Department of Health

Post-legislative Scrutiny of the Mental Health Act 2007: Response to the Report of the Health Committee of the House of Commons

Cm 8735

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Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

October 2013

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Introduction

1. The Department of Health (the Department) welcomes the report of the Health Select Committee (HSC) on its post-legislative scrutiny of the Mental Health Act 2007 (the 2007 Act). The 2007 Act was an amending Act which updated the Mental Health Act 1983 (the 1983 Act), the Mental Capacity Act 2005 and the Domestic Violence, Crime and Victims Act 2004.

2. The Department keeps all aspects of the 1983 Act under review within the context of wider policy on mental health. All the Select Committee's recommendations will inform that process. This response addresses the specific recommendations in the Select Committee's report.

Background

3. The 2007 Act received Royal Assent on 19 July 2007. Most of its key provisions came into force on 3 November 2008. Provisions for independent mental health advocates (IMHAs) came into force on 1 April 2009.

4. The Department submitted a memorandum on the post-legislative assessment of the 2007 Act to the Select Committee in July 2012. The Committee took oral evidence from members of the Mental Health Alliance on Tuesday 26 February 2013 and from Department of Health officials on Tuesday 12 March 2013. The Committee's report, *Post-legislative Scrutiny of the Mental Health Act 2007,* was published on Wednesday 14 August 2103.

Recommendations

	Recommendation
1.	We recommend that the Department of Health urgently investigates whether patients have been sectioned in order to access psychiatric units.
2.	We recommend that the professional regulators should review their advice to clinicians about their obligations in the context of the use of sectioning powers under the Mental Health Act, this should include the obligation for the clinician to be the advocate for the patient.
3.	Local commissioners and NHS England will be responsible for achieving 'parity of esteem' for patients needing mental and physical healthcare. The Department of Health can support these efforts by accelerating the development of commissioning and payment systems which reflect the policy objective.
4.	We recommend that the IMHA service becomes an opt-out rather than an opt-in service. This measure would help address the difficulties patients face in accessing

	advocacy and eliminate some of the practical problems clinicians face in making patients aware of their right to request an IMHA.
5.	The Committee agrees that local commissioners should manage their own priorities and budgets, but draws their attention to their statutory duties in this respect (provision of IMHAs). It recommends that every Health and Wellbeing Board should seek specific and quantified evidence from their local commissioners to satisfy themselves that these statutory duties are being discharged.
6.	The Committee recommends that the 2007 Act should be amended to extend entitlement to IMHA support to all patients undergoing treatment on psychiatric wards or subject to Community Treatment Orders (CTOs).
7.	The Committee recommends that the Department should issue new guidance which clarifies both the scope and limitations of the advice and support which IMHAs are able to provide. The Committee also recommends that the Department should ensure that the training and accountability systems for IMHAs are appropriate in the context of the role they are expected to fulfil.
8.	The Committee also recommends that the Department should ensure that the training and accountability systems for IMHAs are appropriate in the context of the role they are expected to fulfil.
9.	Access to quality IMHA services to be improved for black and minority ethnic patients.
10.	Improve the operation of section 136:
	10a. The Department should commission an independent assessment of the impact of the power to convey in order to ensure that the legislation is working as intended.
	10b. The Committee recommends that Health Ministers should work with their Home Office counterparts and police representatives to improve the operation of the place of safety provisions of mental health legislation.
	10c. The Committee recommends that the Department of Health reviews as a matter of urgency the practice of detaining children under section 136 and, that as part of the review, it examines the outcomes for children detained in this way. This review should be undertaken with a view to identifying effective alternative options that can be used by the police and health care professionals.
11.	The Committee recommends that the Ministers keep CTOs under review. The Committee recommends that the Department should commission a fuller analysis of the value of a CTO in different clinical situations. The Committee recommends that the Royal College of Psychiatrists should engage with the evidence review and draw its conclusions to the attention of its members.
12.	The Committee recommends that the Department should initiate an urgent review of the implementation of Deprivation of Liberty Safeguards (DoLS) for people suffering from mental incapacity and calls for this review to be presented to Parliament, within twelve months, together with an action plan to deliver early improvement.

Responses

R1. Recommendation: The Department to investigate urgently whether patients are being detained in order to access psychiatric units.

R1.1 The Department agrees that no one should be detained under the Act unless they meet all the criteria for detention under the Section of the Act which applies. There should be no complacency about any suggestion that people are being detained in order to ensure hospital treatment.

R1.2 Following the publication of *Post-legislative Scrutiny of the Mental Health Act 2007*, the Care Quality Commission (CQC) took immediate steps to look into this. On 23 August CQC board member Professor Louis Appleby said: 'We have heard anecdotal evidence that patients may be detained under the 1983 Act simply to obtain access to an inpatient bed. Our view is clear: the principle of least restriction is a fundamental consideration for professionals making decisions about a course of action under the Mental Health Act. Detention solely as a mechanism to secure access to hospital treatment would not be lawful and if hospital or local authority staff think it is happening, or feel pressured to admit people in this way, they should report it to their trust – and if necessary to CQC.' CQC will explore this further in its forthcoming thematic review of emergency mental health care.

R1.3 CQC's next annual report) on the 1983 Act, due to be published later in 2013, will report on evidence from the year 2012/13 on access to care following detention under the 1983 Act.

R1.4 CQC's Mental Health Act Commissioner visits routinely look at lawfulness of detention. CQC is currently developing a new approach to its responsibilities as a regulator of the 1983 Act. This will include more routine data collection on the operation of assessment and decision-making at the point of detention.

R1.5 We already know from the analysis Professor Scott Weich and his colleagues have undertaken "Understanding the increasing rate of involuntary admissions in NHS Mental Health Care" (the ENSCA study) that an association was demonstrated between a reduction in in-patient beds and an increase in involuntary admission. We understand that in addition, the research team are undertaking further multi-level modelling. The factors that influence whether a person is detained (personal characteristics, area of residence, GP Practice, local Mental Health Trust) will be compared. They will study local variations in rates of involuntary admissions. See http://www.netscc.ac.uk/hsdr/projdetails.php?ref=10-1011-70

R1.6 This work is being funded by the National Institute of Health Research's Health Service and Delivery Research Programme and is due to complete in March 2014. Taking account of the emerging findings we will consider what further research would allow us to understand the factors driving the increase in detentions under the 1983 Act, including the impact of readmissions if that has not already been examined, and what policy changes might reduce or reverse that increase.

R2. Regulators to advise professionals on their obligations in the use of powers under the Mental Health Act, this should include the obligation for the clinician to be the advocate for the patient

R2.1 Whenever a person is detained under the 1983 Act the application from the Approved Mental Health Professional (AMHP) or nearest relative has to be supported by two medical recommendations. One of these must be from a doctor approved under section 12 of the 1983 Act as having special experience in the diagnosis or treatment of mental disorder.

R2.2 The Department of Health assumed responsibility for the Mental Health Act approvals functions (approval of section 12(2) doctors and approved clinicians) on 1st April 2013. Previously this responsibility was discharged by Strategic Health Authorities (SHAs). Each SHA area had an administration team and a panel of experts who decided, based on nationally agreed criteria, whether applicants were suitably qualified for section 12(2) Mental Health Act 1983 approval and approved clinician roles.

R2.3 Before approval for either role, clinicians must attend a training course. As part of its work to improve the approval process and ensure consistency of practice across the country, the Department is reviewing the content and delivery of this training. An initial scoping exercise confirmed that there are currently significant differences in both areas. The first step will be to ensure consistency from current training providers. A longer term piece of work will focus on refreshing the content and delivery of the training. The intention is to ensure that all clinicians prove that they understand their role, including changes in practice and the latest case law.

R2.4 CQC does not currently provide advice to providers on operation of the 1983 Act nor to professionals on correct use of its powers – other than through drawing attention to existing guidance in the "Code of Practice Mental Health Act 1983" (the Code) or that published by the professional bodies. CQC is currently designing a model of monitoring the 1983 Act that is integrated with their regulatory model. They will work with partner organisations and experts in the sector to strengthen the standards against which they monitor the 1983 Act – and publish guidance for providers accordingly.

R2.6 The Department agrees that voluntary inpatients should never be told that if they try to leave hospital they will immediately be detained under the 1983 Act. It is, however, important to ensure that no clinician feels constrained from making correct use of section 5 of the 1983 Act (emergency holding powers) when appropriate. It may be necessary to detain an inpatient under section 5 where they seem likely to pose a risk to themselves or others if they were to leave hospital.

R2.7 At the time that a voluntary patient decides to discharge him or herself a doctor or suitably qualified nurse has to make a judgement about this. The doctor or approved clinician in charge of the patient's case may take action under section 5(2) to prevent the person from leaving for up to 72 hours and under section 5(4) a specialist mental health or learning disability nurse may similarly prevent the person from leaving for up to six hours.

R2.8 The Department will make clear the principles of the use of the power to detain and the principle of least restriction when the Code is revised in 2014.

R2.9 Elements of CQC's new approach to regulating the 1983 Act will support this. They will be looking at ways of strengthening the patient's voice and experience in their approach to mental health services.

R2.10 We also need to ensure that staff can raise concerns if any of the principles of the 1983 Act are not being observed. This Government supports the right of staff, working in the NHS and social care, to raise concerns and expects all NHS organisations to support staff in this. We have made progress on this in recent years.

R2.11 Where an individual raises a concern in the public interest, this is referred to as 'whistle blowing'. The whistleblower is protected when disclosing information believed to be in the public interest to the correct 'prescribed' person, with the disclosure being made in good faith, as set out in the Public Interest Disclosure Act 1998 (PIDA).

R2.12 Under the current system, all regulated health and social care professionals have a professional duty to raise concerns. Each respective regulatory body has standards and codes of conduct that professionals must meet in order to remain on their respective registers.

R2.13 We expect all NHS organisations to have in place whistle blowing policies that are compliant with PIDA. We have introduced a contractual right to raise concerns and have issued guidance for NHS organisations. In March 2012, we strengthened the NHS Constitution to include an expectation that staff will raise their concerns early and a pledge that their employer will act upon those concerns. The changes also highlighted the existing legal protection for whistle blowers. All providers of NHS services are required by law to take account of the NHS Constitution.

R2.14 The Department of Health funds a whistleblowing helpline, which offers free, impartial and confidential advice to those working within the NHS and social care sectors who wish to raise concerns but would appreciate further advice and support.

R2.15 We will also consider whether any changes should be made to the Code to remind clinicians of their professional duty to raise concerns.

R2.16 We agree that the introduction of IMHAs should not be seen as removing the important role played by clinical staff, both on the ward and in the community, in ensuring that mentally ill people understand their rights and gain access to any safeguards and other support (including IMHA support) that they may need or are entitled to.

R2.17 We will reinforce guidance in the Code and work with professional bodies to remind professionals of their obligations towards detained patients.

R3. The Department to accelerate development of commissioning and payment systems to facilitate parity of esteem.

R3.1 A set of currencies for payment by results for mental health services for working age adults and older people was mandated by DH for use from April 2012. These currencies should be used as the basis for contracting and paying for mental health services. They apply the same principle that is used for physical health services of money following the patient. At the moment prices are locally agreed. Responsibility for the operation of the payment system has now moved to Monitor and NHS England. Monitor is ensuring that the payment rules for mental health are in line with those for physical health. Monitor is also undertaking a project to look at how costing can be improved for mental health community services.

R3.2 In the current mandate from the Government to the NHS Commissioning Board we stated that the NHS Commissioning Board's objective is to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole. By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence-based services. The Mandate is currently being refreshed and the public consultation on the 2014/15 Mandate ended on 29 September.

R4. Access to IMHA services to become opt-out rather than opt-in.

R4.1 The report on IMHAs "The Right to be Heard" (University of Central Lancashire, June 2012) recommended:

> "Consideration should be given to establishing an opt-out rather than an opt-in system to promote access to IMHA services and ensure that those most in need of IMHA services are not missing out on the opportunity. This should involve consultation with service user groups and in particular with those with experience of compulsion."

The full report can be found at:

http://www.uclan.ac.uk/research/environment/projects/the_right_to_be_heard.php

R4.2 We understand the aim is to ensure that all patients who need one receive the support of an advocate. Since a provision to opt out would need a change to primary legislation we need to complete a full assessment of the costs, impacts and benefits of such a change.

R4.3 In the meantime we will continue to take opportunities to improve the availability and accessibility of IMHAs. We are funding further work with the University of Central Lancashire to support the improvement of commissioning of IMHA services and will also make any appropriate updates to the guidance in the Code.

R5. Health and Well-being Boards to obtain factual information from local commissioners on adequacy of advocacy services.

R5..1 We agree that it is a matter for local commissioners and Health and Wellbeing Boards to assure themselves that good quality IMHA services are available in their local areas. The Department is working with partners including the Local Government Association, Public Health England and NHS England to provide a programme of support and resources for local Health and Wellbeing Boards. We will raise awareness of this issue through the various resources and communication channels provided by that programme; and through the regional and national partnerships that underpin the delivery of this work.

R6 Extend IMHA support to all psychiatric inpatients

R6.1 We agree that a skilled advocate is of considerable benefit for any mental health in-patient who wants one. We are aware that there are many local advocacy services available for mental health patients, both detained and voluntary, which provide help and support with general matters which are beyond the ambit of the 1983 Act.

R6.2 Patients eligible for support from an IMHA are those detained under the 1983 Act (even if on leave of absence), conditionally discharged restricted patients, people subject to guardianship under the 1983 Act and patients on CTOs. Voluntary patients are eligible for support from an IMHA if they are being considered for a treatment for mental disorder which is subject to special rules and procedures (section 57 or 58A treatments).

R6.3 However, the principal distinguishing feature of an IMHA is knowledge of the 1983 Act, so there is an issue whether IMHA support would be most appropriate for voluntary (informal) patients. We acknowledge that entitlement to an IMHA has been extended to informal patients in Wales but feel that for England, it should remain possible for advocates who are not formally accredited IMHAs to continue to provide their advocacy services.

R6.4 In the context of wider action on availability of advocacy we will consider with local commissioners how best to provide high quality general advocacy services for all mental health patients who need them. As part of the Care Bill currently in Parliament, the Government is committed to widening access to advocacy services to ensure that all people can be appropriately involved in their social care, assessment, care planning and review process. It includes a similar duty to provide independent advocates to facilitate people's involvement in the safeguarding processes. Subject to Parliament and the development of regulation, this will come into force from April 2015 and apply to who the local authority deem to have substantial difficulty in understanding, retaining, using or weighing the necessary information to allow this involvement, where there is no appropriate person to represent the individual.

R7. The Department to issue new guidance for IMHAs.

R7.1 In August 2009, the National Institute for Mental Health (England) published "Independent Mental Health Advocacy: Effective Practice Guide". Whilst its references to Primary Care Trusts were superseded on 1 April 2013, in all other respects it remains a good guide to IMHA practice for both commissioners and providers of these services. NIMHE also published "Independent Mental Health Advocacy Guidance for Commissioners" in December 2008.

R7.2 We are in the early stages of discussing with the Association of Directors of Adult Social Services whether it would be helpful to commission an update to these publications now that local authorities are responsible for commissioning IMHA services. We have also committed £113,000 funding to the University of Central Lancashire to work with local authorities to improve commissioning of IMHA services, building on their previous study.

R7.3 There are also chapters on IMHAs in the Code (chapter 20) and the "Reference Guide to the Mental Health Act 1983" (chapter 34). We will revisit the guidance given in these two publications when we review the Code in 2014.

R7.4 Other advice available to IMHAs includes the "Independent mental health advocacy handbook", published by Mind.

R8. The Department to ensure that IMHA training and accountability systems are appropriate.

R8.1 Accountability of IMHA service providers and the training requirements of individual IMHAs are subject to "The Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008" – S. I. 2008/3166) as amended (with effect from 1 April 2013) in the light of the Health and Social Care Act 2012. A person may only act as an IMHA in England if they satisfy the conditions set out in these regulations.

R8.2 Regulation 3 of S.I. 2008/3166 sets out the legal basis for accountability. It states that:

> "Where a commissioning body, in exercising section 130A functions, enters into arrangements with an individual who may be made available to act as an IMHA, the Secretary of State directs that the commissioning body must be satisfied that the conditions set out in regulation 6 are satisfied.
>
> > "(1) Where a commissioning body, in exercising section 130A functions, enters into arrangements with a provider of advocacy services the Secretary of State directs that such arrangements must include a term that the provider of advocacy services is satisfied that the conditions set out in regulation 6 are satisfied.
> >
> > "(2) The Secretary of State directs that a commissioning body, in exercising section 130A functions must, as far as reasonably practicable, have regard to the diverse circumstances (including but not

limited to the ethnic, cultural and demographic needs) of qualifying patients in respect of whom that commissioning body may exercise those functions."

R8.3 Regulation 6 similarly sets out the training, experience and other qualities required of an IMHA. Regulation 6(2) says that an IMHA must:

> (a) have appropriate experience or training or an appropriate combination of experience and training;
> (b) be a person of integrity and good character;
> (c) be able to act independently of any person who is professionally concerned with the qualifying patient's medical treatment; and
> (d) be able to act independently of any person who requests that person to visit or interview the qualifying patient.

R8.4 The Department provides the "Local Reform and Community Voices Grant" to Local Authorities, which includes funding to commission IMHA services. Local Authorities are accountable for the use of these funds and service providers are accountable to their commissioning (or, in the case of direct employees, their employing) local authority for the service they provide.

R8.5 We are aware that there is a wide range of general and specific advocacy training available to IMHAs. We are in the early stages of discussion with the Association of Directors of Adult Social Services whether any further IMHA training or development initiatives may be required. "The Right to be Heard" and the further work of the University of Central Lancashire may also inform these discussions.

R9. Help black and minority ethnic patients to access IMHA services.

R9.1 The University of Central Lancashire's report "The Right to be Heard" notes that "The IMHA workforce was predominantly female and white, which meant services were generally limited in the extent of choice that could be offered to IMHA users". However service users were most concerned about the effectiveness and professionalism of the advocate rather than their personal characteristics. The further work we have agreed to fund to support local authorities in commissioning IMHA services will include having regard to the diverse circumstances (including but not limited to the ethnic, cultural and demographic needs) of qualifying patients.

R10. The Department to:
R10a. Commission a study into how the freedom to move people between places of safety has worked in practice.
R10b. Work with the Home Office and the police to improve the operation of section 136.
R10c. Review as a matter of urgency the practice of detaining children under section 136 and establishing what outcomes were achieved.

R10.1 We accept that we do not know how much practical difference has been made by the power to move a person who has been removed to a place of safety from that place to another such place within the overall 72-hour period permitted under sections 135 or 136, within the significant increase in the use of health-based places of safety

since 2007. We will consider the feasibility of research to investigate the extent to which this power has been used and its impact on patients within the work the Department and the Home Office are undertaking to improve the access to mental health services of people who are detained or likely to be detained under sections 135 and 136.

R10.2 Health and Home Office Ministers, senior officials and representatives from the police and health services have been meeting regularly since November 2012 to improve the operation of this part of the 1983 Act. The Department of Health will lead a review of the operation of sections 135 and 136, and the legislative framework underpinning them. A report of the joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and Healthcare Inspectorate Wales to examine the extent to which police custody is used as a place of safety under section 136 of the 1983 Act was published in June 2013.

R10.3 The Government recognises that mental health crisis services should be as accessible and responsive as other health emergency services at all times, to help individuals in crisis and support police work in this area. The Government plans to publish a multi-agency agreement or concordat later this year that will set out what should happen when people in mental health crisis need support, whether from health and care services or the police. The Department of Health will work with colleagues in NHS England to explore how clinical commissioning groups (CCGs) as commissioners can extend the services available so that mental health needs are met by accessible and responsive services.

R10.4 The Department of Health is funding nine police forces in England to pilot "street triage". These are services where advice from mental health professionals to police officers making decisions about people, who might require detention under section 136, leads to better outcomes and improved access to mental health services. The Department anticipates that these pilots will show a better understanding of how alternatives to section 136 can be used by officers, and thereby reduce the use of police stations as a place of safety.

R10.5 Both the street triage pilots and the concordat on mental health crisis care will include a focus on actions which enable services to respond appropriately in cases involving people under the age of 18, with the aim of minimising the use of section 136 for this group.

R11. The Department and the Royal College of Psychiatrists to review policy and clinical practice aspects of Community Treatment Orders (CTOs).

R11.1 The Department keeps all aspects of the 1983 Act under review, in particular it commissioned research on CTOs when they were introduced in November 2008.

R11.2 The Oxford Community Treatment Order Evaluation Trial (OCTET) study, results from which were published in April 2013, is part of a wider research stream entitled "Coercion in Mental Health, Patterns and Prevalence of Coercion in Mental Health Care and a Trial of the Effectiveness and Costs of Supervised Community Treatment Orders". Further research is scheduled to be completed by August 2014. Details are given in Appendix 1.

R11.3 During 2014, as part of the review of the Code, we will review the policy and clinical practice aspects of CTOs which need to be updated in the Code and consider any other further steps which may be needed.

R11.4 We also understand that the Royal College of Psychiatrists is working on CTO good practice guidance, although this is still at an early stage.

R12. The Department to initiate an urgent investigation into the implementation of Deprivation of Liberty Safeguards with a report and action plan to deliver early improvement to be submitted to Parliament within a year.

R12.1 We consider that the Deprivation of Liberty Safeguards provide an important statutory framework of scrutiny, checks and balances which both empower people and protect their rights. The Government led a major programme over five years to implement the 2005 Act, including the Deprivation of Liberty Safeguards, which made a significant contribution to changing practices. However, the Government recognises that further progress needs to be made and welcomes the work of the Health Select Committee and that of the House of Lords Committee conducting post legislative scrutiny of the 2005 Act in helping it understand what further action is needed.

R12.2 The Department will work with national and local partners through a newly set up Mental Capacity Act Steering Group to examine the evidence to understand the progress which has been made so far implementing the Deprivation of Liberty Safeguards. As part of this, it will look closely at the evidence heard by the Health Select Committee during its work and the current evidence being gathered by the House of Lords Committee conducting Post Legislative Scrutiny of the Mental Capacity Act 2005.

R12.3 Working together, we will identify the key priorities to make further progress and agree the actions each organisation can take to continue to implement the Mental Capacity Act and the Deprivation of Liberty Safeguards in health and care settings. The Department considers that improvements in the understanding and use of the Mental Capacity Act 2005 amongst health and care professionals will support improvements in the use of the Deprivation of Liberty Safeguards.

R12.4 As a first step, the Government is revising the Code of Practice for the 1983 Act for publication in 2014. This will include new guidance on the interface between the 1983 Act, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. In response to concerns we have heard about the complexity of the forms which support the process for depriving someone of their liberty, the Department will review and simplify them, learning from experience over recent years.

R12.5 The Department will work closely with NHS England which is committed to supporting further action to implement the Deprivation of Liberty Safeguards. NHS England has appointed safeguarding leads throughout England to support CCGs to deliver safeguarding assurance and accountability. Training is offered to staff using e-learning tools and through multi-agency workshops with local Safeguarding Adults

Boards. Each commissioner has a named lead with responsibility for supporting clinicians with advice relating to these issues.

R12.6 The Department will also work closely with CQC which is responsible for monitoring compliance with the Deprivation of Liberty Safeguards. CQC will continue to develop its view of the Deprivation of Liberty Safeguards as it monitors compliances, engages across the system and develops its annual report. CQC will use its next report, which will be published at the end of this year, to promote examples of good practice, including evidence from a sample of Independent Mental Capacity Advocacy services on the operation of the Safeguards and to extend the work it started last year looking at the activities of local authorities as supervisory bodies.

R12.7 The Government will publish an assessment of progress and the actions taken to continue to improve the implementation the Deprivation of Liberty Safeguards by the end of 2014.

Conclusion

5. The Department will feed consideration of all the recommendations into future work programmes, in particular the revision of the Code in 2014.

APPENDIX 1

Summary of Research programme "Patterns and Prevalence of Coercion in Mental Health Care and a Trial of the Effectiveness and Costs of Supervised Community Treatment Orders"

Further work on the OCTET Randomised Control Trial:

1. To test whether social and clinical outcomes were increased/reduced due to the CTO intervention and whether the outcomes changed in time (comparison of baseline data with 12 months data).
2. To test whether people of particular age, gender, ethnicity, marital status, diagnosis, duration of illness, education, severity of symptoms, functioning etc. are more likely to be readmitted to hospital (primary outcome), have longer/shorter hospitalisation, have higher/lower number of readmissions, multiple readmissions, longer/shorter time in the community until first readmission, better functioning and severity of symptoms.
3. To examine factors associated with readmission by investigating the relative risk of readmission under predefined subgroups and develop a risk prediction model.

Qualitative aspects:

1. A paper has been submitted for publication on the following qualitative aspect of CTOs: patients', psychiatrists' and families' views and experiences of CTOs.

Health Economics of CTOs:

1. An economic evaluation to include: (i) a detailed cost analysis of health, social care and other agency costs; (ii) a cost-effectiveness analysis; and (iii) a modelled estimate of the national costs of introducing CTOs based on the results of the evaluation.

2. A novel approach to measuring quality of life has been developed to identify the capabilities most affected by mental illness and their associations with socio-demographic and clinical characteristics and other measures of well-being. Further papers will investigate the sensitivity of measured capabilities to different levels of legal coercion and their potential impact on the cost-effectiveness of the intervention (CTO) and control treatments in the OCTET Randomised Control Trial.

OCTET Follow-up Study:

1. This study adds a fourth time point to the current research plan, in order to collect data over 24 additional months. Data will be collected from the medical records of the 333 patients across 32 Trusts.

   Its aims and objectives are to establish**:**

i. whether CTOs are associated with a change in levels of subsequent engagement with mental health services;
ii. the pattern of CTO use and whether there are persisting benefits from a period on CTO.

Included with thanks to:
Ksenija Yeeles
Research Fellow
Department of Psychiatry
University of Oxford

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