



Government response to the report of the Joint Committee on the draft *Mental Health Bill* 2004



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Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
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Government response to the Joint Committee's report on the draft Mental Health Bill 2004 [HL Paper 79-1, HC 95-1]

Introduction

1. The Government is very grateful to the Joint Committee for their detailed pre-legislative scrutiny of the draft Mental Health Bill. We have considered their report and recommendations in great depth, along with much of the evidence submitted, and are now responding to those recommendations.

Improving mental health

2. Before responding to the report, we need to set mental health legislation in a wider context.
3. At any point in time, one in six of the population has a common mental health problem; and one in three people has a mental health problem at some time in their lives. At any point in time, about 630,000 people are in contact with specialist mental health services. The main thrust of the Government's work is to improve services for people with mental health problems and to promote good mental health.
4. The great majority of people with a mental disorder will never be treated under mental health legislation. Mental health legislation is about the circumstances in which people with a mental disorder can be treated without their consent, in order to protect them and/or others from harm; and the processes that have to be followed if someone is to be treated without consent. At any point in time, about 14,000 people are being treated for a mental disorder under the Mental Health Act 1983.
5. In terms of the small minority of people with a mental disorder for whom compulsion might be necessary, we want to achieve a level and type of service provision that minimises the risk of people with a mental disorder deteriorating to the point where compulsion is necessary. When compulsion has become necessary, we want that service provision to be of a level and type to ensure that everything possible is done to prevent the need for any further episodes of compulsion. In other words, by improving the services to promote better mental health, we want to reduce the need for compulsion.

6. We have made enormous strides in improving service provision generally. There is improved access to effective treatment and care, standards have been raised, and services are quicker and more convenient. Evidence of our success and of our commitment to improve services and outcomes includes the following:
- The rate of death from suicide has been steadily falling for the past five years – it is now at its lowest recorded figure. The overall death rate from suicide in the most recent period (2001–03) has fallen to 8.6 deaths per 100,000 population. This marks a reduction of 6% from the baseline rate in 1995–97 of 9.2 deaths per 100,000.
 - As at the end of March 2005, there were 343 crisis resolution, 261 assertive outreach and 109 early intervention teams established in England. Some 17,500 people are now being seen by assertive outreach teams and around 69,000 people benefited from crisis resolution services in 2004/05.
 - In addition to the new teams mentioned above, around 1,500 community gateway workers are being employed to co-ordinate and ensure prompt access to mental health care; and around 600 graduate primary care mental health workers trained in brief therapy techniques are being appointed to provide first-line treatments within primary care teams and to support clinical governance in primary care.
 - The increase in spending on mental health between 1999/2000 and 2002/03 was £728 million (or 19% in real terms).
 - The National Institute for Mental Health in England (NIMHE) is leading on the implementation of the Social Exclusion Unit's recommendations (published in June 2004) for the development of better access to employment and to social, educational and community activity for people with mental health problems. NIMHE's work on this area entails co-ordinating action across 22 government departments and agencies.
 - Central to future developments will be the new anti-stigma programme, *From Here to Equality*, to tackle discrimination against people with mental health problems, and the work to improve mental health care for ethnic minorities. *Delivering Race Equality in Mental Health Care*, an action plan for reform both inside and outside NHS mental health services over the next five years, was published in January 2005, setting off a period of change in how we oppose discrimination and provide mental health care for a diverse society. Related to this, phase one of the Healthcare Commission, Mental Health Act Commission (MHAC) and NIMHE census (*Count me in*) of mental health and ethnicity took place in March 2005. It is looking at all inpatients, ethnicity, use of seclusion, legal status, referrals, control and restraint.

- Work to develop mental health within the context of key national initiatives such as extending patient choice and the Public Health White Paper *Choosing Health* is also under way. Within these programmes, there will be a focus on improving information to support self-help, access to services, including psychological therapies, improving care for those with long-term conditions and reducing health inequalities.
- Similarly, in Wales, work is under way to develop mental health services within the context of the Welsh Assembly Government vision for health and social care *Designed for Life*. This includes the target of all areas having home treatment and crisis resolution teams in place and improving the therapeutic inpatient environment by March 2006, action on workforce reconfiguration, a significant level of capital investment in modernising mental health services in the next three years to build upon substantial recent progress in replacing outdated mental health hospitals, and the production of a mental health promotion action plan that will include a focus on social inclusion and tackling stigma. The Welsh Assembly Government has also established a scheme to modernise mental health services through the improvement of care pathways for mental health service users. The Assembly Government is rolling out a bibliotherapy scheme designed to improve access to self-help materials in primary and secondary care settings.

Mental health legislation – the story so far

7. Mental health legislation is about getting the right balance between protecting an individual's rights to make decisions and the need for society to take steps to protect an individual from harming themselves and/or others as a result of a mental disorder. The current legislation is the Mental Health Act 1983. In 1998, the Government announced that it wished to introduce new legislation, which would reflect contemporary patterns of care within a framework that achieved this balance. Following a report from an expert committee, Green and White Papers and a draft consultation Bill in 2002, in September 2004 the Government published a draft Bill for pre-legislative scrutiny. In March 2005, the Joint Committee published its report on the draft Bill. This document represents the response to that report.
8. There has been an enormous amount of consultation on the Mental Health Bill. At each stage of the process listed in paragraph 7 above, views have been sought. When the draft Bill was published for consultation in 2002, about 2,000 sets of comments were received. We are very grateful for the help that we have had from so many people in developing the legislation.

The Government's response to the Joint Committee

9. We have looked carefully at all of the Committee's 107 recommendations. We are in the process of reconsidering some parts of the Bill, and are planning to make a significant number of changes as a result of the recommendations. While we agree or agree in part with many of the recommendations, there are areas of the report with which we disagree.
10. First of all, the report says that the legislation should be about improving services. The Bill is not about service provision. It is about the legal processes for bringing people under compulsion. As outlined above, steps are being taken separately to improve services through a number of means, such as implementation of the NHS Plan and the Mental Health National Service Framework (NSF). The Bill is one part of the Government's strategy to improve outcomes for people with mental health problems, but other parts of the strategy are tackling service provision.
11. Secondly, we must state very firmly that we disagree with the Committee's criticism that the Bill places too much emphasis on public safety and not enough on patient rights.
12. We consider that the Committee's concerns about the balance of public safety and patient autonomy miss the point that our concern is about the balance between **patient and** public safety and patient autonomy. The great majority of people with a serious mental disorder are more likely to harm themselves than others, and it is wrong to paint a picture of a government or society obsessed with public safety. The Government's and society's concern is to protect very vulnerable people from harming themselves or, much more occasionally, others. And the concern to ensure that people can get the treatment they need to protect them from harming themselves or others is balanced by a concern to respect patients' rights to make decisions for themselves.
13. In addition, the Committee, while recognising that public protection is a relevant issue, does not in our view recognise the significance of this. The great majority of evidence came from stakeholders who represent health and social care professionals and service users, and relatively little from those with responsibility for protecting the public or from the general public themselves – the majority of whom do not share the Committee's belief that the Bill is inappropriately concerned with public safety.
14. Media coverage of homicides leads to a distorted view of the risk that is posed by mentally disordered people, the great majority of whom will never be a risk to anyone. But the fact remains that there are significant numbers of homicides by mentally disordered people each year – some of which are preventable. The 2001 report *Safety First: Five-Year Report of the National Confidential Inquiry into Suicide*

and Homicide by People with Mental Illness found that, of the 500 or so homicides each year, about 15% are committed by people who had a mental illness at the time of the homicide. Although there is a wide range of issues which need to be addressed to try to reduce the risk of such homicides – many of which the Government is seeking to address – society has a reasonable expectation that the law will provide protection, as far as possible, from patients with a serious mental disorder who present a risk of harm to others.

15. We believe that it is in patients' interests to bring them under compulsion if their mental disorder is so serious that they represent a serious risk to themselves or a risk to others – not only because treatment may be able to help them but also because we will never overcome the stigma associated with mental illness if the public is concerned that people with a mental disorder represent a risk to public safety.
16. We must stress that we see no conflict between protection from harm and ensuring that patient rights are fully and appropriately promoted. The Bill does both. The Bill introduces a range of new safeguards, such as rights to advocacy and rights to choose a nominated person. While our response identifies some specific points on which we propose to review the drafting, in general our belief is that the conditions for compulsion have been misunderstood, and that they will not bring people under compulsion inappropriately. In particular, the conditions need to be seen in terms of the overarching principle that the degree of compulsion must be proportionate to the risk that someone presents, and clinicians will use their judgement as to whether or not a person meets the conditions for compulsion, including whether appropriate treatment is available. There is no question of clinicians being required to use compulsion where they do not consider it justified.
17. Detailed responses to each of the recommendations are included in this document, and so we will not cover their content within the introduction. However, what we will do is to reiterate briefly how the legislation will bring significant improvements for patients. The Bill will:
 - provide new support for patients:
 - a nominated person to help the patient, represent them and be able to apply to the Mental Health Tribunal on their behalf
 - help from independent Mental Health Act advocates for patients and their nominated person
 - strengthen safeguards for them:
 - authorisation of the use of formal powers by an independent judicial body, the Mental Health Tribunal

- new powers of inspection
- safeguards for children who have a serious mental disorder but who are refusing treatment that is being given by virtue of parental consent
- notifications given to the appropriate people, such as carers, at different stages in decision-making
- the requirement for individual written care plans for compulsory treatment
- ensure that patients receive appropriate treatment:
 - raise the threshold of risk of harm to self so that formal powers can be properly targeted on patients who present a serious risk to themselves or a risk to others
 - require that appropriate treatment must be available for the individual patient before formal powers can be used
 - enable some patients (including non-dangerous offenders) to be treated, subject to requirements, in the community, reducing the risk of social exclusion that can result from the need for detention in hospital under the current Act
- increase choice for patients under compulsion:
 - involvement in decision-making (as will be the case for their carers)
 - choice of a nominated person to represent their views
 - the right to refuse electroconvulsive therapy (ECT) where they have the mental capacity to do so.

Next steps

18. Plans to introduce the Mental Health Bill into Parliament in this session were announced in the Queen's Speech. We are now redrafting the Bill to take account of changes to be made following consideration of the Committee's report. We are also looking at a number of other issues, mainly technical ones, that have arisen.

Government responses to the Committee's recommendations

Introduction

Recommendation 1

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

Response

We are pleased that the Committee recognised, as do the great majority of stakeholders, the need for new mental health legislation to replace the Mental Health Act 1983. The Government believes that the new legislation, specifically designed to be compatible with European Convention on Human Rights (ECHR) obligations, is necessary to provide a comprehensive new legal framework that reflects and responds to developments in mental health treatments and services.

Recommendation 2

We fully accept the need to incorporate effective risk management and public protection into mental health policy and a new Mental Health Act. However, this objective must never be allowed to predominate as the primary objective of reform.

Response

Mental health legislation is concerned with providing a balance between the rights of the individual and the need to protect that individual and society from the harm that may arise as a result of the individual's mental disorder. The Government believes that the Bill achieves the correct balance between the rights of individuals and the need to prevent harm. Achieving this balance is vital to the proposed legislation, and will help ensure that formal powers are properly targeted so that individuals with a serious mental disorder receive the right care at the right time to protect their own health and safety, as well as that of others. The patient safeguards introduced by the Bill will help ensure that compulsory treatment does not inappropriately affect a patient's rights or liberty.

Recommendations 3 and 45

We hope that any Bill the Government presents to Parliament will be clearer and easier to read and follow than the current draft Bill.

We recommend that the Government give serious consideration to ways of improving the drafting so that the provisions of the whole Bill, and particularly Part 3, can be more easily understood, and can be read in conjunction with the Criminal Justice Act 2003.

Response

The Government has considered the comments made by the Committee about the clarity and readability of the Bill. It is accepted that the Bill is not always easy to understand. As this is a draft Bill there is the opportunity to make improvements before introduction. However, although the aim is to make the Bill as accessible as possible to practitioners and others, it is also important to get the legal effect correct. The Bill deals with complex situations and it will be important in reviewing the drafting to ensure accuracy and completeness. Moreover, we would not wish drafting changes to add further to the length of the Bill unless there are real improvements in the readability of particular provisions. The policy in the Bill is such that many areas are interdependent, there are many different situations to be dealt with, and there are some new areas such as the non-resident orders and the need to address criminal as well as civil patients in relation to new requirements such as care plans.

Principles and codes of practice

Recommendation 4

We believe that it is essential that fundamental principles be set out on the face of the Bill. It is not appropriate to leave fundamental guiding principles to the codes of practice.

Response

The Government accepts that principles ought to be set out on the face of the Bill, provided that they can be drafted in a way that allows for due protection to an individual's rights and autonomy, while also facilitating practitioners and others to take decisions that are necessary to minimise harm.

Recommendation 5

We conclude that the Mental Health (Care and Treatment) (Scotland) Act 2003 serves as an excellent model for the range and specificity of principles that must be set out on the face of a new Mental Health Act for England and Wales. We recommend that the Government use this model as a starting point for creating a set of explicit guiding principles to be set out in clause 1 of the Bill when re-drafted. It follows that the provisions of the Bill proper must reflect and support the principles included.

Response

The Government is considering a range of possible principles. However, we are not in favour of including a long list of principles on the face of the Bill – to do so would risk over-codification. The principles on the face of the Bill should be broad, so that the codes of practice can provide more detailed information about the supporting considerations that need to be made in order to meet the general principles.

Recommendation 6

We propose that for the principle listed in the Scottish Act of ‘minimum restriction of the freedom of the patient necessary in the circumstances’, there be substituted in the Bill proper a principle based on the wording of the draft Bill, namely interference with, and restrictions imposed on, patients must be kept to the minimum necessary to protect their health or safety or the health or safety of other persons.

Response

The Government acknowledges that if principles appear on the face of the Bill, they must balance patient rights with the need to minimise harm. However, this consideration is an integral part of how all the principles should apply, and does not relate solely to the principle of least restriction.

Recommendation 7

We recommend that the Bill include a concept of capacity as one of its principles in the form of ‘significantly impaired decision-making’. The concept would be most directly expressed as one of the conditions for the use of compulsion. However, this will also need to be reflected in the principles and other provisions of the Bill. It should also be an explicit principle that practitioners must have regard to the past and present wishes of the patient.

Response

The Government accepts that practitioners should have regard to the past and present wishes of the patient. These considerations are an integral part of any principle about patient involvement. See recommendation 26 for the Government’s response in relation to the issue of impaired decision-making.

Recommendation 8

We conclude that a provision on the face of the Bill that anyone operating the legislation ‘must have regard to’ a range of principles would provide a reasonable balance between flexibility, on the one hand, and transparency and confidence on the other.

Response

The Government agrees that a requirement to have regard to principles would provide a reasonable balance.

Recommendation 9

We recommend the removal from the Bill of the provision for the possible disapplication of any principles when the Bill proper is brought forward.

Response

The Government agrees that a provision for the possible disapplication of principles would not be necessary provided that principles are drafted according to the response given to recommendation 4.

Recommendation 10

We consider that, in cases where draft Bills leave significant provisions to be contained only in secondary legislation or codes of practice, it is not feasible to conduct completely effective pre-legislative scrutiny of the draft Bill without access to draft codes as well. We believe that, in cases such as the draft Mental Health Bill, the best option is to publish skeleton codes and, if necessary, regulations, at the same time as the draft Bill, and undertake a full consultation on the codes and regulations in tandem with pre-legislative scrutiny of the draft Bill. We urge the Government to consider this option for future pre-legislative scrutiny wherever possible. We note, in the present instance, that several years have passed since the draft legislation was first mooted. We are disappointed that some of that time was not used to produce draft codes of practice.

Response

The Government appreciates that it can be difficult to assess the full effect of a Bill without seeing related secondary legislation and codes of practice. The Government's *Guide to Legislative Procedures* (paragraph 8.27) reminds departments that, when draft regulations are central to the effect of a Bill, it is helpful to make them available to Parliament when it considers that Bill. This applies equally to draft codes of practice. While we appreciate that, similarly, it would be helpful if they were available to the Committee, this may not be practicable in the time available. We would not wish a commitment to publish codes of practice with draft Bills to have the effect of inhibiting the publication of legislation in draft. Nevertheless, we will seek to publish codes of practice wherever possible, and, where it is not possible to offer fully drafted codes, the Committee is at any rate entitled to expect an account of the state of thinking on what the codes might contain.

The Government recognises that draft codes of practice will assist Parliament's consideration of the Mental Health Bill, and that is why, in line with the Government's *Guide to Legislative Procedures*, we plan for first drafts of the code of practice and of key regulations for England to be available when Parliament considers the Bill.

In Wales, the National Assembly will be responsible for making regulations and issuing a code of practice. All secondary legislation and the draft Welsh code will additionally be subject to the full scrutiny of Assembly committees and the Assembly in plenary.

Definitions and conditions

Recommendations 11 and 12

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

We conclude that a broad definition of mental disorder in the draft Bill must be accompanied by explicit and specific exclusions which safeguard against the legislation being used inappropriately as a means of social control.

Response

We welcome the Committee's support for a single definition of mental disorder, which we believe will provide greater clarity and certainty than the approach taken in the Mental Health Act 1983. However, as Ministers said in their oral evidence to the Committee, the intention is for the definition of mental disorder for the purposes of this legislation to exclude people whose disability or disorder of the mind or brain does not result in psychological dysfunction. We are looking at the definition of mental disorder to clarify this. See below for the Government's response to specific recommendations on exclusions and conditions.

Recommendation 13

We recommend that a specific exclusion on the grounds of substance misuse alone (including dependence on alcohol or drugs) be inserted into the Bill.

Response

The Government believes that there is a danger that qualifying the definition of mental disorder by specific exclusions focuses attention on diagnostic labels, rather than on the needs of the individual patient and the consequences of their mental disorder. This in turn may lead to people wrongly failing to get necessary treatment.

However, in this one case, the Government is persuaded that an exclusion of some kind is desirable to ensure that the Bill does not encompass the compulsory treatment of people whose only mental disorder is dependency on alcohol or drugs.

It will therefore be reviewing the drafting of the Bill to make this clear, while creating no barrier to the proper use of compulsory treatment, where necessary, for people who suffer from substance dependency and, in addition, one or more other mental disorders (so-called 'dual diagnosis'). This would include mental disorders that arise out of, or are connected with, their substance misuse.

Recommendation 14

We recommend that a specific exclusion on the grounds of sexual orientation be inserted into the Bill. We do not agree that any exclusion should extend to sexual deviance.

Response

We believe that the conditions for compulsion could not be met solely on the grounds of a patient's sexual orientation. Such an exclusion is therefore not necessary.

Recommendation 15

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

Response

We do not agree that an additional condition should be introduced. To have a condition that applies only to patients with a certain category of mental disorder would be discriminatory and would lead to different outcomes for patients at the same degree of risk but with different diagnoses. The Government believes that an important benefit of a single definition is that it allows decisions to focus on the effects of the disorder, not its diagnostic label. It is the effect – not the diagnosis – that should determine whether compulsory treatment is necessary and justified.

Recommendation 16

We recommend too that the codes provide illustrative examples of the full range of developmental conditions, including Asperger's Syndrome.

Response

There is planned to be a chapter in the codes of practice on people with learning disabilities and one on people with social and communicative disorders. Explanation and guidance on how the Bill applies to people with learning disabilities or with social or communicative disorders will be given in those chapters and/or in the chapter on the conditions for compulsion.

Recommendation 17

We recommend that the Bill be amended to contain a specific exclusion for the use of compulsory powers on the grounds of cultural or political beliefs or behaviours alone.

Response

We acknowledge the Committee's concerns about the high representation of certain minority ethnic groups in mental health services. That is why in England we published an action plan for delivering race equality in mental health care at the beginning of this year. In Wales, an action plan is being worked on. We are also conducting a Race Equality Impact Assessment on the Bill. We do not agree, however, that a specific exclusion on the grounds of cultural or political beliefs or behaviours alone is appropriate. Such beliefs and behaviours are not mental disorders, and so do not need to be excluded.

Recommendation 18

We recommend that the second condition for the use of compulsion at clause 9(3) of the draft Bill be amended so as to read: the 'mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him under compulsory powers'.

Response

All the relevant conditions must be met before compulsion can occur. The second condition must therefore be read in conjunction with the other conditions. The first three conditions require that the patient has a mental disorder, that the mental disorder is serious enough to warrant specialist mental health services, and that treatment is necessary because the patient is at serious risk of self-harm or neglect or is a risk to others. The fourth condition requires the examiners further to consider whether the medical treatment that patients need because of the risk they pose can be delivered without compulsory powers under the draft Bill being invoked (but see also the response to recommendations 24 and 25). The fifth condition requires appropriate treatment to be available to meet that particular patient's needs. The amendment to the second condition is therefore not necessary.

Recommendation 19

We recommend that the Government tighten criterion (a) at clause 9(4) in the draft Bill to prevent compulsory powers from being used on a permanent basis in respect of patients who either have a diagnosis associated with a constant risk of suicide or serious self-harm or who engage in chronic risk behaviours.

Response

Once a patient is brought under compulsion, decision-makers must keep under review whether all the relevant conditions continue to be met. In deciding whether the third condition is met at clause 9(4)(a), those decision-makers must be satisfied that the risk to the patient's health or safety remains a serious and foreseeable one. The fifth condition means that the clinician must consider that appropriate treatment continues to be available for a patient to meet the conditions for compulsion.

Recommendation 20

We recommend that the criterion at clause 9(4)(b) of the draft Bill be changed to read 'for the protection of other persons from significant risk of serious harm'.

Response

The Government does not agree with this recommendation. The wording in the Bill replicates that in the Mental Health Act 1983, and we have heard no suggestion that it has led to inappropriate use of compulsion. It should be remembered that a determination of risk will always be a matter of judgement by the relevant decision-makers and that, in considering the conditions for compulsion, they must have regard to the requirements of human rights legislation that compulsion is a proportionate response to the harm that might be caused if no action were taken.

Recommendations 21 and 22

We recommend that the Government amend the fifth condition at clause 9(6) of the draft Bill so as to include a test of therapeutic benefit as used in the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003.

We conclude that people with serious mental disorders who cannot benefit from treatment pose a very challenging problem, but recommend they be dealt with under separate legislation.

Response

The Government agrees with the Committee that it would be inappropriate to use the Mental Health Bill to detain (or otherwise apply compulsion to) people who are not in need of specialist mental health care. That is why the relevant conditions in clause 9 (and their equivalents in Part 3) ensure that compulsion can be used only where it is for a clinical purpose. Unless the person needs medical treatment under the supervision of a specialist mental health professional and appropriate treatment is available, compulsion cannot be used. It is not, and has never been, the Government's intention that the Bill should be used to detain people solely for the purpose of taking them out of circulation without offering them appropriate treatment.

However, we do not agree that compulsion should be limited to those cases where the benefit of treatment will be expressed by an improvement to the patient's condition, or by preventing deterioration. In some cases, treatment may need to be given even though the nature of the patient's condition means that the treatment is unlikely either to improve it or to prevent it worsening. Indeed, some intensive therapeutic interventions may have the effect of temporarily worsening a patient's presentation in the short term. Accordingly, we do not believe that it would be appropriate to adopt the 'therapeutic benefit' test as used in the Scottish legislation.

It follows that we do not consider it necessary to introduce separate legislation for people with a mental disorder who pose a danger to the public but who cannot be treated. Increasingly, appropriate treatment is available. But if there are such people for whom no appropriate treatment exists, then it would be wrong to detain them otherwise than under the criminal law.

Recommendation 23

We recommend that the codes of practice provide extensive guidance, with examples, assisting practitioners and tribunals in interpreting the notion of appropriate treatment. The codes should also emphasise the need for 'appropriate treatment' to be understood as including culturally appropriate, and that services, as far as possible, should be provided in a culturally sensitive manner.

Response

The codes of practice will give advice on the application of all the conditions, including the need to deliver the service in a culturally sensitive manner. See also the response to recommendation 17.

Recommendations 24 and 25

We recommend that clause 9(7) be removed from the Bill.

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

Response

The Government agrees that compulsion should be used only where it is necessary. But equally, where it is necessary, there should be no impediment to its proper use.

The purpose of clause 9(7) is to ensure that there is no such impediment in the minority of cases where there is a risk of serious harm to other people. Where decision-makers have determined that people are at substantial risk of causing serious harm to other people, and that it is necessary to provide them with medical treatment, then the use of compulsion is likely to be necessary to protect the public (and patients themselves) from that risk.

The Government is persuaded, however, that there may be exceptional cases where, even though decision-makers have assessed a patient as being at substantial risk of causing serious harm to others, they nonetheless conclude that the risks can be properly managed without using compulsion because they are satisfied that the patient will comply voluntarily with the necessary treatment.

The Government will therefore be reviewing the drafting of the condition to see if it is possible to accommodate such cases without detracting from decision-makers' ability to use compulsion where it is necessary to protect patients themselves or other people, including, where appropriate, in cases where a patient's capacity to consent is expected to fluctuate.

Recommendation 26

We recommend that the Bill, as in the Mental Health (Care and Treatment) (Scotland) 2003 Act, include a condition at clause 9 that by reason of mental disorder the patient's ability to make decisions about the provision of medical treatment is significantly impaired.

Response

As the Committee notes, the Government set out in detail the dangers we saw with any kind of capacity or impaired decision-making test. We do not agree that these concerns have been convincingly countered by the evidence put to the Committee. The Scottish legislation has yet to be applied in practice. In the Government's opinion, it is not safe to assume that there is a link between the severity of a condition – and therefore the need for treatment – and the person's ability to make decisions. It is possible that people who are at very great risk to themselves or others would nonetheless retain the ability to make unimpaired decisions about their treatment. In other words, we do not think that there is good evidence on the basis of which we could agree with the Committee that 'no one would ever become too ill before the test is met'.

Interface with mental capacity legislation

Recommendation 27

We recommend that, before Parliament is asked to assent to the Mental Health Bill, a clearer analysis of the interrelation between the two pieces of legislation be presented. The relationship between the Mental Capacity Bill and a future Mental Health Bill should be clarified primarily so that clinicians have a clear understanding of their application in each particular case. This could conveniently be a common part of the respective codes of practice.

Response

The Government fully agrees with the Committee's recommendation that there should be clarity about the interface between the Mental Health Bill and the Mental Capacity Act. The two pieces of legislation serve very different purposes, but there will inevitably be some people whose care either could or does fall within the ambit of both.

Now that the Mental Capacity Act has received Royal Assent, the Mental Health Bill will clarify the relationship between the two pieces of legislation. Guidance will also be included in the respective codes of practice, as the Committee recommends. Both the Bill and the guidance will also, of course, take account of the new arrangements to be put in place following consultation on the approach to be taken in response to the judgment of the European Court of Human Rights in the Bournemouth case.

Recommendation 28

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

Response

The Government agrees that advance directives and advance statements are an important way for patients to exercise some dignity and control over their treatment and care. Patients should have the opportunity to record in advance their refusal to receive certain treatments, and should also have an opportunity to make advance statements of their treatment preferences. We agree that these should be taken into account by, but not be binding on, clinicians. We are carefully considering how this can be achieved on the face of the Bill.

Recommendation 29

We urge the Government to bring forward a comprehensive and universal set of proposals to deal with hospitalisation and treatment of patients affected by the Bournemouth judgment, either as amendments to a Mental Capacity Bill (as it appears to be intending now), or, failing that, by introducing proposals in the Mental Health Bill, as soon as possible.

Response

In the light of the Bournemouth judgment, the Government is committed to bringing forward proposals for new safeguards for those incapacitated patients who need to be treated in their best interests in a way that involves deprivation of liberty. Before doing so, the Government believes it is important to consult widely. Accordingly, the Department of

Health and the National Assembly for Wales published a consultation document in March 2005 seeking views on the safeguards that should be put in place. The closing date for comments was 17 June 2005. Once we have decided what new arrangements are required, we will identify a suitable legislative vehicle in order to implement changes as quickly as possible.

Non-residential orders

Recommendations 30 and 31

We recommend that the use of non-residential treatment under compulsion be explicitly limited to a clearly defined and clinically identifiable group of patients.

We therefore recommend the following series of amendments to the Bill, which would focus the provisions of the Bill proper on a clearly defined and clinically identifiable group of patients – for example, patients who frequently relapse – and limit the scope and potential duration of non-residential compulsory treatment.

Response

We welcome the Committee's recognition that treatment in the community could be of benefit to those patients who frequently relapse, and we agree that the group of patients initially eligible for assessment and treatment in the community needs to be clearly defined in legislation. The Government intends that this group of patients will be defined in regulations that will allow amendments to reflect developments in professional practice and service provision in the light of experience in the use of these powers. The Parliamentary procedure for this power in England is affirmative resolution, which will ensure an appropriate opportunity for scrutiny, as will the National Assembly's secondary legislation procedures in Wales. In recognition of the interest in this issue, we plan to consult with interested parties as we develop the policy for the regulations.

We do not, however, agree that there should be any similar restriction on which patients may be non-resident after the initial assessment and treatment stage. Indeed, we have doubts that the recommendations could be achieved in a way that is compatible with the ECHR. Limiting the availability of non-resident status to a specific group in the way recommended would discriminate against those resident patients experiencing their first period of compulsory treatment and whose condition had improved to the point where, although they still required treatment, they no longer needed to be detained as resident patients. This would be an unacceptable limitation on powers that enable treatment to be delivered in the way most appropriate to the needs of individual patients. It would also result in unacceptable inequality between different groups of patients, some of whom may be detained for long periods while others are non-resident.

Recommendation 32

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

Response

The relevant conditions that must be satisfied for all civil patients before compulsory powers can be used set a single threshold that applies whether assessment and treatment are provided as a resident or a non-resident patient. Guidance in the codes of practice and training on the conditions and decision-making about how patients are brought under compulsion will address the need to guard against the inappropriate use of legal powers.

Recommendation 33

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

- a) A non-residential order should not normally be imposed without previous hospitalisation at least for the purposes of assessment.
- b) There exists evidence of previous responsiveness to, and co-operation with, proposed treatment before a non-residential order is imposed.
- c) Provision for non-residential orders should be simple and be used to specify only:
 - i) requirements or limitations on a person's place of residence; and
 - ii) medical treatment.
- d) There must be a maximum time limit for treatment under a non-residential order – certainly of not more than three years in any five-year period.
- e) The non-residential order must not authorise the use of force on the patient in the community (i.e. outside hospitals or clinics) beyond the powers currently available in the 1983 Act, which provide for a patient to be conveyed to the place he is required to attend for treatment or to be conveyed to hospital.

Response

We welcome the Committee's agreement with key elements of the Government's policy that a patient treated under formal powers should not be assessed in the community without previous assessment in hospital and that there should be no forcible treatment of patients outside of a hospital. We agree that the potential responsiveness to treatment and co-operation of patients are relevant factors to be taken into consideration in deciding whether non-resident treatment is appropriate. These issues will be covered in guidance in the codes of practice and in the training of professionals on decision-making under the powers of the Bill.

Limiting the types of condition that may be imposed on patients in the way recommended would not allow the effective management of risk of harm to patients or others and would, therefore, make the powers unworkable. The need for requirements to be reasonable and for restrictions to be appropriate and proportionate will be addressed through guidance in the codes. To introduce a maximum period would be likely to lead to arbitrary detention in a way that would not be acceptable, and we have doubts that this recommendation could be achieved in a way that is compatible with ECHR. The relevant conditions for the use of compulsory powers must be kept under review and, if any condition is no longer satisfied, patients must be discharged from compulsion.

Recommendation 34

We recommend that the provisions for non-residential orders be accompanied by a requirement on health and local authorities to provide adequate care. Further, adequate care means care other than that provided by families and carers, and any provision for non-residential orders must ensure that burdens are not placed upon families and carers that would fall more properly on clinicians and the health and social services.

Response

The purpose of the Bill is to provide the legal authority for the treatment without consent of a person suffering from a mental disorder. The provision of services is dealt with elsewhere. However, the fifth condition, which must be met for compulsory powers to be used, cannot be satisfied unless appropriate treatment is available for the individual patient. NHS bodies and local authorities have responsibilities to meet the needs of their populations and, as now, it will be for service commissioners and service providers to agree whether, when and how services are made available for patients. The decision to assess or treat a patient as a non-resident must include the need to ensure that the fifth condition continues to be satisfied. In order for treatment to be included in the care plan, there will need to be an agreement with the relevant service providers. We need to ensure that the impact on carers and families is fully taken into account, which is why the clinical supervisor is required to consult any carer when drawing up a care plan (subject to the clinical supervisor first considering the patient's wishes and feelings about consultation with the carer).

Child and adolescent mental health services

Recommendation 35

We recommend that the Bill provide 16 and 17 year olds who are being treated under compulsion with the same safeguards as under-16 year olds, in addition to the rights which they enjoy as adults.

Response

We welcome the Committee's agreement that the Bill should provide appropriate safeguards for young people aged 16 and 17 suffering from a mental disorder. Our policy in this area strikes a careful balance between the rights of children and of parents. The law on parental consent to treatment currently allows young people to be treated against their own wishes on the basis of that consent, but with few safeguards. We believe that the best protection for the rights of 16 and 17 year olds is entitlement to the full safeguard regime available under the compulsory powers of the Bill, rather than relying on parental consent.

The Committee's proposal that 16 and 17 year olds should benefit additionally from the new safeguards proposed for under-16 year olds appears to misunderstand two salient points. First, in the absence of the consent of the young person concerned (assuming they are competent to make such decisions), it is either parental consent or the compulsory procedure that provides the legal authority for treatment. It is not legally possible for both means of authority to apply simultaneously. Secondly, there is nothing to be gained by dual coverage by both regimes. Safeguards common to both, for which duplicate entitlement would be superfluous, are:

- the appointment of a nominated person to help the patient and exercise powers of access to the Mental Health Tribunal on the patient's behalf
- access to specialist advocacy for both the patient and the nominated person to ensure that the child's voice is heard
- a written care plan drawn up according to statutory requirements governing content and consultation with the patient, the nominated person and carers
- clear statutory procedures to be followed
- a right to apply to the Tribunal to determine whether detention is lawful
- scrutiny by the Healthcare Commission.

The important point of difference, which gives more protection under the compulsory regime for 16 and 17 year olds, is the independent authorisation of longer-term treatment by the Tribunal.

It is important to note that the proposed change in the legal position regarding the ability of 16 and 17 year olds to consent to, or refuse, treatment for mental disorder does not affect the expectation in the Children's NSF in England for specialist Child and Adolescent Mental Health Services (CAMHS) to be available for all young people up to age 18 over the lifetime of the NSF. Similarly, in Wales, the standards in the CAMHS strategy *Everybody's Business* and the NSF for Children, Young People and Maternity Services include all children up to age 18.

Recommendation 36

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

Response

We will consider this recommendation further in light of the decision to review the drafting of the fourth condition (see recommendations 24 and 25).

Recommendations 37, 38 and 39

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

We recommend that there be a requirement that at least one medical assessment of a person under 18 years of age prior to the imposition of compulsory treatment should be by a clinician specialising in Child and Adolescent Mental Health Services.

We recommend that the Bill require that, when a Tribunal is hearing the case of a child or adolescent patient, it has to seek the advice of a medical member of the expert panel who is a doctor specialising in Child and Adolescent Mental Health Services.

Response

We agree that, generally, all under-18 year olds should be accommodated in age-appropriate facilities, have access to CAMHS, and that the Tribunal should be appropriately advised by specialist experts.

In England, the Government's commitment to increase numbers of CAMHS specialists is reflected in the Children's NSF and in the additional investment being made in CAMHS of around £300 million in the three years to 2005/06. This money will make it possible to build capacity, improve access and help deliver comprehensive CAMHS across the country. In Wales, the Welsh Assembly Government has recognised the need to develop CAMHS and has set a target to increase capacity, improve capability and better manage demand. In both countries, the Adult Mental Health NSF requires each area to have protocols in place for the management of adolescents on adult wards.

While in England and Wales there has been an increase in the numbers of consultant child psychiatry posts over the last decade, and this increase is set to continue, improvements will take time to deliver. A statutory duty could, meanwhile, have the potential to be harmful in individual cases: if it were to create an obstacle to sensible clinical decision-making, it could result in a seriously ill young person or child not receiving the treatment they need or being unable to receive it close to home.

The Government's view is that, where possible, those involved in the care and treatment of children should be child specialists. Where this is not possible, it would be good practice for clinical staff caring for the child to have access to a CAMHS specialist professional for advice and consultation. In addition, the further investment in improving CAMHS will mean that the number of specialist professionals available to contribute to the work of the Tribunal will increase over time.

The codes of practice will include guidance on these and other issues, building on the statutory provisions and both the Children's and the Adult Mental Health NSFs, making clear the need for local agreements and protocols for working between CAMHS and adult mental health services.

Recommendation 40

We recommend that, in order to give a consistency of experience for children dealt with by the law, child welfare principles also be included on the face of the Bill.

Response

The Government accepts that principles should ideally be on the face of the Bill and will look at how this can be achieved and what principles should be included (see the response to recommendations 4 and 5). It is important to note that principles and statutory duties set out in other legislation still apply to patients treated under the mental health legislation, except for decisions made specifically under the Mental Health Bill. This interrelationship will be covered in the codes of practice.

Recommendation 41

We recommend that, where the predominant issue is the need for compulsory treatment for mental disorder, treatment of under-18 year olds be subject to the provisions in the draft Bill.

Response

We welcome the Committee's agreement that, when under-18 year olds need compulsory treatment for a mental disorder, it is important that they benefit from the protection of the safeguards provided by the draft Bill. This is the primary purpose of mental health legislation. The primary purpose of section 25 of the Children Act 1989 is to set out the

conditions under which a child can be placed and kept in secure accommodation. However, this section does not give a power to treat the child. The codes of practice and training on the new legislation will include the proper use of the Mental Health Bill's powers.

Recommendation 42

We recommend, in respect of children and adolescents, that the care-planning process reflect the process designed for a child subject to a Children Act 1989 order, i.e. a multidisciplinary, regularly reviewed, advocacy-based way of working.

Response

The Government welcomes the Committee's endorsement of a multidisciplinary, advocacy-based approach to care planning. It is expected that the majority of cases where patients are so seriously ill as to warrant treatment under the provisions of the Bill will need care by a multidisciplinary team, and it is not the intention to hinder or undermine this approach.

The proposals in Part 2 and Part 6 of the Bill aim to ensure that, wherever possible, care plans are drawn up with appropriate consultation with patients, their nominated persons, carers and parents. Under the Bill, a patient and their nominated person both have access to specialist advocacy to ensure that the patient's voice is heard. Care plans must also be reviewed regularly.

We agree that care planning should reflect current good practice, and the codes of practice will set out how holistic care planning can best deliver services that achieve the aims of the legislation and meet the child's needs, including, for example, family contact and educational and aftercare needs. They will also set out an integrated approach to care planning to meet the different statutory requirements that may apply to an individual child and to attain the standards of the NSF.

Recommendation 43

We recommend that there be a duty, where the patient is 16 or 17 years of age, to ensure appropriate educational provision. Appropriate provision will usually mean specialised education to deal with adolescents who are being treated as in-patients for mental health problems and sufficient to meet their educational needs.

Response

We agree that 16 and 17 year olds who wish to continue their education should not be denied access to learning merely because they are receiving medical treatment for a mental health condition. We do not believe a new duty is required, but we recognise that the current arrangements need improving. The Department for Education and Skills and the Department of Health are discussing this.

Recommendation 44

We recommend that it only be possible to administer electroconvulsive therapy to 16 and 17 year olds in line with the safeguards currently proposed in the draft Bill for those under 16.

Response

The Government agrees with this recommendation and plans to amend the Bill accordingly. There are few cases where ECT is used for young people under 18, and we consider that the seriousness of such treatment, and its rarity, warrant the involvement of the Mental Health Tribunal. Tribunal authorisation will ensure an independent decision, informed by appropriate specialist expertise, in a way that will not only safeguard the patient's rights but will also provide assurance for the parents and clinicians involved.

Patients concerned in criminal proceedings, restricted patients and victims

Recommendation 45

See recommendation 3.

Recommendation 46

We recommend that, where a court wishes to send an offender or person on remand with a mental disorder to a hospital and hospital Trusts cannot agree to which hospital the person should be sent, the Bill contains a duty for the strategic health authority (or authorities, if more than one is concerned) to resolve the dispute.

Response

We agree that there is merit in having a system for resolving disputes between trusts about which hospital should take a patient. However, we do not agree that this is something to go on the face of the Bill. While the Government sets overall priorities for the NHS, it leaves responsibility for organising the delivery of services to a local level. We will consider, however, how far we can tackle this problem through non-statutory mechanisms.

Recommendation 47

We recommend that, where those exercising the functions of clinical supervisor form the view that a prisoner or person on remand meets the conditions at clause 137 and recommend that he is transferred to hospital, the Bill proper contain a duty requiring the Home Secretary to order his transfer to hospital.

Response

The Bill seeks to maximise the opportunities for courts to remand or divert defendants for treatment. If the defendant has been remanded, committed or sentenced to prison, it often indicates either that the court was not satisfied by medical evidence that transfer was appropriate,

or that appropriate facilities were not available. To place a duty on the Secretary of State to direct transfer in those circumstances is unlikely to achieve a placement that the court could not. The recommendation, if implemented, would empower any clinician who wished to oblige mental health services to accept a prisoner to obtain an independent opinion and require the Home Secretary to direct transfer, irrespective of the merits of the individual case or the public interest. The Government is working to maximise opportunities for offenders to receive specialist treatment, but does not think this proposal would necessarily aid that process.

Recommendation 48

We recommend that when courts are considering whether to make a mental health order or hospital direction, there be a requirement that the mental disorder of the offender/patient should be of a nature or degree which makes treatment under compulsory powers appropriate. If the offender/patient is to be resident, then the disorder should be of a nature or degree warranting detention.

Response

We wish to preserve the ability under the 1983 Act to divert offenders from punishment to treatment where it is safe to do so. This recommendation would limit that ability. The combined effect of the second and third conditions for making an order or direction is already that the offender's mental disorder warrants treatment that is appropriate given all the circumstances of their case. To require the condition to justify treatment under compulsion would discriminate against offenders willing to comply with treatment. They would not need compulsion, so could not lawfully be diverted.

Recommendation 49

We recommend, in the interests of non-discrimination, that the Bill proper and accompanying codes of practice be drafted in such a way as to make clear that courts, in making a mental health order or hospital direction, should base their assessment on whether the offender's mental disorder renders him a risk to self or others, irrespective of whether that risk could be minimised by a prison sentence.

Response

This is similar to recommendation 48. It would be discriminatory in that it would frustrate the diversion from prison of people who needed treatment in hospital but who would not be dangerous if they did not receive it. We recognise that the Committee has sought to minimise the discriminatory effect by requiring courts to discount the effect of containment in prison, but that would require a very complex assessment and seems less effective than simply removing the condition, as we have done.

Recommendation 50

We recommend that the Mental Health Tribunal be given the power to order the transfer and leave of absence of restricted patients.

Response

We are satisfied that the current system for the management of dangerous mentally disordered offenders is effective. In law, the Home Secretary is the primary avenue of discharge for restricted patients. This proposal would remove the Home Secretary's control over the rate at which these patients are exposed to the risk of reoffending in the community, and would give it to the Tribunal. That would undermine the Home Secretary's ability to manage these patients according to the risk of harm they pose to others. The Tribunal must always base its decision on evidence about the state of the applicant's mental health. It cannot take decisions purely on the basis of the risk of harm. This is not a system that would attract the confidence of courts or of the public.

Recommendation 51

We recommend that there be a duty on judges to consult a member of the Expert Panel when considering a care plan.

Response

We do not think it should be mandatory for courts to hear this evidence. The task of a court is to provide a fair trial on a criminal charge, and, on conviction, to satisfy itself whether an alternative disposal is available that enables the offender to be diverted from punishment. The court will have heard evidence from at least two doctors before concluding that diversion is appropriate, and it needs to be satisfied that a package of care is currently available to the defendant. If it believes it needs further advice before agreeing the care plan, it may appoint members of the expert panel to advise it. We believe that is the right balance.

Recommendation 52

We recommend that, when drawing up care plans for patients involved in criminal proceedings, courts (directly or indirectly via the member of the Expert Panel) and clinical supervisors be subject to the same duties to consult as apply to non-offender patients.

Response

The court's primary function after conviction is to consider the appropriate disposal for the offender. For the reasons explained in the answer to recommendation 51, we do not think it appropriate to require courts to consult on the care plan in the same way as the Mental Health Tribunal has to before making an order. Once the court has selected a medical disposal, the offender will acquire the rights, and his clinical supervisor the responsibilities,

that accompany their restricted or unrestricted status. Given the special circumstances of restricted patients, consultation will need to be based on the individual circumstances of the case.

Recommendation 53

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

Response

We accept that the significance of victims' evidence and needs should be updated when considering the appropriate disposal of a mentally disordered offender. The Victim Personal Statement Scheme already exists for victims to tell criminal justice agencies and services dealing with their cases how the crime has affected them physically, emotionally, financially or in any other way. The statement forms part of the case papers and is available to all criminal justice agencies dealing with the case. The procedure is optional, but every victim should be offered the opportunity to complete a personal statement. The police should take the initial statement at the same time as a witness statement, but the victim should be given the opportunity to update their statement over time. The term 'victim' includes bereaved relatives or partners, including same-sex partners, in homicide cases.

We accept that we need to do more to ensure that all victims are given the opportunity to complete a personal statement, and that everyone who sees the case file understands how the statement should influence their decisions. We will be publishing a revised *Victims' Code of Practice* later this year, and this will promote the use of personal statements.

Recommendation 54

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

Response

We are committed to involving victims' interests when decisions are taken about the management of those who harmed them. Work in this area is already under way.

Victims are not currently defined in the Bill but are defined in section 69(3) of the Criminal Justice and Court Services Act 2000 as being the victims of an offence. For the purposes of the work of the Victims' Commissioner, section 52(2) of the Domestic Violence, Crime and Victims Act 2004 defined a victim as a victim of an offence or a victim of anti-social behaviour. The Act also placed an obligation on the Home Secretary to issue a *Victims' Code of Practice* outlining the minimum service obligations that criminal

justice agencies must offer to victims. A draft Victims' Code has been published and has gone through a period of public consultation. We will look at the potential for extending the obligations in the Code to victims of mentally disordered offenders whose cases fall under mental health or criminal insanity legislation.

The Domestic Violence, Crime and Victims Act 2004 also extended rights to information for victims of mentally disordered offenders. Where a person commits a serious offence and receives a disposal with a restriction order under mental health or criminal insanity legislation, victims have the right to information about decisions taken for their protection. Victims in such cases also have the right to make representations to the Mental Health Review Tribunal. We are considering how those rights might be extended to cover victims of serious offences where there is no restriction order. If they are, it will be in the context of giving them rights to information about offenders' management. However, we need to address the issues of medical confidentiality attached to divulging information that is not linked to a conviction, and we are considering the detail of how the rights of victims can be extended further.

Institutional safeguards

Recommendations 55, 56 and 57

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

We recommend that the opinions of medical practitioners on the best way forward be sought as a matter of urgency. Prior to the publication of any future Mental Health Bill and the introduction of the new Mental Health Tribunal system, we expect the Government to publish realistic plans detailing exactly from where the increased number of members of Tribunals will be drawn, and explaining in detail how the new Mental Health Tribunal system will administer more than 40,000 hearings a year.

We recommend that no new Act be brought into force until the Government can demonstrate that sufficient resources are available, both financial and human, to allow for the proposed extensions in hearing numbers and remit.

Response

We accept the recommendations of the Committee, and work is in hand to provide the extra information and evidence it calls for. We have commissioned further work on the Regulatory Impact Assessment (RIA) and, as part of the Bill implementation project, a

Tribunal Project Group has been established. The group, which includes representatives of key stakeholders – Tribunal members and its secretariat, Mental Health Act administrators, NIMHE, the Department for Constitutional Affairs and the Legal Services Commission – will do further work on the mechanics of the new Tribunal. The project has commissioned a specific piece of consultancy to provide firmer information on the potential supply of Tribunal and expert panel members. Discussions have taken place with key bodies, including the Royal College of Psychiatrists, on how to ensure that consultants are available to carry out statutory functions. In Wales, there is an equivalent workstream on tribunals.

It is important that these improvements go hand in hand with developments in hospitals. The implementation project includes a Mental Health Act Managers and Administrators workstream, and there is cross-representation between this and the Tribunal Project Group.

We are also looking again at the Tribunal model, to see whether there are alternative options that would safeguard patients' rights while being more practicable. The Bill will not be introduced until this review of the Tribunal model and the assessment of workforce implications have been completed.

Recommendation 58

We recommend that, in the interests of ensuring that hearings are both fair and seen to be fair, there be a clearer distinction between the roles of the Tribunals as a detaining body and as a review Tribunal. So, for example, a member of a Tribunal that has imposed an order for assessment or treatment should never hear the review or appeal of that order.

Response

We note the Committee's recommendation but still see an important distinction between appeals against earlier Tribunal decisions and applications for a review of a case. In hearing a patient's application for discharge, the new Tribunal will not revisit an earlier decision but will consider the patient's case afresh and make a new decision according to the up-to-date facts and the circumstances prevailing at the time. Regulations will set out what information must be provided with an application to the Tribunal. This will ensure that the Tribunal has sufficient information, such as details of previous periods of compulsory treatment, to make a decision. We are reviewing the Tribunal procedures to ensure that they are practical and able to be implemented.

Recommendation 59

We recommend that the current discretion in section 72 of the 1983 Act, which permits the Mental Health Review Tribunal to discharge patients even where the detention criteria are met, be included in the Bill.

Response

We do not believe that it is possible for the Tribunal to conclude that a patient should be discharged without finding that one or more of the conditions is not satisfied.

Recommendation 60

We recommend that, in order to ensure a fair hearing, Tribunals, when hearing substantive matters and sitting as a panel, sit only as a panel of three members. Furthermore, we consider it to be wholly inappropriate for a single member panel, consisting of a lawyer sitting in a judicial capacity, to decide substantive clinical issues. A panel only should be permitted to sit with fewer than three members at case management hearings.

Response

We note the Committee's recommendation. We are looking at this issue as part of the work on the Tribunal model, as explained in response to recommendations 55 to 57.

Recommendation 61

We recommend that clause 249 of the draft Bill also include provision for NHS trusts to appeal to the MHAT on a point of law.

Response

It has always been the Government's intention that the managers responsible for patients' treatment in NHS trusts should have the right to appeal to the Mental Health Appeal Tribunal (MHAT) on a point of law. This will be clarified before the Bill proper is presented to Parliament.

Recommendation 62

We recommend that the Bill set out powers and duties that will ensure the preservation of a specialised system to monitor patients subject to compulsion.

Response

The inspection and regulation landscape has changed substantially since the MHAC was established in 1983. In that context, there are strong arguments in favour of integrating the MHAC's functions into a wider inspection body. The Government's view is that complementary and related functions are often best discharged from within the same organisation, rather than in isolated pockets. In bringing organisations together, the best way of ensuring that functions do not get diluted or lost is through prioritisation and resourcing decisions, backed by strong business processes, rather than by keeping them separate. However, in light of the recently announced move towards a single inspectorate for health and adult social care, and to ensure that we are taking account of the Committee's concerns, we are giving further thought to how we can ensure that these functions are

carried out appropriately and that the organisation responsible for them retains a focus on its statutory functions for patients treated under mental health legislation. The Government is committed, however, to reducing the number of arm's length bodies.

Recommendation 63

We recommend that the body charged with monitoring patients subject to compulsion have a duty similar to the visiting duty already imposed on the Mental Health Act Commission. That role includes a duty to visit routinely mental health facilities to interview patients.

Response

The Bill already sets out a visiting duty on the Healthcare Commission that is similar to the visiting duty that exists in the current Act. Clause 270 refers to visits and interviews with current or ex-patients as necessary or expedient for the purpose of exercising the Healthcare Commission's role, which includes reviewing functions in relation to patients. The Government is against setting out in the Bill a specified frequency for visiting, because it would be too prescriptive and inflexible.

Recommendation 64

We recommend that the responsibilities of the reformed Mental Health Act Commission include investigating and reporting on the Secretary of State's management of restricted patients.

Response

The Government does not agree that the Healthcare Commission could appropriately oversee the Secretary of State's management of restricted patients. The purpose of the Secretary of State's functions in respect of restricted patients is to provide an exclusively risk-management perspective on the management of dangerous offenders diverted from prison. We do not think it would help to subject that perspective to oversight by a body responsible primarily for standards in the care and treatment of patients. Courts continue to be the appropriate avenue for scrutiny of the Secretary of State's functions.

Recommendation 65

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

Response

See the response to recommendation 62.

Other rights and safeguards for patients, carers and relatives

Recommendation 66

We recommend that the widening of the number of people who can request an examination be tempered by a test or safeguards in the Bill to prevent vexatious, malicious or frivolous requests.

Response

We recognise the Committee's concern and agree that it is important that authorities' resources should not be tied up in handling vexatious, malicious or frivolous requests for examinations. Under the draft Bill, the appropriate authority has a duty, whenever requested to do so, to make a determination as to whether the conditions for compulsion appear to be met in a patient's case. We will explore the possibility of an addition to the Bill to highlight the need to identify any unfounded requests at this initial stage.

The appropriate authority need not consult anyone before proceeding further if it is minded to determine that not all the conditions appear to be met. This means that the professionals who will be responsible for arranging examinations on behalf of the appropriate authority will be able to deal with any unfounded requests by determining at the outset that not all the conditions appear to be met.

We will support them in this duty through guidance in the codes of practice.

Recommendation 67

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

Response

We agree with the Committee about the importance of referral to appropriate services, where this is appropriate in the light of the nature of the problem and the individual's wishes. This is normal good practice, which we propose to reinforce through guidance in the codes of practice.

Recommendations 68 and 69

The evidence presented to us of people seeking help voluntarily, only to be turned away and then committing an offence and ending up detained under the Mental Health Act leads us to recommend that service users have the right to ask for an assessment of their need for mental health care as a resident or non-resident patient, and that the authorities be required to justify in writing any decision to decline such voluntary assessment.

We recommend that the Bill should include a duty on public services to assess and to seek to meet the mental health need of people with mental health problems.

Response

We agree with the Committee about the importance of assessment and treatment at an early stage for people with mental health problems, and believe that the best way to achieve this is through measures to support and develop best practice on the ground.

The Government's role is to set priorities and standards for the NHS, while the NHS has responsibility to plan, commission and provide services in line with local circumstances. The NHS cannot be run from the centre. It would be inconsistent with this principle to impose specific requirements to carry out assessments or to provide services.

In England, the 1999 Mental Health NSF, which was supported by substantial extra investment, set seven standards for the NHS and social services to achieve in mental health. Standard 2, in particular, addresses the area of the Committee's concern, specifying that service users who contact their primary healthcare team should have their mental health needs identified and assessed, and be offered effective treatments, including referral to specialist services if needed. The NSF therefore specifies that the NHS should do what the Committee is seeking. The methods local authorities may choose to justify their decisions to service users are matters of good practice and should be made locally.

We are around halfway into a 10-year period of transformation, and it is to be expected that more needs to be done at this stage. Further action is planned or under way, using the mechanisms we have put in place to drive progress, including the performance management system for the NHS and developmental support from NIMHE. The Healthcare Commission has a key role in assessing local performance against national standards.

Similarly, the Welsh NSF (April 2002) covers the need for services to be effective, comprehensive and responsive, and for individuals with mental illness to have their needs assessed and receive appropriate advice, treatment, care and/or support.

We will reinforce good practice through guidance in the codes of practice, and will also consider what further steps might be needed to promote access to appropriate services for everyone with a mental disorder.

Recommendation 70

We recommend that there be a duty on health and local authorities in each case to draw up a discharge plan and to provide the care in the plan, and that the provisions of section 117 of the Mental Health Act 1983, relating to free aftercare based on need, be included in the Bill proper when introduced.

Response

We fully agree that no one should be discharged without a discharge plan. We will make this very clear in the codes of practice. The reason why we are not planning to put this on the face of the Bill is that the discharge plan will be part of the plan under the Care Programme Approach (CPA), and it would be duplicatory and confusing to have two different discharge plans.

We also fully agree that people need to have aftercare based on their needs. The NHS and local authorities have responsibilities to meet the aftercare needs of people with a mental health problem. In order to help bridge the gap between hospital and the community, the Bill provides for people who have been discharged from hospital to have access to free intermediate care for up to six weeks.

We do not, however, agree that there should be special provisions that permit people who have been under compulsion to avoid means-testing after the six-week period. This is inequitable – it leads to people with very similar needs getting different treatment according to whether they have been voluntary or involuntary patients. In our view, everyone should have access to the services they need – and, where means-testing is relevant, it is appropriate.

Recommendation 71

We recommend that the Bill include a requirement on tribunals, when they are examining care plans, to consider wider concerns and considerations than purely medical matters – for example, social and housing needs.

Response

We agree with the Committee that it is important for the Mental Health Tribunal to have information about the patient's wider circumstances, and to have regard to these in making decisions. We plan to achieve this through a variety of means, for example the regulations on Tribunal applications and the Tribunal rules.

Recommendation 72

We recommend that the codes of practice contain guiding principles for drawing up care plans which will govern the treatment and, for example, the privacy, safety and dignity of the patient.

Response

We agree with the Committee that care plans should be prepared in line with guiding principles. Our intention is that overarching principles will be included on the face of the legislation to allow for regard to be had to the privacy, safety and dignity of the patient. We intend that this will be covered in the accompanying guidance on the principles in the codes of practice.

Recommendation 73

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

Response

We welcome the Committee's agreement about the importance of patients' involvement in their treatment. The draft Bill requires the clinical supervisor to discuss with the patient the treatment to be specified in the care plan (clause 31(4)) and to send a copy of the plan to the patient (clause 31(5)). We believe that further provision for patient involvement is largely a matter of good practice and the responsibility of local services. For example, in England we have taken steps to drive good practice through guidance on the implementation of the CPA. In 2001, we produced an audit pack for the CPA to help local services deliver good practice. This included a comprehensive tool for monitoring the extent of service users' involvement in care plans, such as whether they have been asked for their views and what they need; if they have agreed the care plan and have signed it; whether they have a copy of the plan; and whether they know how any points of disagreement will be recorded. Similarly, in Wales, guidance on the CPA was issued in 2003.

We also propose to ensure, via regulations and the codes of practice, that the Tribunal has available to it information about patients' consent, or lack of consent, to all treatments administered.

Recommendation 74

We recommend that the Bill as introduced place an obligation on health authorities and local authorities to provide the care specified in a patient's care plan, provided that it is in line with normally accepted national standards.

Response

Clause 9(6) of the draft Bill provides that the fifth condition for a patient to be brought under compulsion is that appropriate medical treatment is available, taking into account the nature or degree of the patient's mental disorder and all other circumstances of their case. In order for treatment to be included in the care plan, there will need to be agreement with the relevant service providers to make the treatment available. A treatment cannot be considered available if it is not actually available to the patient in question. As now, there may be circumstances in which it is appropriate for the patient to travel to another area for treatment, for example where that is the patient's own preference or where particular specialised facilities are required.

If appropriate treatment is not available for the patient, then the fifth condition is not met and the patient would no longer be liable to compulsion under the Bill and must be discharged.

Recommendation 75

We recommend that Type A treatments at clauses 191 to 195 of the draft Bill be under no circumstances used for patients lacking capacity, not even with the consent of the High Court. Where the patient has capacity, we recommend that Type A treatment only be given with the patient's informed consent and, furthermore, that, given the nature of these procedures, Type A treatments be subject to the ratification of a tribunal, even if the patient is able to give informed consent.

Response

Although psychosurgery is very rare, and psychosurgery for people without capacity is likely to be even more rare, there have been occasional cases where people without capacity have been considered likely to benefit from psychosurgery, but have not been able to do so because of the provisions of the current Act. The Government has decided to introduce the scope for psychosurgery for people without capacity, but with strong safeguards. As well as the safeguards included in the Bill itself, patients will be able to make binding advance decisions to refuse psychosurgery in accordance with the provisions of the Mental Capacity Act.

We recognise that, occasionally, patients push inappropriately for psychosurgery because they are desperate to try everything to solve their mental health problems. For this reason, we agree that there may well be a good case for Tribunal authorisation of psychosurgery, even when a patient with capacity consents. We will consider this further.

Recommendation 76

We recommend that the main safeguards which will apply to Type B treatments at clauses 196 and 197 of the draft Bill be listed in the Bill. The safeguards should follow the model of the safeguards for ECT and thus should introduce a requirement to establish whether or not the patient has capacity and can give consent.

Response

It would be difficult to set out specific safeguards in the Bill because we do not know what types of treatments might need special safeguards, and so it is difficult to know the specific safeguards that would be needed. We recognise, however, the importance of doctors seeking consent before giving any treatment for which consent is not required. In any case where a Type B treatment may be given without the patient's consent, it is intended that the regulations will provide that treatment is not to be given unless it is first determined whether or not the patient is capable of consenting.

Recommendation 77

Where a course of electroconvulsive therapy is prescribed under the emergency procedure, we recommend that the Bill specify the maximum number of treatments which can be given, to prevent emergency treatments becoming a route to a full course of treatment and bypassing the general requirements on ECT. We recommend that the maximum number of treatments under emergency procedures be limited to two.

Response

We agree that the maximum number of treatments should be specified. We are planning to specify this in regulations rather than on the face of the Bill, as practice regarding the frequency of ECT may change. At present, National Institute for Health and Clinical Excellence (NICE) guidance is that ECT should be given at a maximum rate of two sessions per week – and we would expect regulations to specify this. Our current view is that we might wish to specify a rate of up to two sessions per week for up to two weeks, so that there would be time for the ECT to have an effect. The codes of practice would make clear the considerations that need to be taken on board in using emergency ECT. We have commissioned some research on emergency ECT for people with capacity, and the results of this research will inform both the legislative provisions.

Recommendation 78

We recommend that the Bill transfer to the new expert panel the safeguarding function of the current second-opinion doctor (SOAD) system, which includes the power to veto proposed treatment.

Response

As we have explained in response to recommendations 55 to 57, following the Committee's concerns, the Government is looking at the workability of the new Tribunal process. This includes the arrangements for approving care plans. We are taking account of this recommendation as part of that review.

Recommendation 79

We recommend that the Bill make provision for the recording of details of the treatment being given under consent during the assessment period and of the details of the consent itself. We believe that treatment should be audited under all circumstances, and we believe this to be particularly important in relation to treatment under the proposed new system of non-residential orders.

Response

We sympathise with the Committee's wish for transparency in the administration of treatments, but believe that a specific provision in the Bill, as in this recommendation, is not needed. Details of treatments are recorded in patients' notes, and information relating to a patient's consent, or lack of consent, to treatment is included in care plans made under the CPA. We propose to supplement these provisions by the requirement for care plans under the Bill to set out the treatment to be provided under compulsion. In addition, we propose that regulations to be made under the Bill will require applications to the Mental Health Tribunal to include a summary of treatments actually provided and information relating to the patient's consent, or otherwise, to the treatments. Audit of medical treatment will remain a matter for clinical governance and not a matter for this legislation.

Recommendation 80

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

Response

This is a matter of clinical practice and is not appropriate for inclusion in the Bill. The preface to the British National Formulary (BNF) explains that it is designed as a digest for rapid reference and may not include all the information necessary for prescribing and dispensing. In areas requiring specialist expertise, it is expected that the BNF will be supplemented by specialist knowledge. There are adequate mechanisms in place for clinical governance, and the Healthcare Commission will have a role in overseeing the discharge of functions under the Bill.

We agree, however, that a further safeguard is desirable. We propose to require care plans under the Bill to set out the maximum dosage of drugs it is proposed to administer, specifying whether this is over BNF limits, so that this factor can be taken into account in the approval process.

Recommendation 81

We recommend that the Bill regulate the use of seclusion and mechanical restraint by requiring the same kind of safeguards provided in the current Code of Practice to ensure that decisions to seclude or restrain are only made when absolutely necessary, are subject to regular monitoring and review and that the seclusion or restraint is brought to an end immediately the intervention is no longer needed for the protection of others. There should be a requirement to report such interventions to the Mental Health Act Commission and, if seclusion or restraint is prolonged, a member of the expert panel should visit the patient.

Response

We agree with the Committee that it is important to make sure that the same kind of safeguards surrounding the use of seclusion and restraint provided in the current code of practice continue under the new Bill. We also share the Committee's concern about patients subject to prolonged periods of seclusion and restraint. We are exploring how best to safeguard the interests of patients subject to these interventions in the context of the new legislation.

Recommendation 82

We recommend that the Bill provide a framework for the review of the emergency administration of medication for mental disorder. In our view, the review should be carried out by Tribunals, although we accept that such reviews may be carried out retrospectively after emergency treatment has been administered.

Response

In considering the Committee's recommendation, we have given further thought to the evidence from the MHAC that led to that recommendation. Our preliminary view is that provision could usefully be made in the Bill for emergency treatment, with safeguards, and we are investigating this further, along with arrangements for the review of emergency treatment after it has been administered. The intention is to bring forward new provisions when the Bill is introduced.

Recommendation 83

We recommend that, before the Government introduces the Bill proper to Parliament, it review the costs of setting up a discrete mental health advocacy service, as distinct from the new advocacy function to be introduced under the Mental Capacity Bill 2004. This review should be undertaken in consultation with those providing advocacy services, and the Regulatory Impact Assessment should be expanded to ensure that it reflects detailed and robust costings and a sensitivity analysis taking account of, for example, possible variations in the number of persons detained and the provision of advocacy services at examination stage to 'voluntary' patients and those under compulsion in the community.

Response

We acknowledge the concerns raised by both the Committee and several stakeholder organisations about the estimated number of advocates required to implement the Bill. We are reviewing the estimates and costings in light of the evidence given to the Committee and other information, and we will provide updated information in the RIA when the Bill is introduced.

Recommendation 84

We recommend that local authorities and health authorities be placed under a statutory obligation to produce local advocacy plans for the development and funding of independent health advocacy services to meet the needs of all service users, including mental health service users.

Response

While we acknowledge the Committee's desire to ensure that all local authorities and health authorities have a strategic plan for the provision of advocacy in their area, we do not think that it is appropriate to enforce this through a statutory obligation. The Government's expectation is that local authorities and health authorities will respond to guidance where it exists and will plan service provision to meet the needs of their local populations.

Recommendation 85

We recommend that the Bill charge the Mental Health Act Commission with duties to set national standards for mental health advocates, provide accreditation and investigate complaints.

Response

As stated in response to recommendation 62, in light of the recently announced move towards a single inspectorate for health and adult social care, and to ensure that we are taking account of the Committee's concerns, we are giving further thought to how we can ensure that MHAC functions are carried out appropriately. We do have concerns about the suitability of an inspection body to fulfil the role envisaged by the Committee. To do so would create insufficient separation of powers, and possible conflicts of interest. The inspection body should be separate from any organisation that sets standards and provides accreditation, otherwise there is a possible conflict of interest where the inspection body is not satisfied with an aspect of advocacy, for which it is ultimately responsible.

However, the Government agrees that Independent Mental Health Act Advocacy (IMHAA) should be focused on the quality and standards of the service provided, and we are committed to taking steps to ensure that this is the case. Regulations will set out the minimum standards that individual advocates, and the services they are employed by, must meet in order to act as IMHAA advocates. In addition, we propose developing commissioning guidance and a model contract for advocacy commissioners, to help form the basis for monitoring quality and standards.

Recommendation 86

We recommend that there be a duty in the Bill on the appropriate authority to provide independent mental health advocates to meet the reasonable requirements of patients as soon as any statutory procedure with regard to the potential exercise of formal powers in their case is commenced.

Response

We are confident that the provisions in the draft Bill are sufficient to ensure that advocacy must be made available for patients who are treated under powers of compulsion. However, we acknowledge the Committee's concerns (mentioned again in recommendation 88) that patients may benefit from the support of an advocate before compulsory powers have been applied, such as at the initial examination. We also note the connection with recommendations 93 and 96, which highlight the important role nominated persons and carers can play at the time of the initial examination. We are keen to ensure that patients are given adequate support at all times when the legislation is in operation, and recognise that this is important at the time when the decision is being made as to whether to use powers of compulsion. The codes of practice will, therefore, make clear the importance of considering how best to assist the patient at all stages.

Recommendation 87

We recommend that there be a duty in the Bill on the appropriate authority to ensure that independent advocacy is available to all people with a mental disorder and that they have an opportunity to use the service.

Response

While we acknowledge the Committee's concern about advocacy provision for patients who are not subject to mental health legislation, we do not think that the Mental Health Bill is the appropriate place to tackle issues that relate to service provision more widely. The provision of advocacy for people with a mental disorder is the responsibility of individual NHS bodies and local authorities.

Recommendation 88

We recommend that patients have the right to an independent mental health advocate from the start of the initial examination stage or upon arrival at a place of safety, and that the Bill place a duty on the authorities to remind patients of the availability of the advocacy service at key stages.

Response

See the response to recommendation 86, regarding the first part of this recommendation.

The Government acknowledges the Committee's concerns that authorities must make patients aware of the support and assistance that an advocate can provide. Clause 19(4) of the draft Bill provides for this at the point at which the patient is made liable to assessment. However, we agree that it is important for patients to be reminded of that service at key points during their treatment. We consider that it will be most appropriate to use the codes of practice to provide guidance on the points during the patient's treatment when it might be particularly important to remind the patient of the support that an advocate can provide, and which professionals should be responsible for providing that information.

Recommendation 89

We recommend that the right of patients to meet their advocates in private, unless it is unsafe to do so, be reinstated in the Bill.

Response

We agree that a provision should be included, as in the 2002 draft Bill, that allows the advocate to decide if a meeting with a patient should be in private. We plan to amend the Bill to reflect this.

Recommendation 90

We recommend that the independent mental health advocate have no access to patient records without the patient's informed consent and, for people whose decision-making is impaired, the nominated person be asked to make the decision for the patient.

Response

The Government welcomes the Committee's endorsement of the principle that the right of access to records should be vested in the patient. We agree that the advocate should have access to the patient's records only if authority is given by the patient or by a representative on the patient's behalf. We are exploring how we can make that intention clear in the Bill.

Recommendation 91

We recommend that the nominated person have broadly the same rights and powers currently exercised by the nearest relative under the 1983 Act. In particular, the nominated person should be able to:

- a) make an order for the discharge in respect of a patient where the patient is liable to be detained in a hospital in pursuance of an application for admission to hospital, and
- b) make an order for the discharge of a patient who is detained in a hospital, subject to 72 hours' notice. The clinical supervisor would then be able to block discharge by certifying that, if discharged, the patient would be likely to act in a manner dangerous to himself or to others. If that happens, the patient, carer or nominated person should have the same right to appeal to the Mental Health Tribunal for discharge on the same basis as patients detained for assessment.

Response

We welcome the Committee's thoughts on ensuring that the legislation provides comprehensive safeguards to protect patients. We acknowledge the Committee's concerns about eroding the position of families and carers to take responsibility for the care needs of the patient, and their desire for checks and balances to be in place against the power of the professionals. However, the safeguards in the Bill are constructed differently to the 1983 Act, and we do not agree that nominated persons need to be given the rights of the nearest relative in order to address the Committee's concerns.

The current nearest relative powers ensure that the patient's case is reviewed. Under the Bill, the clinical supervisor has an ongoing duty to review whether the conditions continue to be met – if, at any time, the patient does not meet the conditions for compulsion, then the patient must be discharged from compulsion.

Where patients are treated under powers of compulsion, the Bill provides a comprehensive package of additional safeguards for them, in addition to the duty for clinical supervisors to review the conditions. These include a requirement that each patient's case is reviewed regularly by the Mental Health Tribunal, and that the patient can have the support of particular people, such as an advocate or a nominated person, in applying for their case to be reviewed by the Tribunal. If the patient, or a representative on their behalf, is not satisfied with the decision of the clinical supervisor when reviewing the case, then they can apply to the Tribunal for discharge or for treatment on a non-residential basis. Within this comprehensive package of safeguards, we do not think there is anything further to be gained by transferring the powers of the nearest relative to the nominated person.

The effect of the recommendation would be to allow nominated persons to compel clinicians to discharge patients who meet the relevant conditions for compulsion but who do not satisfy the test of 'dangerousness'. The Government does not think this is appropriate. Being a patient's nominated person carries with it no responsibility for the continuing care of the patient once discharged. Patients will meet the conditions for compulsion only if they need treatment in order to prevent harm to themselves or others. While that continues, compulsion should also continue. To apply a different test of dangerousness would run the risk of patients failing to get the treatment they need.

Recommendation 92

We recommend that patients be able to appoint an enduring nominated person. This could be done through an advance statement, as explained in chapter 4, if the Government brings forward proposals for advance statements, or, if it does not, through a simple process and free-standing instrument.

Response

We welcome the Committee's views about improving the process for appointing a patient's nominated person. We agree that the rights and interests of a patient will be better safeguarded the sooner the nominated person appointment takes place. We also agree that, in some cases, the process of appointing a nominated person could be made more efficient if the nominated person could be appointed in advance, or at least if the patient has a formal mechanism to express in advance of compulsory powers being used their wishes and feelings about possible nominated persons. We are carefully considering how we might achieve this in the Bill.

Recommendation 93

We recommend that a nominated person be able to exercise his powers from the start of the initial examination stage and be entitled to participate at the time of the examination.

Response

See the response to recommendation 86.

Recommendation 94

We recommend that, where the patient lacks capacity to appoint a nominated person and has not nominated someone previously, there be a default provision along the lines of the Scottish Act, whereby the carer is the default first choice with the nearest relative as the default second choice.

Response

We acknowledge the Committee's concerns that the appointment of the nominated person could end up being a complex or time-consuming process, particularly where the patient lacks capacity. However, the default arrangements recommended by the Committee fall short of the provisions in the Bill by not allowing scope for flexibility, such as where the patient would prefer their nearest relative to act as the nominated person rather than their carer, or vice versa. Even where a patient lacks capacity to choose their nominated person and has not already appointed someone, they may still be able to indicate some preference, and regard should be had to this in deciding who is most suitable and eligible.

However, we acknowledge that finding the 'most suitable and eligible' person could be a difficult task for the appointer, and we propose to set out very clearly in guidance that, in most cases, the carer or nearest relative (who will often be the same person) will be the most suitable and eligible person to be the nominated person, unless the appointer has good reason to believe otherwise.

See also the response to recommendation 92 regarding the patient expressing in advance of compulsory powers being used their wishes and feelings about possible nominated persons.

Recommendation 95

We recommend that, to safeguard the interests and autonomy of the person under compulsion, the Approved Mental Health Professional be able to disqualify a person's choice of nominated person only if the nominated person is exploitative or lacks capacity.

Response

We acknowledge the Committee's concerns about the appointer wrongly or unfairly dismissing the patient's choice of nominated person on the grounds that they are 'unsuitable'. We believe that, where possible, the patient's choice of nominated person should be appointed. However, as the Committee pointed out, there are occasions where the nominated person may lack capacity or may be involved in an exploitative relationship with the patient. In such situations, we think it appropriate that the proposed nominated person be disqualified, but there may be other circumstances as well, such as availability, that are better covered in the codes of practice. The codes will provide guidance on the sort of criteria by which to judge what is meant by 'unsuitable'. We will also look at whether there is scope to introduce provision to strengthen the likelihood that the patient's choice is not inappropriately disregarded.

Recommendation 96

Clause 12(2) provides that carers cannot be consulted without first ascertaining the patient's wishes and feelings, unless it is inappropriate or impractical to do so. We recommend that this be strengthened so as to contain a presumption to consult a patient's carer when examinations and assessments are carried out, unless the patient is expressly opposed to it.

Response

We fully appreciate the thinking behind the Committee's recommendation that there should be a presumption in the Bill to consult carers. Our view is that the Bill already contains a presumption to consult carers – it sets out the points at which the carer should be consulted, with clause 12 providing additional considerations that should be made before consulting the carer.

We recognise the important role that carers play in providing care and support for patients, and will explore ways in which the Bill and the codes of practice can be used to strengthen the presumption to consult carers.

The Government does not agree with the Committee's view that the Bill should provide for the carer to be consulted unless the patient is 'expressly opposed'. We believe that requiring the relevant person to 'make a determination' is more appropriate because it removes the burden from the patient to make an objection. This provides protection for patients who have not objected to, or are not able to object to, carer involvement, but where consulting the carer would clearly be against their wishes or interests.

Resources and professional roles

Recommendation 97

We recommend that, when presenting draft Bills, the Government attach as annexes any models underpinning the Regulatory Impact Assessment (RIA) in order to allow interested parties more fully to examine the appraisals behind the figures in the RIA.

Response

The Government accepts that this is desirable. The RIA presented alongside the Mental Health Bill will include sufficient detail about the underlying assumptions behind any data that are presented.

Recommendation 98

We recommend that the Government, as a matter of urgency, complete its studies into the potential impact of widening the definition of mental disorder, removing exclusions and introducing non-resident orders, and that, in doing so, it takes account of the opinions of practitioners. In the light of these studies, we expect the Government to reconsider and re-analyse the assumptions used in the Regulatory Impact Assessment and to produce a much more comprehensive RIA when it introduces the Bill.

Response

Further work will be undertaken to update the assumptions and calculations made in the RIA that was presented alongside the draft Bill. Where appropriate, assumptions will be underpinned by new evidence.

Recommendation 99

We recommend that the Government re-examine the accuracy and strength of data used in the Regulatory Impact Assessment prior to the presentation of any associated Bill, and ensures that the figures used are the result of direct measurement or improved sampling.

Response

See the responses to recommendations 97 and 98.

Recommendation 100

We recommend that no new Act be introduced without assurances that the increased workforce requirements in the legislation will be met and, moreover, that the additional requirements will not be met at the expense of other parts of the mental health service, in particular the non-compulsory services. We believe that this recommendation can be achieved in part by implementation of the Act being phased in several steps.

Response

The Government has in place a substantial set of actions to improve recruitment and retention and increase the number of staff working in mental health services, and to introduce new ways of working that will help relieve the pressure on psychiatrists and other hard-pressed groups of staff. Further information about the actions to be taken to achieve the workforce requirements arising from the Bill, and the additional funding that will be required to implement the Bill, will be published with the RIA when the Bill is introduced to Parliament.

The Government's aim is to secure improvements in mental health services for all patients. There has been substantial investment and growth in mental health services as a result of the NSFs and the NHS Plan. Recruitment initiatives and increases in the number of staff available nationally should be enough to meet the workforce requirements arising from the Bill. It is the responsibility of primary care trusts in England and local health boards in Wales and of the providers of services to determine the balance of priorities and services to be provided to meet local needs.

In response to this recommendation, the Government has examined options for the phasing of implementation. The main options related to the phasing in of the approval of care plans by the Mental Health Tribunal; the introduction of non-residential orders; the introduction of the Mental Health Tribunal; the introduction of the expert panel; and implementation in England and in Wales. The Government's view is that the interdependent nature of these provisions would make it very difficult to phase in at different dates specific individual provisions without undermining the operation of the new legislation as a whole. Because the new legislation is designed to replace the 1983 Act, delaying implementation of specific provisions would also mean that parts of the 1983 Act would have to be kept in force alongside the new legislation during a transitional period. In addition to the great difficulty of running two legislative regimes at the same time, the need to continue to provide staff to operate parts of the 1983 Act would minimise the workforce and resource benefits of phased implementation.

Another group of options relate to provisions in the Bill that are less central to the main operational procedures of providing compulsory assessment and treatment and to the role of the Mental Health Tribunal. These other options relate to IMHAA, safeguards for children whose parents consent to treatment, and the introduction of the MHAT. Although delaying implementation of these provisions would to some extent ease the resource requirements and the programme of change arising from the Bill, it is these very safeguards for patients that, on the whole, have been most widely welcomed by service users, carers and the voluntary groups that represent their interests and views.

Phasing implementation could also be discriminatory and would possibly breach article 14 of the ECHR, and it could add to the complexity of the drafting of the Bill.

For these reasons, the Government considers that the possible benefits of phasing implementation are, on balance, outweighed by the disadvantages.

Recommendation 101

We recommend that the Government speed up efforts to develop appropriate systems for the effective monitoring of mental health funding streams.

Response

The Government does not agree with the Committee's concerns. Figures on spending come from two sources. Firstly, the Department of Health collects information on the amount of money that has been spent by NHS Hospital and Community Health Services (HCHS) and by local authority Personal Social Services (PSS), and spending on mental health (for all ages) can be calculated from this. Secondly, NIMHE has carried out a financial mapping exercise annually since 2001/02. The two sources differ in that the financial mapping covers planned spending in health and social care in the NHS and in the independent sector and is limited to adults of working age, and Department of Health data reflect actual spending. In addition, the financial mapping exercise analyses planned investment in 16 broad service areas. Within the 16 service areas, it is possible to carry out analyses in greater depth, thereby tracking specific investment trends over time, which shows greater transparency in the tracking of resources.

Department of Health mental health figures show that, in the financial year in which the Mental Health NSF was published (1999/2000), mental health spending on people of all ages was £3.87 billion. By 2002/03, this had risen to £4.60 billion (2002/03 prices in both cases). The increase in spending over this period was therefore £728 million (or 19% in real terms). The proportion of HCHS spend devoted to mental health rose from 12.3% to 13.1% – higher than in any other European country.

It is said that an increase of 19% on mental health is smaller than the increase in spending in the NHS as a whole. However, spending in the NHS as a whole includes the spend in primary care (which is not included in HCHS). Up to one quarter of GP consultations concern mental health-related problems, so it is likely that resources are spent in association with this; however, primary care spend is not disaggregated by care group so it is difficult to quantify. Also, spending in the NHS as a whole also includes spending on IT (which covers all care groups, including mental health).

In the future, overall health spending is planned to rise on average by 7.2% per year in real terms over the five years from 2003/04 to 2007/08. This is supported by the biggest ever investment in capital and IT. PSS funding in England is also planned to increase by 2.7% in real terms from 2005/06 to 2007/08 – an extra £1.9 billion. Steps have also been taken to improve the physical environment in psychiatric intensive care. The Government recently allocated an additional £30 million for this, and is exploring with the Health and Safety Executive what more is needed.

The financial mapping exercise also reported that the total planned investment in adult mental health services in 2004/05 was £4.47 billion, or £140 per head of weighted working-age population. The real increase in total planned investment in adult mental health services between 2001/02 and 2004/05 (at 2004/05 prices) was £708 million or 18.6% over the period. In 2004/05, there was an increase of 7%. The key modernisation services identified as priority developments in the Mental Health NSF and the NHS Plan are assertive outreach, crisis resolution/home treatment and early intervention in psychosis. The level of investment in these areas from 2001/02 to 2004/05 almost trebled, from £78 million to almost £229 million. Adjusting for inflation over the period reduces the £150 million cash increase to a real increase of £136 million. Over the same period, secure and high-dependency planned investment increased by 81% in real terms (£264 million), investment in access and crisis services increased by 79% (£132 million), and investment in home support increased by 75% (£44 million).

Similarly, in Wales, expenditure that has been specifically earmarked for mental health is directly monitored, and all other expenditure is now monitored through the programme budgeting exercise.

Overall, it is the Government's view that there is transparency in mental health spending and that tracking of resources is possible for the 16 broad service areas.

Recommendation 102

We conclude that provisions for the move from Approved Social Workers to Approved Mental Health Professionals are satisfactory provided that national training standards are created which ensure that AMHPs:

- a) bring a separate professional perspective and model of mental disorder
- b) are trained to assess social factors, and have experience in social care and community resources
- c) are equipped to provide comprehensive risk assessments
- d) are trained to explore the least restrictive alternatives to hospital admission; and

- e) are trained to manage the practical tasks involved in the assessments and admissions to hospital.

Response

We welcome the Committee's conclusion that, provided appropriate training is in place, it is right that we replace the approved social worker role with that of the Approved Mental Health Professional (AMHP). We agree that training that enables professionals to bring an alternative perspective, act independently and assess if all of the conditions for compulsion are met will be key to the success of the new role. To this end, we are working closely with stakeholders to ensure that the training is comprehensive, and fit for purpose, and underlines the importance of the social care model.

Recommendation 103

In appropriate cases, professionals other than psychiatrists should be able to act as clinical supervisors provided that they meet appropriate standards. We recommend that regulations stipulate the appropriate standards and competencies to be demonstrated following training.

Response

We accept the Committee's recommendation to define in regulations who can be a clinical supervisor. This will be done by defining the training requirements and experience necessary for a person to be an approved clinician under the Bill. All clinical supervisors must be approved clinicians.

Recommendation 104

We urge the Government to reconsider the issue of whether clinical supervisors with non-medical backgrounds should be able to prescribe ECT, even with the safeguards provided by the Tribunal.

Response

We agree with the Committee that only those professions who have been trained to prescribe ECT should be able to do so. The regulatory frameworks for professionals other than doctors who might become clinical supervisors would not allow them to prescribe any type of care for which they have not been trained. We are therefore confident that no professional other than one with a medical background who had been trained to prescribe ECT would consider prescribing ECT for a patient for whom they were the clinical supervisor.

Application of the Bill in Wales and devolved issues

Recommendation 105

We conclude that the standard of mental health services in Wales must be at least as good as it is now in England before the provisions in the draft Bill can be implemented. Resources should be allocated in order to enable the service to be brought up to the English standard.

Response

Responsibility for resource allocation in Wales lies with the National Assembly for Wales. We understand from the Welsh Assembly Government that the quality of mental health services varies across Wales as it does across England. The vast majority of health expenditure on mental health services is through discretionary allocations to local health boards. The NHS in Wales has seen an increase in expenditure from £2.6 billion in 1999/2000 to £4.8 billion in 2005/06. In March 2005, the Welsh Assembly Government announced major capital investment of £75 million in the mental health estate over the next three years. In 2005/06, the NHS in Wales has been set a target to introduce crisis resolution/home treatment services by March 2006. This will assist in the implementation of the draft Bill when enacted. Mental health is one of the Welsh Assembly Government's top health priorities, and this is reflected in the 10-year strategy *Designed for Life*. The Welsh Assembly Government has commissioned from the Wales Audit Office a baseline review against the standards of the NSF and a national review assessing risk and quality in mental health services across Wales, and it will be using these reports to produce a national action plan.

Recommendation 106

Upon the Welsh Assembly Government introducing a requirement that mental health services in Wales be available in both English and Welsh, the Welsh codes of practice can be tailored accordingly. We emphasise that the Committee is concerned about the patchy level of mental health service provision in Wales, irrespective of language.

Response

We understand from the Welsh Assembly that the Welsh code of practice will take full account of Welsh-language issues, the Assembly Government's responsibility for equality of access and the requirements of the Welsh Language Act 1993.

Recommendation 107

We bring the representations from the devolved legislatures about legislators who become mentally ill to the attention of the Department and suggest that discussions between the Department and the devolved legislatures take place to ensure that these issues can be resolved before the Bill proper is presented to Parliament.

Response

The Government thanks the Committee for bringing this matter to their attention. The Department of Health and the devolved legislatures are currently in discussion to resolve these matters before the Bill proper is presented to Parliament.



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