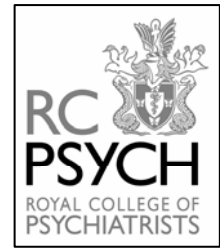


Royal College of Psychiatrists

Briefing on the Mental Health Bill 2006
House of Lords Second Reading: 28th November 2006



The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry. The College is a member of the Mental Health Alliance and is in agreement with their briefing. This supplementary briefing selects particular issues of importance for the College.

"We start from the proposition that mental health patients are a particularly vulnerable group. Their dignity and autonomy, and their related human rights including their liberty and physical integrity, are specifically threatened by a regime of compulsory assessment, treatment and detention. Compared with most other people, they are less likely to be able to take action to protect their own rights. Because of this, they therefore depend heavily on other people to provide proper safeguards, and on legislation to ensure that those safeguards will be in place." *Joint Committee on Human Rights, 25th Report, Draft Mental Health Bill 2004*

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Summary

The Royal College of Psychiatrists is of the firm view that the Mental Health Bill and the 1983 Mental Health Act, and the Bournemouth gap provisions in the Mental Capacity Act (MCA), need to be subject to significant revision, in line with policies agreed by the 78 stakeholders of the Mental Health Alliance and the Joint Scrutiny Committee on the Draft Mental Health Bill 2004.

This briefing contains the following:

- (1) Introduction: Background to the Mental Health Bill (p. 3)
- (2) The College's general approach to mental health legislation (p. 3-4)
- (3) Comments on the Bill's amendments to the Mental Health Act 1983 (p. 5-10)
 - The scope of compulsory powers needs to be narrowed to include:
 - The exclusions from the definition of mental disorder.
 - The treatability test.
 - Impaired decision making.
 - Community treatment orders :
 - need to be substantially restricted to target revolving door patients.
 - need to be have better treatment and procedural safeguards, including access to Tribunal to appeal conditions
 - Anomalies in professional roles need to be addressed.
- (4) Comments on the amendments to the Mental Capacity Act "Bournemouth gap" (p. 10)
 - Greater protection is required for patients who are not deprived of liberty.
 - Greater parity needs to be provided between the MHA and MCA.
 - Second opinions for serious medical treatment should be mandatory.
- (5) An Act that is fit for purpose (p. 11-12)
 - Principles should appear on the face of the Bill
 - The Bill needs to give the patient a voice through advocates, nominated persons, and in consent to treatment provisions
 - There should always be an assessment period for patients under compulsion (the single gateway)
 - Special provisions are needed for children and young people

1. Introduction: Background to the Mental Health Bill

1.1 Mental health legislation deals with the involuntary treatment of patients. It directly affects a minority of all patients¹. Indirectly however the law affects the provision of care to all other patients. By absorbing the time of clinicians and social workers it affects resources. It sets the framework within which psychiatrists practise and patients are protected. The powers it gives to psychiatrists have a profound significance for the doctor patient relationship. For all these reasons the legislation is central to our work.

1.2 The Mental Health Act 1959, as amended in 1983, was seen internationally as a beacon of enlightened practice in 1959. But the approach is now out of date with the practice of psychiatry and the expectations and aspirations of patients, their families and staff. For this reason the Royal College has welcomed reform of mental health law as an opportunity to fashion modern legislation that is just as fitting for its time as was its predecessor. Part of the new context is the enlightened Mental Capacity Act 2005 with which any new mental health law needs to work in harmony.

1.3 The College has participated fully in the process of reform over the last 8 years, providing evidence to all the committees and consultations that have occurred. In the divisions and faculties of which the College is composed – including those specialising in psychiatry for children and young people, forensic patients and older people - there has been detailed consideration of all aspects of the law over this time and agreement reached on the essential features of legislation that would be fit for purpose.

1.4 While the College agreed with some aspects of the 2004 Mental Health Bill- the enhanced role for Tribunals, advocates and the single gateway into compulsory powers - we considered it, in the main, to be unworkable and unethical. We welcomed its abandonment and hoped for a substantial reconsideration of government policy before new proposals were brought forward.

1.5 It is disappointing that the government has ignored the bulk of the recommendations of the Joint Scrutiny Committee on the 2004 Mental Health Bill 2004, retaining instead its central policies bolted on to the 1983 Act. These policies, despite being rejected or criticised by the Joint Scrutiny Committee, remain largely unchanged. In addition, the good features of the 2004 Bill have been jettisoned - for lack of time to consider how they may work in the 1983 Act or because of the .current funding crisis in the NHS.

2. The College's approach to mental health legislation

2.1 The modern health system aims to give mental health patients early access to quality care and treatment. Programmes such as assertive outreach, early intervention and crisis intervention are all examples of this. New programmes are being developed for those with personality disorder and for minority ethnic communities. NHS principles emphasise patient choice and the eradication of stigma for people with mental health problems. Compliance with human rights principles places emphasis on the dignity of the patient and the safeguards for

¹ There were 46,000 detentions in 2004-5 which is estimated to be two fifths of the total of those who were informal or voluntary inpatients. Numbers of patients under detention have however risen significantly in the last two decades.

those whose liberty is infringed. Legislation which was underpinned by these principles and in tune with these directions in patient care would be most welcome. This was the approach which the Expert Committee on the 1983 Act took to new mental health legislation in its Report in 1998. Its approach was supported in the Recommendations of the Joint Scrutiny Committee and is endorsed by the many stakeholders, including the College, who are part of the Mental Health Alliance.

2.2 The principles which, from the College viewpoint, should under-pin modern mental health law and guide law reform are the following. None of these will be realised in the 1983 Act as amended by this Bill unless amended during its passage through Parliament.

(1) The law should support modern principles and practice of care and treatment for mental health patients

This includes the NHS principles of patient choice and participation, the human rights and equality agenda and the new ways of working for psychiatrists and other mental health professionals. The Act should be administered by a properly trained workforce where it is ensured that the decision making role is allocated to those with an appropriate level of training and experience for the decision to be taken.

(2) The law should seek to reduce stigma and discrimination against people with mental illness. Wherever possible the principles governing mental health care should be the same as those which govern physical health.

Stigma and discrimination remain the regular experience of people with mental health problems and, despite anti stigma campaigns by the College and by government, have worsened over the last decade². While legislation can not cure social problems that are rooted in prejudice a law with a discriminatory impact clearly legitimises and contributes to stigma.

(3) The law should be consistent with professional ethics.

Psychiatrists operate in an ethical framework governing all medical practitioners. As NHS consultants we are governed by the Human Rights Act. We also operate within the wider framework of ethical standards of the World Psychiatric Association³. The Hippocratic oath of "first do no harm" should apply in this field of legislation as in any other medical intervention. A law which creates ethical conflicts for psychiatrists is damaging for the profession, for its reputation and for recruitment of new members.

(4) Informal treatment, care and support should always to be preferred over compulsion when circumstances permit.

² The Department of Health's study of public attitudes to people with mental illness found that "levels of fear and intolerance of people with mental illness have tended to increase since 1993" and that "attitudes ...have become less positive between 2000 and 2003" ³ The Social Exclusion Report 2004 found stigma to be the biggest problem people with mental health problems face as a group.

³ World Psychiatric Association Declaration of Madrid (1996) See also the UN Principles for the Protection of persons With Mental Illness and the Improvement of Mental Health Care. 46/119 (reproduced in Memorandum from Professor Thornicroft, Joint Committee on the Draft Mental Health Bill , Vol II Evidence 668

Compulsory admission powers should only be exercised as a last resort (Code of Practice 2.7). This was one of the principles adopted by the Richardson Expert Committee for inclusion on the face of a new Act⁴.

(5) The law should be practical.

It should not be over-bureaucratic nor skew resources towards one group of patients at the expense of others as it is feared this Bill will do. It should not impose, under different legislation, different or conflicting functions for the same group of patients. The Mental Health Act, as amended will cause operational dilemma and confusion for those who work also with the Mental Capacity Act.

3. Comments on the Bill's amendments to the Mental Health Act 1983

(a) The scope of compulsory powers

3.1 A major problem with this Bill is that it is over-inclusive. This will inevitably lead to a greater use of compulsory powers. The Bill broadens the definition of mental disorder for those treated under a treatment order⁵. It also:

- removes exclusions⁶ that have the purpose of limiting and more precisely defining the group of people who may be detained.
- abolishes the 'treatability' test and in so doing opens the possibility for detaining people for whom there is no therapeutic benefit.
- introduces community treatment orders (CTOs) but with such a low threshold for their application that almost every person who would now be discharged, (albeit in some cases under a supervised discharge provision⁷) could be eligible if the cautious clinician decides.
- fails to introduce any form of capacity test which would also help to delimit the scope of the law.

3.2 The cumulative effect of all these is a real likelihood that people may get trapped into a long term system of compulsory care. As Professor Richardson put it, the compulsory system could become like a lobster pot, easy to get into but difficult to get out⁸. As pointed out by the Mental Health Act Commission compulsion increases stigma for patients.⁹ Its impact is likely to be felt most by those from ethnic minority groups who are already disproportionately subject to the Act¹⁰. It is damaging for patients' lives, and will undermine the effort of

⁴ This Bill omits this principle, in relation to community treatment orders.

⁵ Clauses 1-2

⁶ Clause 3.

⁷ The provisions for supervised discharge under section 25A –J which the Bill repeals however apply to a smaller number of discharged patients than will be eligible for a CTO.

⁸ Joint Scrutiny Committee on Draft Mental Health Bill Vol 11 Evidence , 5

⁹ The Mental Health Act Commission reports, "Of all mental health patients, none are so stigmatised as those who receive treatment under compulsory powers, because of widespread ignorance and fear regarding the purpose and usual causes of detention under the Mental Health Act 1983." MHAC 9th Biennial Report p 72, Para 6.34

¹⁰ Findings from the first national census of psychiatric wards revealed African Caribbean's are 44% more likely to be detained under the 1983 Act. They are three times more likely to be admitted to psychiatric hospitals, 50% more likely to be put in seclusion and 29% more likely to be forcibly restrained than the rest of the population despite having the same rates of mental ill health as other ethnic groups. Commission for Healthcare Audit and Inspection (2005) Count Me In, Results of a

nurses, social workers and doctors to establish and maintain cooperative relationships with service users. A law which has the effect of adding to the numbers of patients under compulsion will also take away resources from voluntary patients – both in terms of bed space and professional's time in dealing with the procedural requirements of the Act. The College fears that mental health services will be directed away from those services which should reduce the need for compulsion such as early intervention, assertive outreach and other developments.

3.3 The inappropriate use of the Act may do harm. While some patients whom we detain under the Mental Health Act clearly benefit from compulsory care and are grateful for having been protected at a time when their illness made them refuse the help they needed, others look back on their experience of being under compulsion as traumatic and damaging, or as leaving a "lingering sense of grievance"¹¹. Large numbers of service users wrote to the Joint Scrutiny Committee on the Mental Health Bill 2004 to express that view.

"I fully accept that there are some individuals who do need compulsory treatment. However unless one has been through this experience it is quite impossible to express how degrading and terrifying it is".¹²

As a consequence service users may come to fear and distrust the doctors on whom they rely for help. In the context of the 'blame' culture, where every tragedy caused by a patient can potentially be attributed to a psychiatrist's misjudgement, psychiatrists often feel required to section patients, perhaps against their better judgement or the best interest of the patient. In its evidence to the Joint Scrutiny Committee on the draft Mental Health Bill the Royal College of Psychiatrists stated:

"Enabling people to feel able to seek help early, to talk about their fears and difficulties, without fearing scorn, humiliation or loss of status, freedom, job and friends is the best way to bring about improvement in their health".

3.4 Exclusions The role of exclusions is to make clear what kind of behaviour, beliefs or life style should not be brought within compulsory powers although they may fall within the definition of mental disorder and may be contained in the diagnostic manuals used by psychiatrists. Exclusions also guard against people being swept into the Act when their sexual, cultural or social behaviour offends moral norms or is illegal and could be seen by some to reflect a disordered mental state but where there is no therapeutic health intervention for them. They are a feature of legislation in other countries including Scotland, New Zealand and the Australian states. The College is also of the view that people with learning disability and with developmental disorders should not be subject to the civil detention and compulsion powers unless they have a mental disorder.

3.5 Impaired decision making: The Mental Health Act authorises the detention of the patient in hospital for a period of time and requires him or her to submit to a course of treatment with which he or she disagrees. His or her views and

national census of inpatients in mental health hospitals and facilities in England and Wales,; National Centre for Social Research (April 2002) EMPIRIC Report

¹¹ "What I needed was an arm around my shoulder not a shot in the arm" Joint Committee on the Draft Mental Health Bill Vol II Evidence 736 Eric Stark

¹² Memorandum from Victoria Hanson, Vol II Joint Committee on the Draft Mental Health Bill Evidence 735

wishes or indeed his or her 'best interest' are strictly speaking immaterial. This contrasts with the position for those with a physical illness. The legal position relating to physical treatment was recently spelt out by Dame Elizabeth Butler-Sloss in the case of Ms B (2002):

"A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death". Although the judge did not state it, this principle does not apply to the patient with a mental illness

3.6 Patients have different attitudes to dealing with their illness and to the drugs which may be prescribed for them. For some the side effects of these powerful and toxic chemicals are unacceptable and they may choose to cope with unpleasant symptoms rather than even more unpleasant side effects. This is not so different from the cancer patient who declines chemotherapy even though he knows it may hasten death.

3.7 If both people have a full capacity (that is a full understanding of their illness and the consequences of taking or not taking their medication) why should there be a difference? The difference in the law is based on a mixture of paternalism, prejudice, fear of mental illness and concern for the protection of others. The consequence for service users is profound. The Act should limit the right to act against patients' wishes to those patients whose ability to make decisions for themselves is impaired by their mental disorder.

3.8 The treatability test: The Bill removes the current treatability test and replaces it with a test of "appropriate treatment". While it is acknowledged that case law has led to a very broad interpretation of the current test¹³, this creates even further than now the potential for people to be detained but receive no benefit beyond that of the containment itself. It is vital, as the Joint Committee on Human Rights recognised in its Report that mental health legislation not be used as a form of preventive detention¹⁴. This is both a point of principle but also an essential practical point on the use of health resources. Legislation that takes away a person's liberty for no fault of their own must confer upon them a health benefit. The breadth of powers given to clinicians over what is "appropriate" treatment is amplified also by the fact that the range of clinicians and hence of treatments is expanded.

¹³ the treatability test can be met in practice by claiming that treatment may extend 'from cure to containment' (*Reid v Secretary of State for Scotland* [1999] 1 All ER 481. However this judgment related to a restricted patient. Lord Clyde stated "Anxiety might well be felt over the proposition that a sheriff is bound to discharge a psychopath where he is not satisfied from the evidence before him that treatment is no longer likely to alleviate or prevent a deterioration of his condition, so that he no longer qualifies under paragraph (i). In the civil context the balance may properly fall in favour of the liberty of the individual if further detention in hospital can serve no further purpose in alleviation or securing the stability of his condition. In the case of one who has been convicted of a criminal offence such anxiety would be well justified if the only course open was to release the patient freely into society. But Parliament has allowed for that situation in providing not only for an absolute discharge but also for a conditional discharge".

¹⁴ In the view of the JCHR, it is questionable whether the non-therapeutic detention of persons without conviction of an offence, on the grounds of "speculation about possible future behaviour and resulting risk to identified persons", will be compatible with the HRA. The JCHR noted in its report that explicit powers of preventive detention established by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 had been deemed compatible with the (ECHR) Article 5 by the Judicial Committee of the Privy Council, but pointed to the fact that these powers related only to restricted patients who have been convicted of serious offences and set no clear precedent for patients who have had no contact with the criminal justice system.

3.9 The aim of measures to expand the reach of the 1983 Act is, largely, to protect the public. The College fully accepts that there is a role for psychiatrists in this regard. However the public are not likely to be reassured by a measure that is unlikely to succeed, to give the few patients that are potentially dangerous more reason to avoid services than to engage with them¹⁵. Psychiatrists regularly undertake assessments of the level of risk a person poses to themselves or others in deciding whether to detain or discharge him or her. However the prediction of risk whether done by actuarial or clinical methods is at best an inexact science¹⁶. Safety can best be improved by making the service accessible and effective. Public safety in this area of medicine is no different from, for example, in relation to sexually transmitted disease. It is essential that prospective patients are not deterred from seeking help. Indeed, because suicide and other risks are largely assessed from information given by the patient, it is necessary for the person to feel able to talk freely. Fear that being open will lead to loss of liberty does not aid this process. Hence if mental health law is seen to be overly coercive it will lead to patient avoidance of mental health services and, paradoxically, an increase in risk both to the individual and the public.

In summary the following changes should be made to the Bill.

- Exclusions should be included
- The criteria for compulsion should be narrowed with a test of impaired decision making
- There should be a test of therapeutic benefit
- The threshold for CTOs should be raised.

3.10 **Community treatment orders (CTOs).** The Bill introduces a form of community treatment order. There are at present powers, especially through Section 17 leave or Section 25A-J supervised discharge¹⁷, for professionals to retain a degree of control over patients whom they release into the community. These can be useful in providing a graduated return to home life and as a trial release in which the person's readiness for discharge can be tested. The power of supervised discharge was added to the 1983 Act in 1995. While it has not been widely used it too has been helpful in cases where the condition of a person's health and the degree of risk makes absolute discharge unwise. Its problem has been the lack of enforcement powers.

3.11 The College does not oppose a position in which patients may be under an enforceable CTO in the community. We accept that there may be a small number of patients who respond well to a CTO, who relapse and become ill when released from hospital and for whom the possible sanction of a return to hospital may be in their best interest and those of the community. But studies from abroad do not show CTOs to be the panacea the government makes them out to be¹⁸.

¹⁵ The Michael Stone inquiry (resulting from the death of Lin and Megan Russell) found that, despite much intervention by services on his behalf, there were institutional and communication failures, including a lack of appropriate inpatient services that contributed to his commission of the homicides. Nor did the more recent Barrett inquiry recommend a change in the law.

¹⁶ Academic literature makes clear that to prevent one homicide it would be necessary to incarcerate many more - up to 2000 or even as high as 5000. Szukler 2003, *Risk assessment: 'numbers' and 'values'* in *Psychiatric Bulletin* 27, 205-207. Munro & Rungay: 2000. *Role of risk assessment in reducing homicides by people with mental illness*. *British Journal of Psychiatry* 176 116-120

¹⁷ There is also a form of community supervision and treatment through conditional discharge (s 37 with a s 41 restriction order) and under the guardianship provisions.

¹⁸ Throughout Australia, where community treatment orders were embraced in a major way, the failure of community care to deliver good outcomes for patients over the last decade has been revealed as a national scandal leading to two major national inquiries, re examination of the law and

Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale¹⁹. The Cochrane Library figures (probably the most respected reviews of the effectiveness of medical interventions in the world) showed 85 patients need to be on a CTO to prevent one admission and over 230 to prevent one arrest²⁰. Making the legislation over- inclusive by such a low threshold for entry to a CTO (as explained above) alters the proper balance between clinical discretion and the safeguards of Tribunal review.

3.12 Patients in the community have returned to lead their daily lives. They should be entitled to make decisions for themselves. These decisions may include, as it does for people with physical illnesses, a decision to dispense with the medication which medical practitioners prescribe for them. It has been found for instance that only 8% of patients with heart disease that is potentially fatal take the statins that they have been prescribed²¹. For mental health patients in particular this decision may be because of the side effects which they may understandably find less tolerable than the symptoms of their illness²².

3.13 CTOs should be targeted at the very small group of revolving door patients for whom it may be of benefit. This should include also a test of impaired decision making capacity. Other changes to the Bill should deal with the assessment process for people placed on CTOs, safeguards for those who are recalled to hospital for medical treatment, and the role of the Tribunal in relation to conditions of compulsion.

Changes to Professional roles

3.14 The College is fully supportive of multi-disciplinary working and respects the strengths of other disciplines working within the mental health field. However some anomalies are apparent in the proposed system under which consultants in other disciplines have overall responsibility for patients subject to compulsion. It must be ensured that decisions are taken by those with an appropriate level of training and experience for the decision to be taken.

3.15 For instance, the Government has determined that only registered medical practitioners are deemed to have the necessary training to make the initial

large injection of funds into hospital care and new community service provision National Senate Inquiry into Mental Health , Australian Federal Parliament, March 2006

¹⁹ "Evidence that community treatment orders are effective in reducing relapse and readmission to hospital is limited. High quality community services are essential if there is to be a benefit but the better the services the less likely will be the need for community orders". Memorandum from Kings College London Vol II Joint Committee on the Draft Mental Health Bill Evidence 779

²⁰ Kisely S, Campbell LA, Preston N. "Compulsory community and involuntary outpatient treatment for people with severe mental disorders". Cochrane Database of Systematic Reviews 2005, Issue 3. Art. No.: CD004408

²¹ Heart 2002 88 229-33.

²² Parkinsonism, dystonia, akathisia, tardive dyskinesia, hypotension, hypothermia, hyperthermia, neuroleptic malignant syndrome (which may be fatal), drowsiness, apathy, agitation, excitement, insomnia, convulsions, dizziness, headache, gastro-intestinal disturbances, nasal congestion, dry mouth, blurred vision, difficulty with micturition, acute urinary retention, constipation, tachycardia, arrhythmias, (including sudden death), menstrual disturbances, galactorrhoea, gynaecomastia, impotence, weight gain, agranulocytosis or leucopenia, (both of which may be fatal), photosensitization, contact sensitisation, rashes, jaundice, corneal and lens opacities, and pigmentation of the skin, cornea, conjunctiva and retina (which may cause blindness).

recommendation that a patient meets the relevant conditions for compulsion. It is unclear how a psychologist or other person who is not medically qualified is able to satisfy the legal requirement of ensuring that the relevant conditions are still satisfied when the patient's section is to be renewed if they are unable to determine the presence or absence of these conditions in the first instance. This policy appears to rest on the erroneous assumption that the initial diagnosis is the most complex and difficult and that diagnoses and 'nature and degree' of mental disorder can be more easily resolved once a person's condition is stabilised. The College will be seeking to have the Bill amended to remove this anomaly.

4. Amendments to the Mental Capacity Act for 'Bournewood' patients

4.1 That the Mental Capacity Act and the Mental Health Act provide overlapping regimes for people with a mental disorder is well known. Some of these are the so called Bournewood patients, who lack the capacity to make their own decisions about their residence, their care and treatment.

4.2 Most 'Bournewood gap' patients have little cognitive functioning. They are likely to lack capacity in respect of almost all areas of their life and to require high levels of care and supervision. Many are patients who, but for their compliance with the proposals for their care, would be detained under the Mental health Act. Adequate measures for their protection should have a central place in mental capacity legislation. Department of Health Guidance published in 2004, recommended procedures to prevent the Bournewood patient from being deprived of liberty. These included structured assessments, review mechanisms, access to advocates, involvement of family and others connected with the patient's care and care planning. They represent current good practice. With these processes in place the need to deprive a person of their liberty should be the exception where a serious risk of harm to themselves warrants it.

4.3 The College welcomed the approach in the Guidance. However the Bill starts from the opposite starting point at which a person is already deprived of liberty (or this is imminent) and then sets up, for those patients for whom 'deprivation of liberty' (within the terms of Article 5) would be proportionate and in their best interest, a set of safeguards of less strength and effectiveness than those under the Mental Health Act. There is an initial difficulty in attaching the interpretation of legislative provisions (namely what is deprivation of liberty) to case law under another statute, the Human Rights Act, and doubtful whether that provides sufficient legal certainty for the purposes of human rights law. More important how will care homes and professionals work with such an elusive concept? There are several other points to be made:-

(1) Those for whom deprivation of liberty is adjudged to be not proportionate nor in best interest (but who may in fact still be deprived of liberty) may have no safeguards, leaving a vulnerable group with inadequate protection.

(2) Patients receive a lower standard of care and protection if they are detained under one statute rather than the other and to a certain extent at least this may be disproportionate. For instance, Bournewood patients are likely to be receiving medication and treatment for either/both mental and physical conditions. Under Section 58 of the Mental Health Act there is a statutory second medical opinion procedure for medication beyond three months and for electro convulsive therapy (ECT). The same safeguard should be replicated here. Statutory second medical opinions should be also required for treatment for physical conditions for the same group of serious medical treatments that will be specified in Regulations under section 37(6) of the MCA. The second opinion doctor should be a specialist in the same field as the treatment proposed.

4.6 The professionals may be faced with difficult decisions as to which Act to use. The inconsistency between the two Acts and the dilemmas this presents to psychiatrists is highlighted by the position with regard to electro-convulsive therapy. A patient who lacks capacity to consent to ECT and who is detained may only be given it if authorised by the second opinion doctor. If however that patient were not detained the safeguard would not apply. The decision is being taken involving a treatment which carries a significant risk of harmful side effects. If a patient has been unable, because of incapacity, to weigh the risks and the possible benefits and give informed consent a second opinion should be mandatory whether or not the patient is detained. The College hopes that these anomalies will be remedied as the Bill progresses through parliament.

5. An Act that is fit for purpose

5.1 The following are important additions to the Act. These have been accepted by the Expert Committee Report on the 1983 Act in 1998, the Joint Scrutiny Committee, the Milan Committee on which the Scottish Mental Health (Care and Treatment) Act is based. They are also exemplified in the legislation of Commonwealth jurisdictions. Some were accepted by government within the 2004 Bill but have now been scrapped. We consider them too important to be lost in this way.

5.2 Principles

A modern Mental Health Act should commence with a statement of principles to guide professionals in exercising their powers and the courts in interpreting the law. It is important that these appear on the face of the Act as they are vital to the fair operation of legislation that has such power over people's lives. All of the proposed principles are already uncontroversial. The Mental Capacity Act and the Children Act both contain such a set. These need to be added to the Act.

5.3 A single gateway

The 2004 Bill set up a single gateway into compulsory powers under which each patient had a 28 day assessment period before being either discharged or placed on a compulsory treatment order by the Tribunal. Under the 1983 Act, by contrast, the assessment period (under section 2) may be bypassed and some patients may be placed immediately on a treatment order (section 3). There is a right of access to the Tribunal to challenge each order. In our view there was much merit in the new process which ensured that each patient went through an assessment before there was the possibility that they may then be detained for a period of 6 months. This view is supported by Jones Mental Health Act Manual, the established authority on the Mental Health Act.

"A patient whose mental health and circumstances require him to be subject to the very significant procedure of compulsory detention surely needs to be assessed however well known he might be to the mental health service. Something has happened in that patient's life to justify intervention under this Act and it is the factors that precipitated the detention and their impact on the patient that needs to be assessed".

Although this procedure can not be fully duplicated under the 1983 Act because the Tribunal does not have the same function we would strongly recommend that Section 2 be the normal gateway into the Act. It would ensure that a decision could be made as to whether exclusions apply and whether there is appropriate treatment. Given that patients can be released into the community on a CTO after as little as 24 hours on a section 3 order proper periods of assessment are vital.

5.4 Modern principles of care: patient choice

Patient choice and participation in their care and treatment are central tenets in the new NHS. Maximising personal autonomy is a basis of the Mental Capacity Act. Respect for these principles implies the following:

(a) Patients' right to choose their nearest relative to support them. This Bill instead gives a patient a limited right to displace the legally imposed nearest relative by applying to the County Court - not a procedure that is likely to be of much use to them.

(b) When a patient is admitted to hospital in the midst of a crisis, s/he will be the least able to speak for him or herself or to understand and negotiate with the health system. A mental health advocate is extremely helpful both for the patient and for the professionals to give the patient a voice.

(c) The use of advance statements that set out both what a patient wishes to occur and what treatment s/he refuses in the event of being detained and lacking capacity, are gaining currency as useful and empowering tools for service users. These should, wherever possible, be respected under the Mental Health Act.

(d) Electroconvulsive therapy should never be given in the face of the refusal by a patient with capacity to consent to treatment, even in an emergency.

5.5 Protection for children and young people

Child and adolescent mental health problems are characterised by complexity, severity and often multiple co-existing problems. The equal provision for the assessment and treatment of mentally disordered minors is made more complex by the issues of parental rights and responsibilities and assessment of competence of a growing child (with particular reference to "Gillick" competence). Other legislation relating to minors including the Children Act and the Family Reform Act as well as growing human rights jurisprudence relating to minors also impinges on the issues.

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

5.7 Particular areas of concern in relation to children and young people include the definition of mental disorder and the absence of exclusions. In addition, provisions for minors should include:

- At least one medical assessment prior to use of the Act must be by a doctor specialising in the assessment and treatment of children and adolescents.
- The medical member of the Tribunal must be a doctor specialising in the assessment and treatment of children and adolescents.
- If the responsible clinician isn't a CAMHS specialist and a SOAD is required then the SOAD must have specialist knowledge in relation to the care and treatment of children and adolescents.
- All young people deemed to be competent to consent should also be deemed competent to refuse treatment. This was provided for 16 and 17 year olds in the 2004 Bill and should be reinstated in this Bill.
- Special protection should be provided for young people who may be subject to electro-convulsive therapy.