in ensuring that there are proper facilities available in the National Health Service for the treatment of mentally disordered prisoners.

In general we believe that Part 3 of the draft Mental Health Bill is an improvement on the old Act. There is increased flexibility throughout a defendant's progress through the criminal justice system from arrest to conviction and sentence. We believe that the drafting of Part 3 ensures sufficient flexibility to meet the needs of those potentially subject to Part 3.

Conditions for making a mental health order.

The College believes the conditions for compulsion should generally not differ for different groups of patients dependent only on whether they are alleged to have committed, or have been convicted of, a crime. However the college recognises that those in custody cannot access hospital treatment as informal patients. The College supports the retention in Mental Health Orders of the principle that such orders can be used as the "best disposal" (clause 116 {1b}) at point of sentencing. For these reasons the College would support the omission of impaired decision-making capacity as a criterion under Part 3 of the act.

Court authorisations of care plans.

The College has serious reservations about the likelihood of Courts having a level of experience to enable them to scrutinize care plans to the same standard as the Mental Health Tribunals. Consideration should be given to requiring all care plans to be subject to MHT scrutiny after a defined period.

Interim Hospital Orders.

Section 38 of the Mental Health Act 1983 was designed to allow patients to have a prolonged period of assessment in hospital prior to determining whether conditions for a hospital order are met. In practise section 38 is used to determine if the clinical team in hospital can provide treatment that prevents or alleviates deterioration of a person's condition, particularly in the case of psychopathic disorder. In the draft Bill similar issues would arise for the second and third conditions for detention, namely whether the mental disorder is of a nature and degree to warrant the provision of medical treatment or "that appropriate medical treatment is available which is appropriate in the person's case ....". Clauses 86-92 of the draft bill provides a flexible means of determining the first issue, namely whether a mental disorder is of a "nature or degree" to warrant a hospital order. The Home Office has told us that clauses 93-96 of the draft Bill will allow for a period in hospital to determine if "appropriate treatment" is available. However, we are concerned that

in remanding someone for medical treatment before sentencing, the third condition, under clause 96, already requires that appropriate medical treatment is available in the person's case. We appreciate the subtlety that clauses 93 and 114 (the Mental Health Order) have different purposes and therefore it is possible to have conditions for appropriate "treatment being available" interpreted differently in each section. The Home Office believe that remand for treatment under clause 93 (remand for treatment) will be sufficient to deal with cases where the clinical supervisor (for clause 86) is unable to advise the court after 16 weeks whether the conditions for a medical disposal are met. Yet condition at clause 96 (3) (appropriate treatment available) is drafted in the same words as for making a mental health order at clause 116 (3). If the bill is passed with the proposed uniform wording we can see lawyers arguing that it is wrong to detain somebody on the basis that appropriate treatment is available in order to then determine whether "appropriate treatment is available" for another section of the Act. The bill should make clear that “appropriate treatment” is interpreted differently in each clause.

Question 5 IS THE PROPOSED INSTITUTIONAL FRAMEWORK APPROPRIATE AND SUFFICIENT FOR THE ENFORCEMENT OF MEASURES CONTAINED IN THE DRAFT BILL?

Members of the College found this question difficult to understand and we hope the answers are not inappropriate.

In relation to the processes leading to, and during compulsion.

The requirement for a Trust to arrange an examination of any person at the request of any other person is likely to be particularly burdensome in relation to the available workforce and damaging in relation to stigma. The provision may be abused, for example, as a means of causing embarrassment to neighbours, or inducing guilt in elderly family members. Furthermore it might lead to persecution of a person with a history of mental health problems. The College believes the potential disadvantages of such a provision outweigh the advantages. If it is decided that this provision should remain then consideration should be given to making it a criminal offence to require an assessment without due cause.

The further processes in relation to production of care plans, Tribunals and appeals are appropriate in order to achieve good care and safeguards. However there is currently an insufficient workforce (see below) to achieve these provisions without causing significant detriment to clinical care in two particular regards unless the numbers of patients subject to these provisions is extremely limited..

First, in relation to medical treatment and care plans. Patients who are unable to consent to medical treatment will be deprived of such treatment (unless it is ‘immediately necessary’) until it is authorised by the Clinical Supervisor who must be a Consultant. This may take up to 5 days to arrange potentially resulting in considerable suffering.

Recommendation
Medical treatment, provided it is not irreversible or hazardous, may be given under the direction of a registered medical practitioner, within the first 5 days, if it is necessary to alleviate, or prevent a deterioration, in the patient’s condition.

Secondly, the College fears that mental health services will be directed away from those services which should reduce the need for compulsion such as early intervention, assertive

outreach and other developments. This will have a significantly negative effect in relation to voluntary (informal) patients,

Secure beds

The current and future shortfall in secure beds is difficult to quantify and is currently the subject of a major Department of Health capacity exercise. The shortfall is significant at all levels of security including low secure district level. The length of stay in medium secure units is increasing reducing their ability to respond to demand.

The impact is increasing delays for transfer from:

- Prison, resulting in prolonged suffering.
- General adult psychiatric wards. This causes significant risks to others and frightens many would-be voluntary patients leading to delayed treatment and an increase in use of formal detention.

There is also frustration on the part of Courts at not being able to transfer for treatment many mentally disordered individuals.

There are many factors currently operating which, it is thought, are exacerbating the shortfall by increasing the demand for secure beds.

- The planned contraction of high secure beds in the high secure hospitals through the accelerated discharge programme.
- The transfer of responsibility of prison health care from the Home Office to the NHS (very much welcomed), as this emphasises unmet need for hospital admission.
- There is a trend within the criminal justice system for increased length of sentences, including, life sentences, which will have an impact on length of stay in secure units. The prison population is rising and is set to continue its upward trend for the foreseeable future.
- Multi Agency Public Protection Arrangements are already having an impact on services as they uncover unmet need for treatment.
- The DSPD services may impact by requiring step-down rehabilitation for those treated by those services.
- The proposals in the draft Bill will increase the potential pool of mentally disordered offenders liable to be compulsion.

Question 6 ARE THE SAFEGUARDS AGAINST ABUSE ADEQUATE? ARE THE SAFEGUARDS IN RESPECT OF PARTICULARLY VULNERABLE GROUPS, FOR EXAMPLE CHILDREN, SUFFICIENT? ARE THERE ENOUGH SAFEGUARDS AGAINST MISUSE OF AGGRESSIVE PROCEDURES SUCH AS ECT AND PSYCHOSURGERY

The College welcomes the right to independent advocacy and believes this to be an important advance in ensuring that the patient’s voice is heard in the setting of a system of compulsion. The College has reservations only in terms of how the service is to be developed given the current level of available skills and resources.

Also welcomed is the role and responsibility of the Mental Health Tribunal.

The College welcomes the increased penalties in relation to abuse of patients.

The College supports the proposal that the new inspectorate (The Healthcare Commission) should take over the role of the Mental Health Act Commission. The College strongly supports the importance of good quality information being available, but emphasises that there are particular issues that pertain to patients subject to compulsion. It is important that monitoring arrangements for such patients recognise that different skills and protocols are required.

A) CHILDREN and YOUNG PEOPLE

Child and adolescent mental health problems are characterised by complexity, severity and often multiple co-existing diagnoses. Also legal provision for the assessment and treatment of mentally disordered minors is made more complex by the issues of:
a) parental rights and responsibilities
b) assessment of competence of a growing child (with particular reference to "Gillick' competence)
c) other legislation relating to minors including the Children Act and the Family Reform Act.

Clinical provision is hampered by such a significant resource shortfall that many Mental Health Act assessments of minors are undertaken by psychiatrists specialising in Adult services. Young people detained under the MHA 1983 are commonly detained on Adult wards.

Particular areas of concern in relation to children and young people are:

- The definition of mental disorder and the absence of exclusions. These issues are addressed in detail elsewhere in this draft. It is clear, however , that the breadth of the definition coupled with the absence of exclusion will have a significant impact on CAMHS (Child and Adolescent Mental Health Services) and services for children and young people with learning disabilities.
- The Part 6 safeguards for the under 16 are welcome, although the impact on CAMHS will need to evaluated.
- The Royal College do not consider that the safeguards in relation to the under 16 are adequate. Firstly the safeguards only apply to resident patients. Secondly the non-resisting incapacitated under 16 year old is not eligible for any protection. (These young people will also not fall within the Capacity Bill.). These young people are recognised to be highly vulnerable.
- The potential for conflict between those who have parental responsibility for a child patient needs to be addressed; particularly as the role of the nominated person cannot be shared. We foresee that unless this is dealt with the child patient may suffer.
- The principles and protections provided by the new legislation should, if at all possible, be the same as for adults.

Particular provisions for minors should include:

- At least one medical assessment prior to use of the Act must be by a doctor specialising in the assessment and treatment of children and adolescents.
- The medical member of the Expert Panel giving evidence to the Tribunal must be a doctor specialising in the assessment and treatment of children and adolescents.
- At least one member of the Mental Health Tribunal must have specialist knowledge in relation to the care and treatment of children and adolescents.
- All young people deemed to be competent to consent to medical treatment should also be competent to refuse such treatment.

- All minors detained in hospital should be assessed and treated by, and in, age appropriate services.
- There should be an obligation on commissioners to ensure sufficient numbers of doctors specialist in the assessment or treatment of Children and Adolescent are available to meet the provisions of this Act.

There should be an obligation on Health Trusts to ensure that there is sufficient in-patient provision such that children and adolescents are not detained within Adult wards.

RECOMMENDATION
Safeguards, both legal and clinical, for persons under 16 years of age must be re-evaluated.

B) SPECIFIC TREATMENTS

Medication

Current position

Medication for mental disorder is prescribed for detained patients under the authority of the Responsible Medical Officer. Medication for mental disorder can be given without consent for up to three months. After three months medication for mental disorder can only continue:

a) With the consent of a capacitous patient or
b) With the authority of an independent Second Opinion Appointed Doctor (in practice a psychiatrist) appointed by the Mental Health Act Commission or
c) In an emergency to save life or prevent serious suffering. There is an obligation under these circumstances to request a second opinion from the Mental Health Act Commission at the earliest opportunity.

The Draft Mental Health Bill

It is proposed that the Clinical Supervisor may prescribe medication for mental disorder for the duration of the assessment order (up to 28 days). This presumes the Clinical Supervisor is a registered medical practitioner (prescribing of medication is controlled by the Medicines Act).

It is proposed that at the time the Mental Health Tribunal authorises continuing compulsion it will also authorise the ‘treatment plan’ including medication for mental disorder. Unless the care plan, in relation to medication, is to be very general and over-inclusive, it will likely need review and amendment periodically through a period of compulsion. It is unclear what is proposed for authorising these changes (whether this should be a Tribunal or a member of the Expert Panel alone). If it is to be the Tribunal this will have a significant impact on the workload, and need for prompt availability, of the Tribunal.

The draft Bill leaves it unclear as to whether or not there will be provision for patients to have the authority to consent to medical treatment after 28 days, as opposed to the authority coming from the Tribunal. It is not unusual for patients to believe they shouldn’t be subject to compulsion, or lack the capacity to make such a decision, yet be capable in relation to a specific medical treatment and to wish to consent to it (e.g. “I need anti-depressants but I don’t need to be in hospital, I’d be able to look after myself at home”).

RECOMMENDATION
The College is supportive of reducing the time for authorising non-consensual medication from three months to 28 days. The College would suggest that changes to

the medication plan thereafter should be authorised by a medical member of the Expert Panel, with similar requirements to consultation as specified. If a full Tribunal was to be required there is a real danger that either:
a) necessary changes in medication would be significantly delayed leading to prolonged suffering and increased risks or
b) the initial treatment plans authorised would be very broad giving limited or no protections to the patient.

It should be clear from the legislation, or Code of Practice, that one option for a care plan presented to a Tribunal would include the statement that identified treatments will only be given with the patient's consent (subject to an emergency treatment clause).

Electro-convulsive therapy (ECT)

Current position

Electro-convulsive therapy can be given to detained patients:

a) With the consent of a capacitous patient

b) With the authority of an independent Second Opinion Appointed Doctor (whether or not the patient is capacitous).

c) With the authority of the Responsible Medical Officer in an emergency to save life or prevent serious suffering to the patient. There is an obligation under these circumstances to request a second opinion from the Mental Health Act Commission at the earliest opportunity.

The Draft Mental Health Bill

It is proposed that the Clinical Supervisor may prescribe ECT. As the law stands this would give Consultants who are not medically qualified the authority to prescribe ECT.
ECT could be given to compelled patients:

a) With the consent of a capacitous patient

b) With the authority of the Clinical Supervisor in an emergency.

If ECT is prescribed for an incapacitous patient it would require the authority of the Tribunal in addition to the evidence of a medical member of the expert panel. Whilst there is provision for the giving of emergency ECT it will be essential that tribunals can be established rapidly to ensure full authorisation in order to limit delay causing undue suffering.

RECOMMENDATION
The College believes that ECT should only be prescribed by properly trained and qualified psychiatrists.
The College is firmly against compulsion in relation to ECT in the face of the refusal of a capacitous patient. If a patient retains decision-making capacity he or she cannot be sufficiently ill to warrant ECT without their consent on the grounds of a life-saving emergency.

Brain Surgery for Mental Disorder (psychosurgery)

Current position

Only patients, whether detained or informal, who give capacitous consent and have an independent second opinion may receive this treatment. The second opinion is given by a

three person team (two to confirm capacity and consent the third, a psychiatrist, to confirm the necessity of the treatment), appointed by the Mental Health Act Commission.

The Draft Mental Health Bill

It is proposed extending the availability of this treatment to incapacitous patients with the authority of the High Court.

RECOMMENDATION
The College believes that the current provision in relation to surgery for mental disorder is satisfactory without the proposed extension.

Question 7 IS THE BALANCE STRUCK BETWEEN WHAT HAS BEEN INCLUDED ON THE FACE OF THE DRAFT BILL, AND WHAT GOES INTO REGULATIONS AND THE CODE OF PRACTICES RIGHT?

Recommendation
The College believes the principles underpinning the legislation should be on the face of the Bill, as with the Mental Capacity Bill.

The College would wish to see the limitations on the use of the provisions such as exclusion conditions or limitations on the use of community treatment (non-resident) orders within the Bill.

Question 8 IS THE DRAFT MENTAL HEALTH BILL ADEQUATELY INTEGRATED WITH THE MENTAL CAPACITY BILL (AS INTRODUCED IN THE HOUSE OF COMMONS ON 17 JULY 2004)?

The College is very supportive of the proposals in the Mental Capacity Bill albeit whilst wishing for strengthened safeguards (particularly in relation statutory second medical opinions). Many, perhaps most, patients detained under Part 2 of the Mental Health Act 1983 would also meet the conditions for being subject to the provisions of the Mental Capacity Bill. This is also likely to be the position with the Mental Health Bill.

Some important issues:
1. Rights under the Mental Capacity Bill exceed those in the draft Mental Health Bill in relation to lasting power of attorney (a nominated person with real authority) and advanced refusals of treatment.

2. Safeguards in the draft Mental Health Bill exceed those in the Mental Capacity Bill in relation to statutory second medical opinions, care plans, advocacy, Tribunals authorising treatment, oversight by the Healthcare Commission and, perhaps, ease of access to appeals.

3. Restriction of liberty and enforced treatment (treatment which is resisted by the patient) will have to be authorised by the Mental Capacity Bill (or by Common Law) in relation to treatment of physical illnesses in people who lack decision-making capacity. We are unclear about the provisions for people who resist treatment of mental disorder.

Government has decided that provisions for incapacitous compliant patients (Bournewood patients) should be in the Mental Capacity Bill. Such patients would lose some of the

safeguards present in the draft Mental Health Bill. However they would keep enhanced rights.

An example of the difficulty of differential rights is as follows: A person makes an advance directive in relation to refusing further treatment should they develop advanced Alzheimer's disease. If, having developed the condition that person does not resist medical intervention they will be subject to the Mental Capacity Bill and the advance directive will be honoured. If, on the other hand, they resist medical treatment they may be subject to the draft Mental Health Bill and the advance directive may not be honoured.

Further, the College can see no good reason why, for incapacitous patients, there should be any distinction between using force in relation to treatments for physical disorder as opposed to treatments for mental disorder. There are a number of reasons for saying this:

- there is no distinction made between treatments for physical and mental disorder if the patient is incapacitous but compliant.
- a patient with, for example, Alzheimer's disease would be able to receive treatment (under a mental capacity act), despite resistance, for dental disease but not for the Alzheimer's disease itself.
- the distinction between treatment for mental disorder and treatment for physical disorder is often one of semantics e.g., disease of the thyroid gland may cause depression or pseudo-dementia. In either of these circumstances treatment of the depression or pseudo-dementia would also be treatment of the thyroid disorder.

Note: If it is determined that the Mental Capacity Act should enable treatment of patients who lack capacity whether or not they resist then a Mental Health Act becomes the authority for non-consensual care and treatment solely in relation to persons with a mental disorder who retain decision-making capacity and present risks.

Recommendation
The rights, and safeguards, should be the same under the two Bills.

The recent European Court judgement in relation to 'Bournewood' supports this recommendation.

Question 9 IS THE DRAFT MENTAL HEALTH BILL IN FULL COMPLIANCE WITH THE HUMAN RIGHTS ACT?

The College does not have the expertise to fully to address this issue.

It is essential that mental health law does not place professionals in positions which would put them in difficulty in relation to their international obligations. International ethical standards in relation to psychiatry are attached in appendix 2.

The College has considerable disquiet at the Government's decision that the UK, despite being a signatory, is to be only country, out of 45 nations, to reserve the right not to comply with the Council of Europe's Recommendation ((2004(10)) on protecting the human rights and dignity of people with mental disorder. There appear to be significant discrepancies between the draft Mental Health Bill and the Recommendation which are likely to have an effect when the Act is tested in the Courts. These include:

- the lack of a clear statement that 'lack of adaptation to moral, social, political or other values of society, should not, of itself, be considered a mental disorder' (Article 2.2).

- use of the least restrictive or intrusive alternative, taking into account their health needs and the safety of others, in all circumstances (Art. 8).
- a narrower definition of:
    - mental disorder
    - treatment (Art. 3.3) - an intervention that has a therapeutic purpose, 'taking into account the social dimension', which is in turn defined as 'prevention, diagnosis, control and cure of the disorder including rehabilitation'.
- Conditions (Art. 17) requiring:
    - Significant risk of serious harm to health to self **or other persons**
    - involuntary measures should only be for therapeutic purposes and never for custodial purposes only (EM - para. 132)
- There is a requirement that a doctor provides objective medical evidence in relation to the imposition, extension (Art. 20.4) and termination (Art 24.2) of involuntary measures. Further evidence may be provided by other professionals.
- Measures should be in place to ensure that the approved mental health professional will be taking an independent decision (Art. 2.3 - definition of 'competent body') on the basis of being 'distinct' from those proposing the measure (usually the carer, psychiatrist or care coordinator).
- Registration of all premises in which involuntary placement occurs to ensure effective monitoring (Art. 9.2)
- The stipulation in relation to orders that a 'person does not engage in specified conduct' (draft MHA: e.g. 15.4(b) appears very wide-ranging and should at least be qualified by a requirement that this should be for therapeutic purposes.
- Psychosurgery without consent is contrary to Article 28.2.
- Criteria for involuntary measures by the court are very broad: the Recommendation states that the criteria and other processes used in the courts take into account those used in civil proceedings and 'any non-application should be justifiable' (Art 34(1)).

The College also supports the views expressed in the submission of the Mental Health Alliance.

Recommendation
The Mental Health Act for England and Wales must meet the requirements both of Human Rights legislation and the recommendations of the Council of Europe.

Question 10 WHAT ARE LIKELY TO BE THE HUMAN AND FINANCIAL RESOURCE IMPLICATIONS OF THE DRAFT BILL? WHAT WILL BE THE EFFECT ON THE ROLES OF PROFESSIONALS? HAS THE GOVERNMENT ANALYSED THE EFFECTS OF THE BILL ADEQUATELY, AND WILL SUFFICIENT RESOURCES BE AVAILABLE TO COVER ANY COSTS ARISING FROM IMPLEMENTATION OF THE BILL?

WORKFORCE IMPLICATIONS

The College is only able to comment in relation to psychiatrists.

Current position

Currently approximately 12% of consultant psychiatry posts in England and Wales are vacant. There is a problem with recruiting young doctors into the speciality and a serious fall-out rate during training. All possible initiatives for increasing the number of Consultant Psychiatrists are being pursued, including recruiting from overseas.

The Committee will be aware of the difficulties in relation to Mental Health Review Tribunals. The current delays are primarily due to the shortage of psychiatrists. Many psychiatrists serving on the Mental Health Review Tribunal (and as Second Opinion Appointed Doctors) are retired. Given the new General Medical Council requirements in relation to revalidation, the availability in the future of retired doctors is likely to be markedly diminished.

The removal of the need for psychiatrists from Tribunals will not ease the workforce problem because of the need for the presence of a psychiatrist, from the Expert Panel, at each Tribunal.

The Department of Health have stated that an extra 130 psychiatrists will be needed. The College is unclear how this figure was reached. As far as can be ascertained it relates only to the demands of the Mental Health Tribunal and Expert Panel membership. It takes no account of the increased number of people likely to be subject to compulsion

Furthermore the Bill, correctly, requires markedly increased levels of consultation, enhanced care planning and information sharing. No time is allocated for these important and, if undertaken properly, time-consuming, tasks.

The extra demands on consultant psychiatrists' time include: more Tribunals and appeals (each patient to have at least one Tribunal after 28 days in addition to any appeals), increased numbers of patients subject to the Act, all patients to have formal care plans and expert panel doctors required after 28 days (rather than 3 months as currently), increased care planning, consultation and information sharing. It is the College's view that such medical provision could only be acquired at the expense of patient care, particularly to those patients at earlier, less severe stages of illness or not requiring compulsion.

Recommendation
Further research is required to assess the realistic likely impact of the proposals, on the workforce, in relation to numbers, recruitment and morale.

IMPACT ON THE PROFESSION

"There are many quite well educated people who believe that psychiatrists have special and mysterious powers that are denied to the rest of the profession and to the rest of humanity. Such people do not appreciate the simple fact that a psychiatrist is a physician who takes a proper history at the first consultation." Henry Miller, (Vice-Chancellor, University of Newcastle) 1969

The draft Mental Health Bill suggests that a psychiatrist's primary role relates to public safety rather than the treatment of individual patients. This contrasts with the rest of medicine where the General Medical Council is quite clear about the role of a doctor: "Make the care of your patient your first concern" and "Listen to patients and respect their views". Surveys undertaken amongst trainees demonstrate that if there is a perception of a new law being increasingly coercive, or the role of the psychiatrist moving from that of a doctor (with roles and responsibilities similar to doctors in other branches of medicine) to a role primarily of social control this will exacerbate the recruitment difficulty. Many members of the College have stated they will take early retirement or transfer to branches of psychiatry where the Bill would have little or no impact. It is the College's view that significant damage will be done to

the morale of the profession, the esteem in which the profession is held and, consequently, to patient care.

PROTECTION FOR ACTS DONE IN PURSUANCE OF THIS ACT (CLAUSE 298; MHA 1983 SECTION 139).

The proposal to increase the penalties for offences under the Act is welcomed. However the College has concerns regarding the proposals in clause 298 of the draft Bill. First they exclude entirely protection for staff in relation to criminal proceedings, secondly they reverse the current process so as to place the onus on the person complained against to prove that they acted in good faith and with reasonable care, finally they remove the need for High Court approval in relation to civil proceedings.

It may be that this is required on a ‘human rights’ basis. However many of the actions required in treating detained patients (such as preventing people leaving hospital, forcibly injecting people with medication and so on) would leave staff guilty of both civil and criminal wrong were it not for the requirements of the Bill.

The College believes that such a change is likely to result in:
a) considerable financial and time costs for many staff, given the removal of what was previously a disincentive to potential spurious litigation driven sometimes by mental disorder and
b) a significant and serious impact, particularly on nursing care. For example, there are likely to be circumstances where nurses would be more reluctant to restrain patients or give medication forcibly despite proper authorisation and clinical necessity.

ADDITIONAL INFORMATION

WALES AND THE DRAFT MENTAL HEALTH BILL

The issues of principle, values and ethics raised by the Bill are the same in Wales as England. This is a brief description of particular matters that are brought to the fore by the separation of policy, policy implementation and practice in Wales as compared with England.

Local Health Boards cover smaller areas and populations and command smaller budgets compared with Primary Care Trusts in England. They may be less able with regard to commissioning of new services.

The Care Programme Approach, policy in England since the early 1990s, is just being introduced in Wales.

There has been no substantial increase in funding for mental health services in Wales.

There is a higher reliance on unsuitable traditional institutional bases. Community services are less developed and there few facilities and staff who are available for and trained to deliver assertive outreach and home treatment services particularly for people who have a serious mental illness.

The specialist forensic mental health services in Wales are poorly placed to respond to present challenges and current legislation. In particular, there are few low secure services and limited relationships between them and medium secure units. As a consequence the forensic services may be poorly placed to take on the challenges of this Bill.

In 2002 there were 43 vacancies for all consultant psychiatrists in Wales (28% of the established workforce) and vacancies in general adult psychiatry posts of 34%. It is thought the position may have improved a little since then. New figures are currently being collected. The College estimated that the requirements of the 2002 draft Mental Health Bill would require an additional 30 psychiatrists in Wales if there was to be no diminution to services for patients not subject to detention.

Advocacy, Tribunal and Appeal services will need to be available in the Welsh language. This will have additional financial and training implications.

The College believes these factors, taken together, may make implementation of the Bill particularly difficult in Wales with the risk of even greater damage to services than in England.

Recommendation
A review of the workforce and service impact in Wales of the Bill is undertaken.

BLACK AND ETHNIC MIORITIES

At the present time disproportionately high numbers of people from BME backgrounds are diagnosed with major mental illness and detained in mental hospitals or institutions. The broad definition of mental disorder in the new draft Bill has the potential to increase the already high numbers of people from BME backgrounds in the system with all the negative consequences which will ensue - the hostility with which traditional psychiatric services are viewed, resulting in an exacerbation of the difficulties in providing good care for those who have great need for it.

DANGEROUSNESS

It is with some reluctance that the College includes this section. Mentally ill patients are more likely to be victims than the rest of the population. This is due both to the vulnerability caused by some illnesses and the stigma of being seen as 'a mental patient'. However it is recognised that there is a tiny minority of patients who, at times, may be dangerous to others.

Every death is a tragedy, for the victim, perpetrator, their family and friends and any professionals involved. The percentage of homicides committed each year by the mentally ill, as a percentage of the total is falling (Gunn and Taylor). The following figures are not intended to minimize the importance of each death but may help to put the matter into perspective.

For each citizen killed by a mentally ill person:

10 are killed by corporate manslaughter
20 by people who are not mentally ill
25 by passive smoking
125 by NHS hospital acquired infection

The proposed legislation is extremely unlikely to have any impact on suicide or homicide rates. With reference to suicide, recent research (Powell) demonstrated that even within the high-risk group of in-patients there would need to be 100 patients detained unnecessarily in order to prevent one suicide. With regard to homicide, (Crawford) has shown that with a

predictive test with a sensitivity and specificity of 0.8 (far better than anything available currently) 5000 people would need to be detained to prevent one homicide. Szmukler has shown that if the predictive test became even better (0.9) this would still require the detention of 2000 people to prevent each homicide. This emphasises that prevention of homicide and suicide can only ever arise as a secondary benefit from improved mental health care for a population and never via prediction per-se of such events.

The starting point in risk reduction is encouraging patients to seek help and talk about their thoughts and feelings. The impact on patients' behaviour when they believe that doctors are acting neither with their consent nor in their best interest was demonstrated forcefully in relation to the body parts scandal and agreement rates for post-mortems. It is hard to believe that potential patients will not be deterred from the services if they know that psychiatrists will have a duty to enforce treatment on them, not only in hospital but also in the community, even when they are perfectly able to make decisions for themselves. Patient avoidance will certainly limit effective intervention.

Nonetheless the consequences of violent behaviour, committed by the mentally disordered or not, may be profound. The College is acutely aware of the impact on victims, perhaps exacerbated when there is a perception that the violence was both predictable and preventable. Resources (workforce as well as financial), training and research are necessary in order to try and minimise risk from this (and other) populations. Support for victims must be available.

PSYCHIATRISTS AND PSYCHOLOGISTS

We understand that some explanation as to the differences between the roles and responsibilities of these two professional groups would be welcome.

The College can only comment on the roles and responsibilities of psychiatrists and would advise that similar information is requested from the British Psychological Society in relation to clinical psychologists.

Psychiatrists are qualified registered medical practitioners (clinical psychologists are not), commonly acquiring a science degree during this training. This takes 6 years. Many then undertake further general medical training before embarking on their psychiatric career.

Training in psychiatry consists of:

Basic training taking 3 to 4 years working under supervision in a variety of psychiatric sub-specialities, requiring attendance at a recognised training scheme and passing the specialist examinations set by the Royal College of Psychiatrists (MRCPsych).

Higher training consisting of 3 to 4 years in specialities such as adult, children, psychotherapy, forensic, learning disability, addictions or rehabilitation.

Most psychiatrist also undertake, and publish, research.

Other important factors:

Psychiatrists assess and examine patients physical health in addition to their mental health.

Psychiatrists prescribe medicines.

Psychiatrists have 24 hour 7 days/week on-call and cover arrangements both in the community and in hospital.

FORENSIC PSYCHIATRISTS

We understand that brief clarification of the role of forensic psychiatrists would be helpful.

Forensic psychiatry concentrates on those patients and problems at the interface of law and psychiatry.

The particular skills of forensic psychiatrists include:

1. Clinical risk assessments, especially on the relationship between mental disorder and violence to others. The patient population treated by Forensic Psychiatrists will be mainly those mentally disordered offenders who pose significant risks to others.
2. Writing of medico-legal reports and the giving of evidence in court.
3. The giving of advice to and collaborative working with practitioners in the health service and the criminal justice system. This will include giving advice and working with other agencies in managing exceptional risk offenders subject to Multi Agency Public Protection Arrangements.
4. The use of security as a means of treatment.

MENTAL HEALTH ACTS ACROSS THE UNITED KINGDOM

Transfer of patients from England and Wales, Clause 161. The College is concerned that the legislation in different parts of the United Kingdom should not have substantially different provisions. Should the current proposals be adopted in England and Wales a person who met the conditions for compulsion in England or Wales may not do so in Scotland or Northern Ireland. Sub-clause 10 sets the provisions. A person from Scotland, detained in England, may be unable to be transferred back to Scotland because he does not meet the conditions in that jurisdiction. We see no evidence that the Government have thought through the implications of considerably different forms of mental health legislation in Scotland and England/Wales.

Recommendation
The principles and essential provisions of mental health legislation should not differ significantly between different parts of the United Kingdom.

SEPTEMBER 2004

APPENDIX 1

As the professional and educational organisation for doctors specialising in psychiatry, the Royal College:

sets the standards of training, through examinations and continuing professional development of psychiatrists;

- develops and improves the quality of mental health service provision;
- conducts and promotes research into psychiatry;
- raises medical and public awareness of mental health issues;
- advises government on mental health and disability legislation;
- improves the quality of support for people with mental illness and their carers.

- As an educational body, the College runs the 'MRCPsych' examination for doctors to become psychiatrists, visits and rigorously inspects training facilities, organises scientific and clinical events and overviews psychiatrists' continuing professional development.

- As a professional body, the College advises government on mental health and disability legislation and publishes academic journals, books and policy documents.

- As a registered charity, the College campaigns to raise public awareness of mental health issues and produces a range of public education materials available both online and as leaflets. (see www.rcpsych.ac.uk)

APPENDIX 2

The World Psychiatric Association approved at the General Assembly, on August 25, 1996 the following ethical standards that should govern the conduct of psychiatrists worldwide.

1. Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders; with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are the least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.
2. It is the duty of psychiatrists to keep abreast of scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.
3. The patient should be accepted as a partner by right in the therapeutic process. The therapist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with relevant information so as to empower the patient to come to a rational decision according to his or her personal values and preferences.
4. When the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient.
5. When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when psychiatrists are involved in third party situations.
6. Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or financial or academic benefits. Breach of confidentially may only be appropriate when serious physical or mental harm to the patient or to the third person could ensue if confidentiality were maintained; in these circumstances, psychiatrists should whenever possible, first advise the patient about the action to be taken.
7. Research that is not conducted in accordance with the canons of science is unethical. Research activities should be approved by an appropriately constituted Ethics committee. Psychiatrists should follow national and international rules for the conduct on research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy as well as their mental and physical integrity. Ethical standards should also applied in the selection of population groups in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centres.