Post-legislative assessment of the Mental Health Act 2007

Memorandum to the Health Committee of the House of Commons

Post-legislative assessment of the Mental Health Act 2007

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Introduction

1. This memorandum provides a preliminary assessment of the Mental Health Act 2007[1] and has been prepared by the Department of Health for submission to the Health Committee of the House of Commons. It is published as required by the process set out in the document *Post-legislative Scrutiny – The Government's approach* (CM7320).[2]

2. This assessment does not cover aspects of the Mental Health Act 2007 which are within the legislative competence of the devolved administrations.

Objectives of the Mental Health Act 2007

3. The legislation governing the compulsory treatment of certain people who have a mental disorder is the Mental Health Act 1983 (referred to in this assessment as the 1983 Act). The main purpose of the Mental Health Act 2007 was to amend the 1983 Act in a number of areas, where it was generally agreed reform was needed. The Mental Health Act 2007 also introduced "deprivation of liberty safeguards" through amending the Mental Capacity Act 2005; and extended the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004.

Summary of changes

4. The following are the main amendments to the 1983 Act made by the Mental Health Act 2007:

- Introduction of a **single definition of mental disorder (Section 1 and Schedule 1)**.
- Introduction of a new definition of **appropriate medical treatment (Sections 4 to 7)**.
- The introduction of **guiding principles** into the Mental Health Act 1983 Code of Practice **(Section 8)**.
- Broadening the range of professions who can take on specific **professional roles** in relation to the 1983 Act **(Sections 9 to 16 and 18 to 21)**.
- Changes to provisions on the **nearest relative (Sections 23 to 25)**.
- Introducing requirements for **independent mental health advocacy:** it places a duty on the Secretary of State to make arrangements for help to be provided by independent mental health advocates **(Section 30)**.
- Introducing requirements for **age-appropriate services** so that patients aged under 18 admitted to hospital for mental disorder are accommodated in an

1 Mental Health Act 2007 http://www.legislation.gov.uk/ukpga/2007/12/contents

2 *Post-legislative Scrutiny – The Government's approach* http://www.official-documents.gov.uk/document/cm73/7320/7320.asp

environment that is suitable for their age (subject to their needs) **(Section 31)**.

- Introduction of **supervised community treatment (SCT)** for patients following a period of detention in hospital **(Sections 32 to 35 and Schedules 3 and 4)**.
- **New rights for victims of mentally disordered offenders** who are not subject to restrictions (this is an amendment to the Domestic Violence, Crime and Victims Act 2004) **(Section 48 and Schedule 6)**.
- Introduction of **Deprivation of Liberty Safeguards** to provide for procedures to authorise the deprivation of liberty of a person resident in a hospital or care home who lacks capacity to consent (this is an amendment to the Mental Capacity Act 2005) **(Section 50)**.

5. The Mental Health Act 2007 (the 2007 Act) received Royal Assent on 19 July 2007. An Impact Assessment for that Act can be found on the Department of Health website.[3]

Other post-legislative reviews

6. The Department of Health through the Policy Research Programme (PRP) and the National Institute for Health Research (NIHR) has funded a number of research studies which examine aspects of the implementation of the 2007 Act and these are discussed in the relevant sections of this assessment.

7. The Mental Health Alliance published *The Mental Health Act 2007: a review of its implementation*[4] in June 2012.

8. Since 2009, the Care Quality Commission (CQC) has had a duty under the 1983 Act to monitor the implementation of the Act (this was a role previously undertaken by the Mental Health Act Commission). It reported its latest findings in its *Mental Health Act Annual Report 2010/11*.[5] CQC also has a duty to monitor Deprivation of Liberty Safeguards (DOLS),[6] and published its second annual report *The operation of the Deprivation of Liberty Safeguards in England 2010/11* in March 2012.[7]

Implementation of the Mental Health Act 2007

9. Most sections of the 2007 Act were brought into force on 3 November 2008. Annex A provides more detail on when different parts of the Act were commenced.

3 *Mental Health Bill regulatory impact assessment: revised version* (June 2007) http://www.dh.gov.uk/en/publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_076477

4 Mental Health Alliance, *The Mental Health Act 2007: a review of its implementation* (May 2012) http://www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf

5 Care Quality Commission, *Monitoring the Mental Health Act in 2010/11* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf

6 The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting and Assessments – Amendment) Regulations 2009 http://www.legislation.gov.uk/uksi/2009/827/contents/made

7 Care Quality Commission, *The operation of the Deprivation of Liberty Safeguards in England 2010/11*(2012) http://www.cqc.org.uk/sites/default/files/media/documents/dols.pdf

Preliminary assessment of the effects of the key elements of the Mental Health Act 2007

Single definition of mental disorder

Overview of provisions

10. The Mental Health Act 2007 introduced a single definition of mental disorder. Before the introduction of this definition, the 1983 Act required clinicians to place patients subject to the Act into one of four categories of mental disorder, namely mental illness, mental impairment, psychopathic disorder and severe mental impairment. Some provisions in the 1983 Act did not apply to people in some of these categories. This led to difficulties as some mental disorders did not fall obviously into any of the categories.

11. Section 1 of the 2007 Act abolished the categories and replaced them with a single definition of mental disorder: '"mental disorder" means any disorder or disability of the mind'.

12. To ensure that the single definition does not result in people being detained solely on the basis of learning disability, section 2 of the 2007 Act provides that (for certain provisions of the 1983 Act) a person cannot be considered to be suffering from a mental disorder simply as a result of having a learning disability, unless that disability is "associated with abnormally aggressive or seriously irresponsible conduct" on the part of the person concerned.

13. Section 3 of the 2007 Act further simplified the definition by substituting a single exclusion in place of a number of exclusions. The single exclusion states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind (ie a mental disorder) for the purposes of section 1(2) of the 1983 Act (the definition of mental disorder).

Implementation

14. The Department is not aware of any practical concerns about the introduction of the single definition of mental disorder. The Department acknowledges, however, the issue that someone with a learning disability who displays "abnormally aggressive or seriously irresponsible behaviour" may be displaying such behaviour in an attempt to communicate that they have a problem such as physical pain or fear, rather than as a result of the worsening of a mental disorder. The Department recognises the importance of mental health professionals being alert to this possibility when considering whether someone with a learning disability should be detained for treatment under the 1983 Act. This is addressed in Chapter 34 of the Code of Practice, Mental Health Act 1983,[8] which deals with issues of

8 *Code of Practice: Mental Health Act 1983* (2008) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

particular relevance to patients with learning disabilities, autistic spectrum disorders or both. However, CQC inspections following the BBC Panorama programme on 31 May 2011 about Winterbourne View Hospital revealed that a number of hospitals for people with learning disabilities were not applying the good practice described in the Code of Practice. The Department's interim report[9] recommends that when the Code of Practice is updated following the implementation of the Health and Social Care Act 2012, the update of Chapter 34 should take account of the findings of the review.

15. A multi-site assessment of the impact of the Mental Health Act 2007 (the AMEND study), led by the University of Warwick and commissioned and funded by the Department of Health Policy Research Programme, is looking at the impact of changes introduced in the Mental Health Act 2007, including the definition of mental disorder. This will report in July 2012.

Appropriate medical treatment: The Appropriate Treatment Test

Overview of provisions

16. The 2007 Act changed the 1983 Act's definition of medical treatment, defining a new concept of "appropriate treatment" and replacing the "treatability" test with a new appropriate treatment test.

17. The former so-called "treatability" test required the relevant decision-maker to determine whether medical treatment was "likely to alleviate or prevent deterioration in the patient's condition". The test was felt to lead to some significant problems. In some cases clinicians felt unable to detain people or Tribunals felt obliged to discharge people on the grounds that their disorder was untreatable. It was felt some patients were being denied appropriate treatment and care, especially in the light of emerging evidence about treatments.

18. The 2007 Act introduced a new appropriate treatment test which requires decision-makers to determine whether appropriate treatment is available for the person to be detained under the 1983 Act. The new test was intended to support services which would pre-empt and help to manage behaviour rather than react to behavioural breakdown. It also aimed to deal with the issue of patients refusing to engage with treatment in the hope this would end their detention. In addition its aim was to ensure that assessment and treatment under the 1983 Act was for clear clinical purposes and that it would not be used purely for preventive detention. The definition of the new test was subject to considerable, constructive debate during the Parliamentary passage of the Mental Health Bill 2006.

9 *Department of Health Review: Winterbourne View Hospital Interim Report* (June 2012) http://www.dh.gov.uk/health/files/2012/06/Department-of-Health-Review-Winterbourne-View-Hospital-Interim-Report1.pdf

Implementation

19. The Department thought that the appropriate treatment test might lead to a small increase in the number of people detained under the 1983 Act but has no anecdotal or statistical evidence to suggest that this has been the case. Nor does it have evidence of any problems with the operation of the new appropriate treatment test.

20. The AMEND study (see paragraph 15) is examining the impact of the test by investigating how mental health professionals understand and interpret "appropriate medical treatment" as defined in the amended 1983 Act. The final report will be available in July 2012, but emerging findings in October 2011 showed that:

- Mental health professionals understand the appropriate treatment test and recognise the change in definition which allows treatment for disorders previously considered untreatable.
- For most professionals their practice remains unchanged except that when assessing patients, they now consider if appropriate treatment is available.
- There is little evidence of disagreement about the application of the appropriate treatment test between professionals.
- Clinicians have noticed little change in service provision since implementation in 2008.

Guiding principles

Overview of provisions

21. During the passage of the 2007 Act there was considerable discussion about the importance of fundamental or guiding principles for the operation of the 1983 Act. It was suggested that they should be spelt out in the primary legislation, but this risked possible, unpredictable conflicts between the principles and other provisions of the 1983 Act. It was finally agreed to include principles in the Code of Practice,[10] which could take a more flexible and practical approach. The matters to be addressed in the Code, however, were listed in four new subsections which the 2007 Act inserted into section 118 of the 1983 Act.

Implementation

22. The matters listed in the amended 1983 Act were distilled into five guiding principles which were set out in Chapter 1 of the Code of Practice and then used throughout the Code of Practice to illustrate how they might be applied to decisions taken under the Act. The principles are:

- Purpose principle;
- Least restriction principle;
- Respect principle;
- Participation principle; and
- Effectiveness, efficiency and equity principle.

10 *Code of Practice: Mental Health Act 1983* (2008) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

23. The statement of principles was drafted following extensive consultation on the Code of Practice. There have been no legal challenges. They are intended to inform every decision made under the 1983 Act and improve the quality of services for people who come under the provisions of that Act.

Professional roles

Overview of provisions

24. The 2007 Act made changes to allow a wider range of professionals to perform certain roles which are central to the 1983 Act. As modern mental health services increasingly involve a range of professionals, this was an area where the restrictions in the legislation could be a barrier to the service a patient needed.

25. The 2007 Act introduced greater flexibility in who could undertake certain roles. In particular, it replaced the role of the "responsible medical officer" (RMO) with that of the "responsible clinician" and the role of the "approved social worker" with that of the "approved mental health professional" (AMHP).

26. The responsible clinician may now be any practitioner who has been approved for that purpose (an "approved clinician"). Approval need no longer be restricted to medical practitioners, and may be extended to practitioners from other professions, such as nursing, psychology, occupational therapy and social work.

27. Similarly with approved mental health professionals, the role is no longer restricted to social workers. A wider group of professionals, including nurses, occupational therapists and certain psychologists, is eligible to be approved to be an approved mental health professional – as long as the individuals have the right skills, experience and training set out in regulations.[11]

Implementation

28. The Department does not collect information on how many approved clinicians there are who are not medical practitioners nor how many approved mental health professionals there are who are not social workers. However, the purpose of the change was not to require a different approach but to give flexibility to employers should they feel that the users of their services would benefit from a wider set of clinical expertise. A report in May 2012 of inspections of the 22 AMHP training courses in England found that of the 936 candidates who had completed their training since November 2008, 84% were social workers and 15% nurses. The health professionals were found to be as equally competent in the role as social workers.[12]

11 *Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008*, SI 2008/1206 as amended http://www.legislation.gov.uk/uksi/2008/1206/contents/made

12 General Social Care Council, *GSCC targeted inspections of Approved Mental Health Professionals (AMHP) in England (2011-12)* (May 2012) http://www.gscc.org.uk/news/97/GSCC-launches-report-on-Approved-Mental-Health-Professionals-(AMHP)-courses.html

Nearest relatives' rights

Overview of provisions

29. The 2007 Act introduced a new right for a patient to apply for an order to displace the nearest relative. It also changed the requirement that the acting nearest relative be, in the court's opinion, a "proper person" to act as the nearest relative. It substituted a requirement that the person is, in the court's opinion, a "suitable" person to act.

30. The nearest relative has certain rights in connection with the care and treatment of a mentally disordered patient under the 1983 Act, including the right to apply for admission to hospital, the right to block an admission for treatment, the right to discharge a patient from compulsion and the right to certain information about the patient.

31. The 1983 Act's framework for the appointment of "nearest relatives" was founded upon a hierarchical list without reference to patients' own wishes over whom amongst their family might be considered for this role. This automatic identification of "nearest relatives", coupled with the powers granted to persons who are so identified, was found in certain circumstances to be in breach of Article 8 of the European Convention on Human Rights, as a disproportionate interference with the right to privacy and family life. In response to the first challenge on such grounds to reach the European Court (in March 2000),[13] the Government promised to introduce the changes in sections 23 to 25 of the 2007 Act.

32. The changes introduced in the 2007 Act were designed in the interests of patients to give them more say on who could act as their nearest relative, and to ensure that those acting as nearest relatives were suitable.

Implementation

33. The Department considers that the changes have addressed the issues raised in the challenge in the European Court and is not aware of any further concerns with the implementation of this part of the 2007 Act.

Independent mental health advocacy

Overview of provisions

34. Independent mental health advocates (IMHAs) were an aspect of the 2007 Act that attracted widespread support. The 2007 Act puts a duty on the Secretary of State to make reasonable arrangements to ensure that IMHAs are available to help qualifying patients. Qualifying patients are primarily those detained, or on a Community Treatment Order, subject to guardianship or on conditional discharge under the 1983 Act. Deliberately excluded are people detained under "short-term" sections because an IMHA service could not reasonably provide an "emergency response" service. Small numbers of other patients, such as those being considered for psychosurgery and under-18s being considered for electro-convulsive therapy

13 JT v UK [2000] 1FLR 909

also qualify for independent mental health advocacy.

35. The 2007 Act enabled the making of regulations on IMHAs. These regulations[14] set out requirements for the commissioning of IMHA services. There is a requirement to take account of the "diverse circumstances" of qualifying patients. There is also a requirement that contracts must require IMHA providers to comply with the Regulations about who can be appointed as an IMHA. The 2007 Act itself requires commissioners to have regard to the principle that IMHAs should, as far as possible, be independent of the people professionally involved in the patient's treatment. The Regulations also require that IMHAs must be able to act independently of both commissioner and provider. The IMHA Regulations also require that IMHAs have appropriate training and/or experience, having regard to guidance.[15]

Implementation

Commissioning

36. The duty to make arrangements for advocacy provision is currently delegated to Primary Care Trusts (PCTs). PCTs commission advocacy services, typically from specialist, voluntary sector, advocacy providers. The funding for IMHA services has been made available through PCT allocations. Costs in the first year of implementation (2009/10) were estimated to be £7.64 million.

37. Responsibility for commissioning IMHA services falls on the PCT where the patient is registered with a GP to avoid placing an unfair burden on PCTs which have a disproportionate number of psychiatric hospital beds in their area. This however caused complications for the funding of IMHA services for patients placed out of area, in specialised services or independent hospitals. These issues have been dealt with pragmatically by commissioners.

38. The responsibility for commissioning IMHA services will transfer to Local Authorities in April 2013 under the Health and Social Care Act 2012, and guidance will be issued to ensure that all qualifying patients have access to an IMHA service.

IMHA training and national advocacy qualification

39. The Department was instrumental in the establishment of a national advocacy qualification. The qualification (which has both certificate and diploma levels) is awarded by City & Guilds, and training providers must be accredited by City & Guilds to offer it.[16] It is a largely workplace-based qualification. There are four generic modules, and then a number of specialist modules, including two for IMCAs (independent mental capacity advocates under the Mental Capacity Act

14 *The Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations* 2008 SI2008/3166 http://www.legislation.gov.uk/uksi/2008/3166/contents/made

15 Department of Health, *Standards: Appropriate Experience and Training* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_092056.pdf

16 For further information, see www.cityandguilds.com/48098.html

2005) and one for IMHAs. Guidance on the required qualifications and experience for IMHAs (see paragraph 35) states that IMHAs should normally have successfully completed the IMHA module within a year of being appointed.

IMHAs' access to records

40. The 2007 Act gives IMHAs (when acting as such) certain statutory powers to visit and interview people, and to look at patients' records (with their permission, if they have capacity to consent, otherwise if the record holder thinks it appropriate). This led to questions about whether IMHAs could see parts of patients' records which would be withheld from patients themselves and, if so, whether they could share them with patients. Concerns about patient confidentiality meant that the Department issued supplementary guidance.[17]

Additional support – Action for Advocacy project

41. The Department gave Action for Advocacy (A4A) a three year Third Sector Investment Grant of £195,000 from 2010-11 to 2012-13 to provide a central support and development resource for IMHA providers. This includes a telephone helpline and facilitating regional IMHA forums.[18]

Quality

42. Quality and accessibility of IMHA services varies around the country. This has been shown consistently in reports in 2010 and 2011:

- the Mental Health Alliance Briefing Paper 3 (February 2011);[19]
- the CQC's 2009/10 annual Mental Health Act report[20] found that 18% of wards did not have access to IMHA services. This figure had improved only slightly in the 2010/11 report[21] to 15% of wards.

43. Following the implementation of IMHA services the Department of Health Policy Research Programme commissioned and funded an independent review of the quality of IMHA services undertaken by the University of Central Lancashire. This is, in part, an evaluation of the implementation of IMHA services, but the main aim of the study was to understand the characteristics of a good quality IMHA service.

17 *Independent mental health advocates: supplementary guidance on access to patient records under section 130B of the Mental Health Act 1983* (2009) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098828

18 For more on the project, see www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=73

19 Mental Health Alliance, *Briefing Paper 3 Independent Mental Health Advocacy* www.mentalhealthalliance.org.uk/news/pr_imha_report.html

20 Care Quality Commission, *Monitoring the Mental Health Act 2009/10* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf

21 Care Quality Commission, *Monitoring the Mental Health Act in 2010/11* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf

44. This study commenced in 2010 and the final report *The Right to be Heard* was published on 21 June 2012.[22]

45. The overarching conclusion of this report is that 'when people get access to these advocacy services they really appreciate them but there are specific problems for access for black and minority ethnic communities, and older people'. The report considers that some of these challenges reflect the way services have developed.

46. The report recommends that all people detained under the 1983 Act should be automatically referred to IMHA services with the option of opting out. It finds that this may overcome the problems of access for particular groups.

47. The recommendations of the report, including better assessment of local need to respond to diversity, will be considered as part of the handover of responsibility for commissioning IMHA services to local authorities. This will be a good opportunity to apply the findings from this research more generally to improve the quality and accessibility of IMHA services.

Supervised community treatment (community treatment orders)

Overview of provisions

48. The supervised community treatment (SCT) provisions introduced in the 2007 Act were aimed at allowing some patients with a mental disorder to live in the community whilst still being subject to recall and certain powers under the 1983 Act. Only those patients who are detained in hospital for treatment[23] are eligible to be considered for SCT. In order for a patient to be placed on SCT, various criteria need to be met, and an AMHP needs to agree that SCT is appropriate. Patients who are on SCT are subject to conditions whilst living in the community. Most conditions depend on individual circumstances but the SCT must be for the purpose of ensuring the patient receives appropriate medical treatment which is necessary for their health or safety or for the protection of others. Such conditions form part of the patient's community treatment order (CTO) which is made by the responsible clinician. Patients on SCT must be able to be recalled to hospital for treatment should this become necessary. Afterwards they may then resume living in the community with SCT or, if they need to be treated as an in-patient again, their responsible clinician may revoke the CTO and the patient will remain in hospital for the time being.

49. SCT differs from after-care under supervision, which it replaced, in that it allows patients who do not need to be treated in hospital to be discharged into the community, but with powers of recall to hospital if necessary. It is different

22 The Right to Be Heard Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England (2012) www.uclan.ac.uk/schools/school_of_health/the_right_to_be_heard.php

23 This includes patients who are subject to a hospital order or guardianship order under Part 3 of the 1983 Act (which deals with mentally disordered offenders and defendants in criminal proceedings) who are not also subject to a restriction order or direction.

from leave of absence under section 17 of the 1983 Act, which is primarily meant for patients where there is reason to believe that the patient will need further in-patient treatment as a detained patient. Leave of absence will therefore be suitable to give shorter term leave from hospital as part of the patient's overall management as a hospital patient.

50. SCT is a clinical decision, only the patient's responsible clinician can discharge them onto SCT from detention (and only then with the agreement of an AMHP). A Tribunal can recommend the responsible clinician to consider SCT, but cannot put a patient on SCT itself. CTO conditions are not enforceable: responsible clinicians can include "conditions" in CTOs (eg about treatment or where the patient is to live) which patients are expected to comply with, but those conditions are not directly enforceable. With two exceptions patients cannot be recalled to hospital just because they have breached their CTO conditions. The only exception are the two mandatory conditions in all CTOs, which allow patients to be recalled to be examined by the responsible clinician to comply with the rules on extending CTOs, and by second opinion appointed doctors (SOADs).

Implementation

51. The introduction of CTOs was controversial and a number of issues and concerns continue to be raised about them. They have not yet been in place long enough for there to be sufficient evidence for robust conclusions to be drawn. There are a number of sources of data and a detailed research study which will become available in the next 12 months, which will allow further review and evaluation.

52. The issues and concerns which have emerged since November 2008 when CTOs were introduced are:

- Appropriateness of CTOs for all the patients who are on them
- Length of CTO
- Equality aspects
- Quality and outcomes
- Safeguards for patients on CTOs
- Section 5 holding powers

Use of CTOs

53. One of the objectives of the CTO provisions was to help tackle the "revolving door" syndrome of patients being detained, discharged, disengaging from treatment and then being detained again. The view was that SCT should be used wherever it was necessary. That could mean using it to prevent people getting into the "revolving door" cycle, as well as removing people from it. During the passage of the 2007 Act, the Government resisted attempts to amend the criteria to make SCT apply only to patients with a history of non-compliance with their treatment.

54. Some commentators have asked why SCT is being used for people "it was not intended for", for example CQC's 2009/10 annual report questioned the

number of SCT patients who do not have a history of non-compliance[24] and this concern has been repeated in the Mental Health Alliance's recent report.[25] These comments may be a misunderstanding of the original intention of the 2007 Act which was that SCT should be available to support "modern provision of mental health services, where treatment is based in the community rather than in hospital".[26]

Length of CTO

55. There have also been questions about how long a CTO should last. The 2007 Act intended that this should depend on the individual patient's needs. For some people, a brief period of SCT might be all that is needed to enable them successfully to re-establish their life in the community, while for others, it might be necessary on a long-term basis to help reduce the chances of them relapsing.

56. Currently the Department of Health only has data on the use of CTOs for the period from November 2008 until March 2011 (the latest data available).

Table 1: Use of CTOs, 2008/09 to 2010/11

Year	Number of CTOs	Number of revocations and discharges
November 2008/ March 2009 (5 months operation)	2,134	176
2009/10	4,103	1,789
2010/11	3,834	2,185

Table 2: Numbers of people subject to a CTO on 31 March, 2009 to 2011

Year	Male	Female
31 March 2009 (after five months of operation)	1,178	577
31 March 2010	2,109	1,216
31 March 2011	2,712	1,579

From CQC Annual Report[28]

Equality Aspects

57. There is long standing concern about the disproportionate numbers of people from minority ethnic groups, particularly Black Caribbean, Black African and other Black groups, using in-patient mental health services and detained under the 1983 Act. Consideration of early data[24,27] suggested that Black and Black British were over represented amongst people on SCT, and that more patients from

24 Care Quality Commission, *Monitoring the Mental Health Act 2009/10* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf

25 Mental Health Alliance, *The Mental Health Act 2007: a review of its implementation* (May 2012) http://www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf

26 *Mental Health Bill regulatory impact assessment: revised version* (June 2007) http://www.dh.gov.uk/en/publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_076477

27 NHS Information Centre Mental Health Bulletin – Fifth report from *Mental Health Minimum Dataset (MHMDS) annual returns*, 2011 http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin--fifth-report-from-mental-health-minimum-dataset-mhmds-annual-returns-2011

Black and minority ethnic (BME) groups than might be expected were placed on a CTO in 2009/10. However, further analysis of the latest data shows a more complex picture with CTO rates higher than average for Black Caribbean and Black African groups and slightly higher for Other Black groups,[28] with different patterns of use of the 1983 Act for these three groups. Table 1 in the CQC report gives further detail on the use of the Mental Health Act 1983 (including CTOs) for people from a range of Black and minority ethnic groups in 2010/11.

58. Greater understanding is needed about the factors that lead to the variations that exist between the proportions of some ethnic groups detained under the 1983 Act, which is reflected in the population on CTOs. CQC recommend that comparative provider level data on use of the Mental Health Act is made public, including (where possible) standardisation by age, gender and ethnicity to inform local monitoring and service development.[28]

59. The Mental Health Alliance report[29] highlights the considerable debate and disagreement over the complex mix of factors which leads to the disproportionate representation of black and minority ethnic groups throughout mental health services. There needs to be more detailed understanding of the experience of different population groups at each part of the pathway into and through mental health services. Since patients can only be on CTOs following detention under section 3 or section 37 of the Mental Health Act 1983, consideration of the use of CTOs in BME groups will be part of the wider work on equality in mental health services which is being undertaken as part of the Government's Mental Health Strategy, *No health without mental health* (2011).

Quality and outcomes for SCT patients

60. The CQC report *Monitoring the Mental Health Act 2010/11*[30] raises issues about the quality of care planning and support for SCT patients:

- SCT patients who had a more positive approach to their treatment on a CTO almost invariably felt supported by and involved in their care plans. Conversely patients who were poorly involved in their care planning tended to regard their CTO simply as a way for doctors to enforce their compliance. The CQC found that not only had these patients not had their rights and choices explained to them, but the experience and outcome of the CTO is likely to be poor.
- The CQC continued to find evidence that the legal powers of CTOs were misunderstood within some mental health providers; an issue first identified in the

28 Care Quality Commission, *Monitoring the Mental Health Act in 2010/11* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf

29 Mental Health Alliance, *The Mental Health Act 2007: a review of its implementation* (May 2012) http://www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf

30 Care Quality Commission, *Monitoring the Mental Health Act in 2010/11* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf

Annual Report for 2009/10. The Annual Report for 2010/11 recommends that: 'Providers should ensure that all staff who care for patients subject to CTOs understand the scope and limitation of this power. Any instance of unlawful treatment should be investigated... and patients should be offered due recourse if necessary'.[31]

61. The Mental Health Alliance has drawn attention to the risk that CTO conditions may interfere with patients' human rights to privacy and family life and that there is no right to challenge them in the Tribunal.[32] The Department is not aware of any human rights challenges to CTO conditions, and would not accept that there is such interference, but this is another aspect of experience and outcome of CTOs which might be considered as part of an evaluation of the quality and outcomes of CTOs.

Safeguards for patients on CTOs

62. There was concern at the time of the 2007 Act that patients subject to these new provisions should be given additional safeguards. Some of these have proved in practice to be anomalous and overly bureaucratic.

63. One of the requirements put in place when SCT was introduced in 2008 was that an SCT patient could not be given specified treatments unless a second opinion appointed doctor (SOAD) had certified on a statutory form that the treatment was appropriate in the patient's case. This is known as the "certificate requirement".

64. When SCT was introduced, a SOAD opinion was required for all SCT patients whether they consented to their treatment or not. In this, it differed from the rules which were already in place for consenting patients who have been detained under the 1983 Act for whom second opinions are not required. The 2007 Act thus imposed additional restrictions on SCT patients compared to detained patients.

65. The additional pressure on the SOAD service led to delays in SOAD opinions for all patients and SCT patients have found it inconvenient or objectionable to have to be examined by a SOAD before they can be given treatment to which they are consenting.

66. This part of the 2007 Act has therefore been amended by section 299 of the Health and Social Care Act 2012 (Certificate of consent of community patients to treatment) so that approval by a SOAD will not generally be necessary if the patient is consenting to the treatment in question.

67. The Mental Health Alliance supported this change 'which removes an anomaly whereby treatment cannot be legally given to someone in the community without SOAD approvals even if they are

31 Care Quality Commission, *Monitoring the Mental Health Act in 2010/11* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf

32 Mental Health Alliance, *The Mental Health Act 2007: a review of its implementation* (May 2012) http://www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf

willing to take it and will free up SOAD time to focus on those who lack capacity to consent.'[33]

68. Section 299 of the Health and Social Care Act 2012 commenced on 1 June 2012. The Department of Health and CQC, which runs the SOAD service, will keep the impact of the change under review.

Section 5 holding powers

69. Section 5 of the 1983 Act provides for hospital in-patients to be held temporarily while arrangements are made to have them assessed for an application for detention. This does not apply to SCT patients. It was thought that the responsible clinician's power of recall should be used instead (and the 2007 Act expressly says that an SCT patient who is already in hospital can nonetheless be recalled). However, only a responsible clinician can recall an SCT patient and this may be a problem if a patient needs an urgent assessment, at night for example.

70. The recent judgment of *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2 indicated mental health providers have a responsibility for the safety of voluntary as well as compulsory patients. Consequently, consideration may need to be given to whether providers also have a responsibility in relation to SCT patients, and whether section 5 holding powers should be extended to SCT patients at the next legislative opportunity.

Information available

71. The Department does not consider that there is yet sufficient evidence to allow robust conclusions to be drawn about any adjustments which may be needed. For example, a significant number of patients are still on CTOs who were put on them very soon after they were introduced. The characteristics of that group of patients, for whom this option was rapidly taken up by their responsible clinician, may differ from patients going on to CTOs in 2012. Although numbers of new CTOs are decreasing (see table above) the point at which numbers of new CTOs are balanced by those being discharged from CTOs has not yet been reached. In addition each CTO is an individual clinical decision and the Department understands that individual clinicians have varying practice in their use of CTOs. Areas which need further review are emerging as:

- Overall numbers of CTOs and the length of time that some patients are remaining on them
- Disproportionate use for some groups
- Why CTOs end and the outcomes for patients

72. The Oxford Community Treatment Order Evaluation Trial (OCTET) study is due to report in July 2013. The trial is funded by a Programme Grant from the National Institute of Health Research and is being conducted by the Social Psychiatry Unit at the Department of Psychiatry,

33 Mental Health Alliance, *The Mental Health Act 2007: a review of its implementation* (May 2012) http://www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf

University of Oxford. The overall aim of OCTET is to improve patient outcomes by informing mental health policy and practice. The study seeks to do this by:

- Providing rigorous and convincing evidence as to CTO effectiveness
- Demonstrating whether adding CTOs to high quality community care reduces readmission rates and affects a range of other patient outcomes
- Identifying patient characteristics and care patterns associated with good outcomes
- Informing an economic analysis to model the national cost of introducing CTOs
- Contributing to training for effective implementation.

73. In addition, another set of annual figures (up to March 2012) about patients subject to supervised community treatment will be available from the NHS Information Centre in October 2012. This will increase the available data significantly. During 2012, the Information Centre is conducting a fundamental review of these statistics. As part of the Information Centre review, it has been recommended that the data for these annual figures be sourced via the Mental Health Minimum Dataset (MHMDS). Using the MHMDS as the source data for this publication will mean that more information about the people subject to the 1983 Act (such as gender and ethnicity) and their care pathways will be available.

74. In summary, it is too early to draw firm conclusions on the use of CTOs. The outcomes from the OCTET study in July 2013, a further set of annual figures and the ability to understand more about patients on CTOs and their pathways through in-patient services, will enable the Department of Health to understand more about patients on CTOs and determine what further steps may be necessary to improve the use of CTOs. The Department will pay particular attention to how the use of CTOs may differ for a range of ethnic groups of patients. This will be the opportunity to bring together evidence and carry out further reviews of data to judge whether action on legislation, policy or practice around CTOs is needed.

Places of safety

Overview of provisions

75. Under sections 135 and 136 of the 1983 Act a police officer may remove a person who is believed or appears to be suffering from a mental disorder to a place of safety where they may be detained for a maximum of 72 hours.

76. Places which may be used as a place of safety include a hospital, a care home for mentally disordered persons, a police station or any other suitable place whose occupier is willing to receive the patient temporarily.

77. Police stations are not ideal places in which to detain someone suffering from mental disorder, but the 1983 Act did not permit someone who was removed to a place of safety to be moved to another, more conducive place of safety. The 2007 Act therefore introduced changes to the

1983 Act to allow a person to be taken from one place of safety to one or more other places of safety during the 72-hour maximum overall period. Section 44 of the 2007 Act, which deals with places of safety, came into force on 30 April 2008.

Implementation

78. Informal communications suggest that this provision has allowed some people detained under section 136 to be moved from a police station to a more appropriate environment for assessment, leading to better quality care during the section 136 detention and better decisions on their future care.

79. However the numbers recorded for those detained under section 136 in hospital based places of safety have been increasing since they were first collected on a national basis in 2006/07. There is no suggestion that this increase is linked to the provisions of the 2007 Act.

80. The use of hospital based places of safety has increased from 7,035 in 2007/8 to 14,111 in 2010/11.[34] Some of this increase could be due to improved recording as well as an overall increase in the use of hospital places of safety.

Table 3: Use of hospital based places of safety under section 136

Year	Male	Female
2007/08	4,037	2,998
2008/09	4,893	3,602
2009/10	6,778	5,260
2010/11	7,839	6,272

Source: KP90 Data collection

81. The numbers of detentions following the use of section 136 has not shown such a rapidly increasing trend as the number of uses of section 136 (See Table 4).

Table 4: Detentions following use of section 136

Year	Detained following Section 136
2007/08	2,020
2008/09	1,753
2009/10	1,922
2010/11	2,376

Source: KP90 Data collection

82. However the proportion of all detentions coming via section 136 was at a 5 year high in 2010/11 (4.8% of all detentions).

83. Despite this increase in the use of health-based places of safety a number of police forces still report being unable to access health based places of safety for a significant proportion of section 136

34 NHS Information Centre, *Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2010/11* http://www.ic.nhs.uk/pubs/inpatientdetmha1011

removals.[35] The use of police stations as places of safety is monitored locally and this should inform commissioning of health based places of safety, and local protocols for transfer and acceptance.

84. As far as equality analysis is concerned the gender balance has changed in the recorded use of hospital based places of safety. Although more males than females are still affected, the proportion has changed from 42% of those detained being female in 2007/08 to 44% in 2010/11. Ethnicity was not reported in the NHS Information Centre publication but it is generally accepted that rates of use for BME groups are above average as in other uses of the 1983 Act.

85. The Health and Social Care Act 2012 establishes that from April 2013 the NHS Commissioning Board (NHSCB) will be responsible for commissioning health services for people who are detained in prison or other accommodation of a prescribed description. This is intended to include those in police custody. As police forces transfer health commissioning arrangements, the NHS and police partnerships will be able to develop robust commissioning plans for health-based places of safety.

Recent legal cases

86. Recent decisions of the European Court of Human Rights make it clear that authorities must ensure that mentally disordered persons receive adequate and appropriate psychiatric care and treatment while detained. This was highlighted in the recent case of *MS v UK*,[36] which concerned the use of a police station as a place of safety.

87. MS had been diagnosed with mental impairment and admitted previously to mental hospitals. He was detained, arrested and transferred to a police station as a place of safety under section 136 of the 1983 Act. Although MS was assessed and an order was made for his detention for assessment under section 2 of the 1983 Act, he was not transferred to a psychiatric clinic for four days (a few hours beyond the 72 hour limit). He could not be admitted until the clinic was sufficiently staffed to admit him safely. During his detention in the police station, MS became more agitated and, in the latter stages of his detention, refused offers of food and drink.

88. The Court found that, though there was no intention to mistreat MS, his treatment was nevertheless severe enough to breach Article 3 (the right not to be subjected to degrading treatment) of the European Convention on Human Rights (ECHR). This was because of MS's particular vulnerability due to his visible symptoms of mental disorder and need for urgent psychiatric treatment. Failing to transfer MS sooner excessively diminished his human dignity. The Court ordered the UK to pay damages and costs.

35 Care Quality Commission, *Monitoring the Mental Health Act 2009/10* http://www.cqc.org.uk/sites/default/files/media/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf and Hansard, 14 June 2012 Column 509

36 MS v UK[2012] ECHR 804[1]

89. The Court did not comment on the use of police stations as places of safety, but UK legislation and best practice in relation to their use will be relevant in determining whether or not treatment and/or conditions breach Article 3 of the ECHR.

Age-appropriate accommodation

Overview of provisions

90. The 2007 Act introduced new provisions to help ensure that patients under the age of 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). The Government did not commence this provision until April 2010 to give the NHS additional time to prepare.

Implementation

91. There has been significant progress in reducing the number of children and young people aged under 18 placed on adult wards. For a small number of the latter group, admission to an adult ward may be the most appropriate option because of (a) overriding need when a young person needs immediate admission for their safety or that of others, and (b) atypical need when, even if a CAMHS (Child and Adolescent Mental Health Service) bed was available, an adult ward is the most appropriate clinical placement.

92. The number of bed days recorded for under-18s on adult wards was 10.1% of the total bed days in 2008/09 but reduced to 2.6% in 2010/11. The number of bed days for under-16s on adult wards has reduced to a very low level – five bed days in 2010/11.[37]

93. Information on bed days for under-18s on adult wards is no longer being collected by the Department but the NHS Information Centre is collecting data on bed days for under 16s on adult wards. However, there are data quality issues which are currently being investigated.[38]

94. The reduced number of under-18s being treated on adult wards is encouraging but this should be an issue which commissioners continue to address.

Deprivation of Liberty Safeguards

Overview of provisions

95. The Deprivation of Liberty Safeguards (DOLS) were introduced into the Mental Capacity Act 2005 by the 2007 Act.

96. The DOLS provide a statutory framework for authorising the deprivation of liberty for people who lack the capacity to consent to treatment or care, where in their own best interests, that care can only be provided in circumstances that amount to a deprivation of liberty.

37 See data on child and adolescent mental health services at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Integratedperfomancemeasuresmonitoring/DH_112554

38 See: http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/routine-quarterly-mental-health-minimum-dataset-reports--final-q2-and-provisional-q3-2011-12-summary-statistics-and-related-information

The safeguards apply in hospitals and care homes.

97. The legislation[39] contains detailed requirements about when and how such deprivation of liberty may be authorised. The legislation provides for an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

98. The safeguards regulations cover the following topics:

- The eligibility criteria for, and selection of, deprivation of liberty safeguards assessors
- Timescales within which assessments must be completed
- The information to be submitted with a request for a standard authorisation of deprivation of liberty
- The arrangements that are to apply in certain cases where there are disputes about the place of ordinary residence of a person coming within the scope of the deprivation of liberty safeguards provisions
- The selection and appointment of representatives for people who become subject to a deprivation of liberty authorisation.

99. The DOLS came into effect in April 2009.

100. The Government has issued two Codes of Practice that relate to the Mental Capacity Act 2005. The first, the Code of Practice which related to the original provisions of the Mental Capacity Act 2005, was published in 2007, while the Code in relation to the DOLS was published in 2008 to take effect in 2009. This was supported by an Impact Assessment.[40]

Implementation

101. The introduction of DOLS has resulted in a national statutory framework to protect individuals and raised awareness of human rights in care homes and hospitals. The CQC's second annual report[41] on the operation of the safeguards found that:

- CQC inspections of providers show that many have developed positive practice, notably in involving people and their carers in the decision process
- While the number of applications for authorisation under the safeguards rose from 7,157 in 2009/10 to 8,982 in 2010/11, there continue to be areas that need to be addressed

39 See: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/DH_084948

40 *Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice* and *Impact Assessment of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to accompany the Code of Practice and regulations* http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm#jumpTo4

41 Care Quality Commission, *The operation of the Deprivation of Liberty Safeguards in England 2010/11* http://www.cqc.org.uk/sites/default/files/media/documents/dols.pdf

- CQC is developing its monitoring role so that it forms part of inspections of how well care providers are complying with essential standards
- There continues to be concern about the complexity of the safeguards (some of these are discussed in the paragraphs below). CQC will continue to discuss these with the Department as and when their overview of the system enables identification of areas for exploration.

102. To support implementation of DOLS, the Department funded a national implementation team which was responsible for awareness raising, training, and supporting national and regional initiatives.

103. The Department also issued a series of standard forms, briefing on legal cases, a data collection system and guidance on changes to qualifying requirements for psychologists to assist with the implementation of the DOLS.[42]

104. As well as issuing the Code of Practice on the DOLS, the Department issued a complementary leaflet which was a short introduction to DOLS, designed to assist care homes and hospitals to help staff understand the safeguards. The leaflet was translated into Arabic, Bengali, Chinese, French, Gujarati, Polish, Punjabi, Somali, Tamil and Urdu. Further material was produced to support implementation, see Annex C.

Training

105. The Department worked with the General Social Care Council on developing a framework for the accreditation of Best Interests Assessors training. The Department commissioned the development of a two day training course for all Independent Mental Capacity Advocates (IMCAs) on the DOLS. The training was provided by Action for Advocacy, and was free for all IMCAs.

106. The Royal College of Psychiatrists produced the DOLS Mental Health Assessor Training Modules (and all related training materials) in collaboration with the Department of Health. In line with the regulations,[43] the training is made available by the Royal College of Psychiatrists.

Terminology

107. The terminology (deprivation) is sometimes thought to be an obstacle and some have argued that a more positive description (such as human rights safeguards) would result in a larger number of care homes putting forward their residents for the safeguards.

108. The definition of a 'Deprivation of Liberty' has also been an issue of some debate. The Code of Practice reflects the judgment in HL v UK[44] in stating that there is no simple definition of a deprivation of liberty and it is a matter of

42 See the DH website at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm

43 *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations* (SI 2008/1858) http://www.legislation.gov.uk/uksi/2008/1858/contents/made

44 [2005] 40 EHRR 32

degree and intensity rather than nature and substance. The Code does however offer guidance; it cautions to distinguish between deprivation and restriction, and it summarises some case law on this issue.

Court of Protection

109. Since the publication of the Code of Practice on the DOLS, there have been a number of important judgements by the Court of Protection and the High Court.[45] These have provided important guidance on the issue of deprivation of liberty in the context of the human rights of a person who lacks capacity to make his own decisions and the need to balance protection by the state with recognition of a person's autonomy.

110. The judgements have also provided useful guidance on issues such as the duties of a Supervisory Body, on the issue of restraint and seclusion in social care, and on what constitutes a good care plan.

111. The recent *Cheshire West and Cheshire Council v P* case[46] has introduced the concept of a comparator in determining whether or not there is a deprivation of liberty. Whether or not there is a deprivation of liberty is in part a reflection of whether the care proposed is very different from the care provided for a person of similar needs, limitation and capabilities in a different setting. The Official Solicitor is appealing this judgement in the Supreme Court.

112. These judgements have looked at different aspects of the DOLS and this is clearly still an evolving area of law.

Variation

113. National statistics[47] suggest that there are geographical variations in the implementation of the safeguards, which may mean some areas are using them less than they should. Numbers overall however are increasing, suggesting that the safeguards are becoming better understood and there is increasing awareness.

Interface with the Mental Health Act 1983

114. The Mental Capacity Act 2005 and the Mental Health Act 1983 are different pieces of legislation and DOLS need to engage with both. The Departmental Policy Research Programme has commissioned and funded an independent research project, undertaken by the University of Cambridge, to examine the interface between DOLS and the 1983 Act. The research team is due to report its findings in July 2012. The Department will carefully consider the findings and any recommendations.

Supervisory Bodies

115. There has been some criticism that there may be a conflict of interest inherent in the system as Supervisory Bodies and Best

45 G & E & a local authority and F [2010]EWHC 621; P & Q and Surrey County Council & others[2011] EWCA Civ 190. DM v Doncaster MBC & Secretary of State for Health [2011]EWHC 3652

46 [2011]EWCA Civ 1257

47 Care Quality Commission, *The operation of the Deprivation of Liberty Safeguards in England 2010/11* http://www.cqc.org.uk/sites/default/files/media/documents/dols.pdf

Interests Assessors are often part of the same team. Additionally there is a need to balance two roles: the local authority or PCT role as commissioner of a care home or hospital, and the role of the Supervisory Body authorising the deprivation of liberty of an individual. These roles are different, need to be seen as separate and need on occasion to challenge each other. The Department considers they can be managed effectively within one organisation.

People deprived of their liberty in settings other than care homes or hospitals

116. DOLS apply to people deprived of their liberty in care homes and hospitals. Some have commented that this leaves those in other settings unprotected. There is however a different system for protecting people who may need to be deprived of their liberty in care settings, such as supported living, which are not registered as care homes or hospitals. This system requires an application to the Court of Protection before anyone may be deprived of their liberty in such surroundings. The Court must consider the case and impose such conditions as it considers appropriate. This is a different approach to reflect the different circumstances in which people live.

Compliance of review and appeals process with the European Convention on Human Rights

117. Some have raised concerns that in their view the DOLS review and appeals process within local authorities and PCTs as well as the Court of Protection may not comply fully with human rights obligations. However, the courts have not declared any of these systems to be incompatible with the European Convention on Human Rights. The Department has also commissioned further guidance on mediation, to encourage better use of mediation and understanding of potential human rights issues.

Summary

118. The establishment of DOLS means that there is now a statutory framework which protects against arbitrary detention in a care home or hospital for those lacking capacity. These safeguards have thrown a spotlight on the care and treatment of some of the most vulnerable people in society and ensured safeguards to protect the human rights of people who might need to be deprived of their liberty in their own best interests.

119. The safeguards are still relatively new, potentially uneven in their use, and are still evolving. They play an important part in the range of safeguards available to protect people who need high quality "best interests" decision-making.

Victims' rights (Domestic Violence, Crime and Victims Act 2004)

Overview of provisions

120. Section 48 of the Mental Health Act 2007 introduced Schedule 6 which extends, with some modifications, the rights of victims under the Domestic Violence, Crime and Victims Act 2004. These changes extended rights to the victims of persons convicted of a sexual or violent

offence, where that person is subject to various provisions under the Mental Health Act 1983 (such as a non-restricted hospital order).

121. The changes in the 2007 Act meant that for victims in these groups, the local probation board must take reasonable steps to establish (a) if the victim of the offence wishes to make representations as to whether the patient should be subject to conditions in the event of discharge from hospital; and (b) whether the victim wishes to receive information about those conditions in the event of his discharge.

Implementation

122. Although evidence is limited and there are instances of good practice in implementing the legislation, some people have raised concerns over a lack of clarity in respect of the roles and responsibilities resting with hospitals when communicating with victims of both restricted and unrestricted patients. Anecdotal evidence suggests that where communication works well this is due to time being invested in developing good relationships between victim liaison units and hospitals.

Next steps

123. The changes introduced in the Mental Health Act 2007 are relatively recent. We know that the introduction of independent mental health advocacy is valued and evidence from research on some of the areas of most significant change (supervised community treatment and the interface between the Deprivation of Liberty Safeguards and the Mental Health Act 1983) is emerging. The Department continues to review the implementation of the 2007 Act as the evidence grows. The Department will consider what further evidence may be needed, and whether any further changes to legislation, guidance or policy are required, in the light of this developing evidence base.

Annex A: Overview of when sections of the Mental Health Act 2007 were enacted

1. Most sections of the Mental Health Act 2007 (the 2007 Act) were brought into force on 3 November 2008. *The Mental Health Act 2007 (Commencement No. 7 and Transitional Provisions) Order 2008* (SI2008/1900 (C84)) commenced provisions which:

   - Abolished the previous categories of mental disorder and replaced them with a single definition of mental disorder (section 1 and Schedule 1);
   - Qualified the application specified sections of the Mental Health Act 1983 (the 1983 Act) to people with a learning disability (section 2);
   - Removed some out-of-date exclusions from the 1983 Act – the sole remaining exclusion being dependence on drugs or alcohol (section 3);
   - Spelt out definitions of medical treatment and appropriate treatment for the purposes of the 1983 Act (sections 4 to 7);
   - Set out issues to be addressed by the guiding principles in the "Code of Practice Mental Health Act 1983" (section 8);
   - Replaced responsible medical officers with approved clinicians (sections 9 to 16) and approved social workers with approved mental health professionals (sections 18 and 21 and Schedule 2);
   - Clarified the law on conflicts of interest (section 22);
   - Improved patients' rights (sections 23 to 25 and 27 to 29);
   - Made provisions for specialist accommodation (section 31 (1), (2) and (4));
   - Introduced supervised community treatment (sections 32 to 35 and Schedules 3 and 4);
   - Made changes in relation to mental health review tribunals (sections 37 and 38);
   - Addressed issues affecting cross-border patients (section 39 and Schedule 5, insofar as not already in force); and
   - Improved victims' rights (section 48 and Schedule 6).

2. Section 48 amended the Domestic Violence, Crime and Victims Act 2004. All other provisions described above amended the Mental Health Act 1983 with a few also making consequential amendments to other Acts.

3. Regulation-making powers pertaining to the measures described above were brought into force by "The Mental Health Act 2007 (Commencement No. 4) Order 2008" (SI2008/745 (C30)) on 1 April 2008.

4. Section 36 of the 2007 Act repealed sections of the 1983 Act relating to after-care under supervision, also on 3 November 2008. In commencing this section, "The Mental Health Act 2007 (Commencement No. 6 and After-care Under Supervision: Savings, Modifications and Transitional Provisions) Order 2008" (SI2008/1210 (C52)) made some transitional provision for people who were subject to after-care under supervision on that date.

5. A few substantive provisions were commenced earlier than 3 November 2008

- *The Mental Health Act 2007 (Commencement No. 1) Order 2007* (SI2007/2156 (C80)) commenced section 45 which made a technical changes relating to powers on hospital managers in NHS Foundation Trusts.
- *The Mental Health Act 2007 (Commencement No. 2) Order 2007* (SI2007/2635 (C102)) commenced section 51 which made a minor amendment to the Mental Capacity Act 2005:
- With effect from 1 October 2007, *The Mental Health Act 2007 (Commencement No. 3) Order 2007* (SI2007/2798 (C108)) commenced section 19 to enable the General Social Care Council to approve training courses for approved mental health professionals and section 39 on cross-border patients (in part). It also commenced sections 40 and 41, relating to patients subject to Part 3 of the 1983 Act (patients concerned in criminal proceedings or under sentence) and section 42, which increased the maximum penalty on conviction for ill-treating a patient from two years to five, and section 49 which amended a section of the Mental Capacity Act 2005 dealing with independent mental capacity advocates.
- *Commencement Order No. 3* also commenced section 26 (which inserted civil partners in the list of nearest relatives in section 26 of the 1983 Act, but with effect from 1 December 2007), and commenced section 43 (on informal admission of patients aged sixteen or seventeen) with effect from 1 January 2008.
- *The Mental Health Act 2007 (Commencement No. 5) Order 2008* (SI2008/2635 (C39)) brought section 44 into force on 30 April 2008. This allows a police officer or an approved mental health professional to transfer a person he has taken to a place of safety from that place to another place of safety.

6. A very few sections were not commenced until 2009 or 2010.

- *The Mental Health Act 2007 (Commencement No. 10 and Transitional Provisions) Order 2009* (SI2009/139 (C9)) commenced a number of sections on 1 April 2009. These introduced independent mental health advocates (section 30) and inserted the Deprivation of Liberty Safeguards into the Mental Capacity Act 2005 (section 50 and associated Schedules).
- Finally, *The Mental Health Act 2007 (Commencement No. 11) Order 2010* (SI2010/143 (C17)) introduced a

requirement to care for young people under the age of eighteen in age-appropriate accommodation

7. Section 38, subsections (3) to (9) were never commenced in relation to England as they were overtaken by the Tribunals, Courts and Enforcement Act 2007 which, together with The Transfer of Functions Order SI 2008/2833, transferred the functions of the Mental Health Review Tribunal for England to the new First-tier Tribunal (Mental Health) in England. As a result, the sections amended by section 38 no longer apply to England. They do however provide for Wales to have a Mental Health Review Tribunal.

Annex B: Secondary Legislation

Mental Health Act 1983

1. Several orders, and sets of and regulations and one set of directions were made as a result of the changes the 2007 Act made to the 1983 Act. The main ones were:

- *Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (S.I. 2008/1184)* (Laid on 7 May 2008, came into force on 3 November 2008.)
  These are the main regulations dealing with procedural matters relating to the compulsory treatment of people under the 1983 Act as amended by the 2007 Act. Numerous sections of the 1983 and 2007 Acts refer.

- *Mental Health (Mutual Recognition) Regulations 2008 (S.I. 2008/1204)* (Laid on 7 May 2008, came into force on 3 November 2008.)
  These regulations set out the circumstances in which a practitioner approved in England for specified purposes under the 1983 Act may be treated as approved for those purposes in relation to Wales (and vice versa). Section 142A of the 1983 Act (inserted by section 17of the 2007 Act) refers.

- *Mental Health (Conflicts of Interest) (England) Regulations 2008* (S.I. 2008/1205) (Laid on 7 May 2008, came into force on 3 November 2008.)
  These regulations set out circumstances under the 1983 Act in which clinicians should not act due to a potential conflict of interest. Section 12A of the 1983 Act (inserted by section 22(5) of the 2007 Act) refers.

- *Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008* (S.I. 2008/1206) (Laid on 7 May 2008, came into force on 3 November 2008.)
  These regulations deal with issues to do with the approval of people to be approved mental health professionals.

- *Mental Health (Nurses) (England) Order 2008 (S.I. 2008/1207)* (Made on 28 April 2008, came into force on 3 November 2008.)
  This order spells out the classes of nurse empowered to detain patients under section 5(4) of the 1983 Act.

- *Mental Health Act 1983 Approved Clinician (General) Directions 2008* (Made on 31 July 2008, came into force on 3 November 2008).
  These directions deal with issues to do with the approval of people to be approved clinicians.

- *Mental Health Act 2007 (Consequential Amendments) Order 2008* (S.I. 2008/2828)
  This order made consequential amendments to primary and secondary legislation.

- *Mental Health Act 1983 (Independent Mental Health Advocates) Regulations 2008 (S.I. 2008/3166)* (Laid on 16 December 2008, came into force on 1 April 2009.)
  These regulations make provisions about who can be appointed to act as independent mental health advocates and the arrangements whereby they may be appointed.

2. There have also been a few sets of amending regulations to correct minor mistakes in the drafting of the main provisions identified above. For example, *The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2008* (S.I. 2008/2560).

3. In addition to the formal secondary legislation above, the Department also prepared a new *Code of Practice Mental Health Act 1983* to reflect the many changes to the 1983 Act which were made by the 2007 Act. This was laid before Parliament on 12 May 2008 and came into force on 3 November 2008. Section 118 of the 1983 Act refers.

Mental Capacity Act 2005

4. A number of sets of regulations have been made to implement the Deprivation of Liberty Safeguards (DOLS). These are:

   - *The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (Made on 9 July 2008, came into force on 3 November 2008).

   - *The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008* (Laid on 20 May 2008, came into force on 3 November 2008).

   - *The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) (Amendment) Regulations 2008* (Laid on 12 September 2008, came into force on 3 November 2008).
     These regulations correct a minor defect in the earlier regulations: they prevent supervisory bodies from selecting paid representatives from amongst their own employees, thus avoiding any conflicts of interest.

   - *The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting: and Assessments – Amendment) Regulations 2009* (Made on 31 March 2009, came into force on 1 April 2009).
     They contain measures relating to the monitoring and reporting of the operation of the deprivation of liberty safeguards by the Care Quality Commission.

   - *Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) and Section 75 partnerships under the National Health Service Act 2006 in the NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2009.*
     The Government laid amending regulations to the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. MCA DOLS was included on the list of functions of NHS Bodies in regulation 5, thereby enabling PCTs to enter into formal partnership arrangements with a local authority under Section 75 of the National Health Service Act 2006. Local authorities were enabled to carry out MCA DOLS functions on behalf of PCTs.

Annex C: Materials Produced to Support Implementation

1. The National Institute for Mental Health (England) produced several publications and other materials to support implementation of the 2007 Act. They can be found at: www.nmhdu.org.uk.

2. These include:

   Supervised Community Treatment: Pathway (May 2008)

   Supervised Community Treatment: A Guide for Practitioners (October 2008)

   Mental Health Act 2007: New Roles (October 2008) (Guidance for approving authorities and employers on Approved Mental Health Professionals and Approved Clinicians.)

   Shoulder to Shoulder, a new DVD for Independent Mental Health Advocates (December 2008)

   Independent Mental Health Advocacy, Guidance for Commissioners (December 2008)

   The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals (January 2009)

   Independent Mental Health Advocacy: Effective Practice Guide (August 2009)

   Independent Mental Health Advocacy: Workbook for Independent Study

3. A range of material has been produced to support the implementation of the Deprivation of Liberty Safeguards. They can be found on the Departmental website. They include:

   Making decisions booklet: The IMCA role

   Information on DOLS: a guide for family, friends and unpaid carers

   Dear colleague letter from David Nicholson outlining roles and responsibilities around DOLS for health and social care providers

   A Guide for primary care trusts and local authorities

   A guide for hospitals and care homes

   A Guide for the Relevant Persons Representative

4. The Department also issued a number of DOLS Newsletters in 2008 and 2009, together with 'Frequently Asked Questions' and developed an implementation tool that Mental Capacity Act 2005 Networks were invited to use to estimate the number of assessments and staff that might be required.

5. The Department issued LAC(DH) 2009 (2) which set out the resources for the Mental Capacity Act 2005 and the DOLS for the year 2009-2010 and the provisional figures for 2010-2011.

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