RESEARCH PAPER 07/33
30 MARCH 2007

The *Mental Health Bill [HL]*

Bill 76 of 2006-07

The *Mental Health Bill [HL*] was introduced into the House of Lords in November 2006 and was brought to the Commons on 7 March 2007. The Second Reading in the House of Commons has been announced for 16 April 2007.

The Bill amends the *Mental Health Act 1983*, which provides for compulsory treatment and detention of people suffering from a mental disorder, according to criteria specified in the Act.

The Bill comes at the end of years of extensive consultation, debate and evolution. It remains controversial and has been heavily amended during its passage through the House of Lords.

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ISSN 1368-8456

Summary of the Bill

The Labour Government first announced that it would introduce new mental health legislation in 1998. The proposals have been hotly contested since they first appeared. In 2006 the Government announced that it was dropping plans to replace the existing legislation, the *Mental Health Act 1983,* and would amend it instead. The amending Bill was introduced into the House of Lords in November 2006, where it has been heavily amended by House of Lords Members opposing the Government's plans.

The Government's response is that the Lords have altered the entire balance of the Bill and that their changes must be reversed. Fewer people will get the services that they need, including people with severe personality disorder, who will continue to be turned away because they are deemed 'untreatable'. The Government's view is that the Bill introduced into the House of Lords struck the right balance between getting treatment to people who need it, patient safeguards and minimising the risk to the public.

The debate has sometimes been cast in broad terms, such as right to liberty or the need for public safety, but it has also been highly technical and may be hard to follow without some knowledge of the 1983 Act. This Research Paper, written for the Second Reading in the House of Commons, attempts to provide background information necessary for understanding the technical issues. Below is a summary of some of the key measures in the Bill as it is now, with the amendments introduced in the House of Lords. The issues surrounding them are described in the rest of the Research Paper.

The Bill introduces:

A simplified single definition of mental disorder throughout the Act and abolishes the current four separate categories of mental disorder This was in the original version of the Bill and goes ahead with added exclusions despite Government opposition to them. The Bill originally dropped the 1983 Act's exclusions except for dependence on alcohol or drugs. It now says that mental disorder cannot be defined solely on the grounds of substance misuse (including dependence on alcohol or drugs); sexual identity or orientation; commission, or likely commission, of illegal or disorderly acts; and cultural, religious or political beliefs (not the same list as in the 1983 Act).

The Bill, like the 1983 Act, includes learning disability within the definition of mental disorder only where it is associated with abnormally aggressive behaviour or seriously irresponsible behaviour. This has not been changed (clauses 1 - 3)

A new criterion for detention and for Community Treatment Orders (civil patients), which is that the patient's ability to make decisions about medical treatment is significantly impaired. This was introduced in the House of Lords despite opposition from the Government (clauses 4 and 32).

A new requirement that appropriate medical treatment must be available if patients are to be subject to detention for treatment or to the new regime of supervised community treatment This was in the original version of the Bill and goes ahead but the definition of appropriate medical treatment is now qualified by the requirement that it must be likely to alleviate or prevent a deterioration in the patient's condition. This requirement was

opposed by the Government. It is similar to the existing one in the Act but will apply more widely within it (clauses 5, 7 and 32).

A requirement that those performing functions under the 1983 Act have regard to the Code of Practice issued under the Act and that the Secretary of State include in the Code a statement of principles to inform decisions under the Act. This was not in the original version of the Bill. It is the result of a Government amendment responding to demands for guiding principles to be written onto the face of the Act.

Provision for a broader range of professionals to be able to take on key roles under the Act. The Bill replaces the *Responsible Medical Officer*, who is normally a consultant psychiatrist, with a *Responsible Clinician* (RC), who has a new role. He may or may not be a doctor. It will replace the *Approved Social Worker* with an *Approved Mental Health Professional*, to be drawn from a wider range of professionals but with similar functions. This goes ahead largely as planned but a new clause (clause 6) requires a fully qualified medical practitioner to be involved in the renewal of detention, which could affect the role of the RC. The change was opposed by the Government. A new stipulation that the competencies required of an Approved Mental Health Professional should be set out in Regulations is the result of a Government amendment (clauses 11-25 on professional roles).

Provisions requiring children (if admitted) to be admitted to age-appropriate settings; to be assessed by a medical practitioner with specialist training in child or adolescent mental health (except in an emergency); and for the Responsible Clinician to be a child specialist (except in an emergency). This is a new clause, which was opposed by the Government (clause 24).

Changes to the Nearest Relative (NR) provisions in order to remedy a Human Rights incompatibility Patients will be able to apply to court to displace their NR. At the moment they have no say over the appointment of the NR. The Bill also adds civil partners to the NR list, who are not mentioned in the 1983 Act but have in practice been included as the result of a Consent Order. These provisions go ahead unchanged (clauses 26-29).

More scope for patients to refuse Electro-convulsive Therapy and provision to add other treatments that patients could refuse in the same way. This provision was added to the original Bill by a Government amendment (clauses30-31).

Community Treatment Orders for suitable patients following an initial period of detention and treatment in hospital. This goes ahead but a great many extra conditions and restrictions have been placed on the use of Community Treatment Orders in the face of opposition from the Government (clauses 32-35).

A maximum period before which all hospital managers must refer civil patients to the Mental Health Review Tribunal (MHRT) and an enabling power for the Secretary of State for Health and Welsh Ministers to reduce the time before a patient's case is automatically referred to the tribunal This goes ahead as planned (clause 36).

Safeguards into the *Mental Capacity Act 2005* for people with mental health problems who lack capacity to consent to care or treatment and who may effectively be detained in a hospital or a care home but not under the 1983 Act. The Bill's original provisions go ahead with a number of Government amendments (clauses 47 and 48).

CONTENTS

I Background

A. Introduction

Reform of the mental health law dealing with compulsory detention and compulsory treatment in England and Wales has been a long drawn-out and controversy-ridden process. In 1998 Frank Dobson, then Secretary of State for Health, announced that the Government intended to legislate to replace the existing *Mental Health Act 1983*. Since then the proposal has gone through numerous phases, including a "blue paper"[1], a Green Paper, a White Paper, a draft Bill published in 2002, another Draft Bill published in September 2004, on which a Joint Committee of both Houses reported in March 2005, the Government's response to it,[2] and the present Bill, introduced in the House of Lords in November 2006.[3]

A *Mental Health Bill* was announced at the beginning of two Parliamentary Sessions (2003/3 and 2005/6)[4] but neither Bill was ever introduced. Instead, in March 2006, following the critical report of the Joint Committee on the *Draft Mental Health Bill 2004*, the Government announced that it was no longer proposing a wholesale replacement of the 1983 Act and would be introducing a shorter Bill that would amend it instead.[5] This announcement and the briefings associated with it form the basis of the current Bill, which was introduced in the House of Lords in November 2006. It has completed its stages there and is awaiting Second Reading in the House of Commons on Monday 16 April.

What is it that has caused so much controversy? In broad terms, it has been about the circumstances in which individuals may be detained or treated against their will. This has been seen as an issue of personal liberty, raising questions about what are considered to be fundamental human rights. The Government's proposals for change have , rightly or wrongly, also been seen against the background of some highly publicised murder cases where the perpetrator was suffering from a mental disorder and for one reason or another appeared to have been failed by the mental health system.

Regardless of whether a change in the law would have a prevented any of these particular murders,[6] they helped to focus attention on the conditions for compulsory treatment in the law, and in particular whether the conditions exclude people who have a personality disorder and are dangerous but are considered to be untreatable because the treatment would not prevent or alleviate their condition. The murders have also focused attention on the extent to which compulsory treatment could or should be made available to people who are not detained in hospital. The two themes have recurred throughout the debates since 1998 although they have been supplemented by many other related and unrelated ones.

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1 The report of the expert committee (see) had a blue cover and is sometimes called a "blue paper".
2 See. Bibliography
3 The *Mental Health Bill* [HL]s Bill 1 of 2006/7
4 The first was announced by Alan Milburn, then Secretary of State for Health in the debate on the Queen's Speech, HC Deb 14 November 2002 c171. The second was in the Queen's speech itself.
5 Written Ministerial Statement by Rosie Winterton, HC Deb 23 March 2006 30WS
6 Information about this may be obtained from some of the enquiries into these murders. See Bibliography.

While it is true that the current Bill deals with detention and compulsory treatment of people who have committed no crime, the same is true of existing legislation (contrary to what some press reports suggest). The debate has largely concerned when and how this should apply although many mental health organisations have also argued that the focus on compulsion is misguided and that far more attention needs to be paid to the availability of services for people who have mental disorders.

The Department of Health has summarised the main purpose of existing mental health legislation in one of its briefings:

> Mental health law is about providing the legal authority to take steps to protect people suffering from mental disorders and the wider public from any potential harm arising from the effects of those disorders. This may include detention in hospital, treatment without consent, guardianship and other forms of restriction on patients designed to help manage their disorder safely. It is also about setting clear rules for the use of these powers and establishing effective safeguards against their inappropriate use.
>
> Most countries have mental health law to set out the circumstances in which a person with a mental disorder can be treated without their consent and the safeguards that must be provided for them. There has been mental health law of this kind in the UK since the early 19th century.
>
> The current legislation is based on the *Mental Health Act 1959* which replaced and simplified the various different pieces of legislation in force before then. After significant amendment in 1982, the legislation was consolidated in the 1983 Act, which is the Act now in force. Since then, the 1983 Act has been amended over time, most significantly by the *Mental Health (Patients in the Community) Act 1995,* which introduced after-care under supervision.[7]

B. The *Mental Health Act 1983*[8]

This section outlines some key features of the *Mental Health Act 1983* that are relevant to understanding the debates on the current Bill. It is not a comprehensive outline of the Act, which has 149 sections and 6 schedules.

The 1983 Act is primarily about detention in hospital. Outside of hospital, most mental health services are provided under general health and social services legislation.[9] There are a few provisions in the Act that relate to patients in the community such as the provisions on supervised discharge introduced by the Conservative Government in the

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7 from Department of Health, Mental Health Bill Amending the Mental Health Act 1983 General Information about the *Mental Health Act 1983*: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134229

8 This section draw on several sources, including Richard Jones, Mental Health Act Manual Tenth Edition, 2006 and the Explanatory Notes to the Bill, Bill 76-EN

9 The Government's policy for these services is set out in the National Service Framework for Mental Health.

Mental Health (Patients in the Community) Act 1995,[10] extended leave (with the possibility of instant recall and renewed detention) and section 117, which requires Primary Care Trusts and social services authorities to provide after care services.

Supervised discharge is aimed at "the small group of severely mentally ill people sometimes characterised by the term 'revolving door'".[11] After discharge from hospital, certain ex-patients can be required to live at a specified place and attend a specified location at specified times for medical treatment or rehabilitation services. There is also a power to convey the ex-patient to a place where he or she is required to live or attend but not to require patients to accept medication or compulsory treatment in the community. [12]

These three provisions relate to patients who have been detained in hospital. An exception to this rule is the appointment of a Guardian, that is, someone with authority over a mentally disordered person. The latter does not necessarily have to have previously been detained in hospital. The powers of a Guardian are similar to the supervised discharge requirements although there is no power to "take and convey" the patient to the place where s/he is required to be.

The 1983 Act provides for two broad routes into hospital: one through the criminal justice system (on remand, at the time of sentencing or by transfer from prison) and the other through civil procedures, often referred to as "sectioning". "Sectioning involves a decision made by professionals that does not require a court order or confirmation by a Tribunal. The civil route accounts for over 90% of formal admissions.[13]

Key provisions on "sectioning" are contained in sections 2, 3, and 4 of the Act, which are often referred to by name.[14] They relate to people with a mental disorder and cover respectively short term admission for assessment (generally for not more than 28 days), admission for treatment (initially for six months, renewable for another six months, then yearly, but potentially indefinite) and emergency admissions.

Section 1 of the Act defines *mental disorder* as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind". Some powers in the Act apply to only some of these categories. Mental illness is not defined. The other three categories all include in their definitions "abnormally aggressive or seriously irresponsible conduct". The section explicitly rules out "promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs" as, on their own, constituting a mental disorder.

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[10] The 1995 Act amended the *Mental Health Act 1983*, which applies to England and Wales and the *Mental Health (Scotland) Act 1984*, which has now been replaced.

[11] John Bowis, then Minister at the Department of Health, during the Second Reading of the Bill, HC Deb 20 June 1995.

[12] John Bowis, as above.

[13] See Part V of this paper.

[14] Other sections are also relevant to these provisions. For example, section 11, which specified who can apply for a section 2 or 3 order.

The Act provides that only two kinds of people, the *Nearest Relative* or an *Approved Social Worker* (defined below), may apply for someone to be detained under the 'sectioning' provisions. Except in the case of emergency admissions under section 4 of the Act, the application has to be founded on the written recommendations in the prescribed form of two registered medical practitioners. The recommendations must state that certain conditions specified in the Act are fulfilled.

Much of the debate has focused on section 3 of the Act and the conditions contained within it relating to "treatability"[15] Section 3 requires that anyone being detained must have a mental disorder that warrants "medical treatment" in a hospital. Those with a "psychopathic disorder" or "mental impairment" must be subject to an extra condition requiring the treatment to *alleviate or prevent a deterioration* of the condition. In all cases it must be "*necessary for the health or safety of the patient or for the protection of other persons*" that treatment be provided and also that it cannot be provided unless the person is detained under section 3.

A separate section of the Act on interpretation defines medical treatment to include care, nursing habilitation and rehabilitation under medical supervision. Some have argued that this and related case law has made the definition of treatment so broad that under the 1983 Act virtually every patient is treatable in some way[16] although the debate about the extent to which treatment for people with a mental disorder is available illustrates that this is not a view shared by all.

Section 3 is reproduced in full below:

> 3 Admission for treatment
>
> (1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.
>
> (2) An application for admission for treatment may be made in respect of a patient on the grounds that—
>
> (a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
>
> (b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and
>
> (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.

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15 Some of the issues are also relevant to other sections of the Act but for simplicity this sketch of the Act concentrates on section 3.

16 See, for example, David Hewitt, "Detention and Discharge under the Human Rights Act 1998", in *NHS Litigation Authority Review* Issue 30, 2004, Special Issue on Human Rights.

> (3) An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include—
>
> (a) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and (b) of that subsection; and
>
> (b) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

Approved Social Workers are appointed by social services authorities. They have various functions under the Act, including responsibility for assessing whether an application for a patient's admission to hospital under the Act should be made. *Approved* means they must have the appropriate competence in dealing with people suffering from mental disorder. In practice it is normally the *Approved Social Worker* who makes the application for a patient to be "sectioned".

The Act also defines the role of the *Responsible Medical Officer (RMO).* The *RMO* is the registered medical practitioner in charge of the treatment of the patients. The RMO has various designated functions, including deciding when patients can be discharged and allowed out on leave. In practice RMOs are usually consultant psychiatrists.

The *Nearest Relative* has various rights, including the right to apply for admission to hospital (mentioned above), the right to block an admission for treatment, the right to discharge a patient and the right to information about the patient although these rights are conditional. For example, the right to information is subject to the patient's consent and the provisions do not apply to *restricted patients* (see below).

The Act lists people who may be a *Nearest Relative*, starting with husband or wife, followed by son or daughter and ending with nephew or niece. There are rules for appointing the *Nearest Relative*, starting with the highest on the list. The rules include situations where the patient has no *Nearest Relative*. There are also provisions for the courts to order the displacement of a *Nearest Relative*. The patient cannot choose who it will be or apply to the courts.

Same sex partners are not listed by the Act but have been included in the list by means of a Consent Order because of incompatibility with the *Human Rights Act 1998*. The lack of provision for patients detained under the *Mental Health Act* to apply to change the person designated as their *Nearest Relative* has been the subject of a declaration of incompatibility under the *Human Rights Act* [17] But no action on this has been taken until now.

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[17] in the case of M v Secretary of State for Health.[[2003] EWHC 1094

Under the Act, *Mental Health Review Tribunals* deal with appeals for discharge and reviews of a patient's detention. They do not deal with admissions or with the renewal of the authority for detention. Patients detained under section 3 can apply to a Tribunal for discharge once in the first six months of their detention, once in the second six month period and once a year thereafter. There are also requirements on hospital managers to refer a patient's case if there has been no application, including referral at six months and also at renewal if the patient's case has not been reviewed for three years. A Tribunal must consist of a legal member, a medical member and a lay person. In practice the medical members are consultant psychiatrists. A patient may be discharged without reference to a Tribunal.

Although detention in hospital under section 3 is for compulsory treatment, there are some restrictions. In general after 3 months treatment cannot continue without a patient's consent unless a SOAD (Second Opinion Doctor, a function normally administered by the Mental Health Act Commission) has agreed. In some cases there are extra provisions that apply immediately. For example there are special safeguards relating to ECT (electric shock treatment),[18] which require a SOAD to certify that even though the patient cannot or will not consent to the treatment, it should be given nonetheless.

Psychosurgery may not be carried out unless the patient consents. A SOAD and two other people appointed by the Mental Health Act Commission must also certify that the patient is capable of giving that consent (and that the patient has done so).The SOAD must additionally certify that the treatment should be given. The same provisions apply by Regulations to surgical implantation of hormones for the purpose of reducing male sex drive.

This brief account of the 1983 Act has focused on the civil routes by which most patients detained in hospital arrive there. This is the area on which most of the debate on the current Bill has focused. The Bill does, however, have some impact on the criminal justice aspects of the Act as some its provisions, such as the definition of mental disorder, would be carried into that part of the Act. In addition, there are provisions in the Bill relating to *restriction order*s. Under the 1983 Act, where a court orders a patient to hospital instead of prison and it is necessary to protect the public from harm, the court may impose restrictions, which may or may not be time limited. *Restricted patients* remain subject to decisions of the Secretary of State (in practice the Home Secretary).

Although the Act is about compulsory detention in hospital, it does not rule out voluntary and informal stays. In practice *informal patients* have also featured as an issue in current debates. Of particular concern has been the person who is not "sectioned" but does not have the mental capacity to decide to leave hospital or to communicate that decision to hospital staff, resulting in "de facto compulsion". The lack of legal safeguards in such a situation has been called the "*Bournewood gap*" after a case involving Bournewood Hospital, a psychiatric hospital in Surrey, where the hospital's authority to keep the person in hospital and give treatment was challenged in the European Court of Human Rights (ECHR).

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[18] The Act makes provision for the safeguards. ECT is specified in Regulations.

The ECHR found that the person in question was detained, so that the 'right to liberty' in Article 5 of the ECHR was relevant. It held that detention under the common law doctrine of necessity (under which the House of Lords had judged that he had been detained) contained insufficient safeguards to protect him from arbitrary or mistaken detention and was therefore incompatible with Article 5. It also held that the remedies that had been available to the person's carers to secure his release, habeas corpus and judicial review, did not provide the kind of rigorous challenge that was required by ECHR, Article 5(4).[19]

The *Mental Health Act* requires the Secretary of State to produce a *Code of Practice* (guidance on the implementation of the Act). The Act does not require anyone to observe it or to give reasons for departing from it but its status has been the subject of legal action. The Court of Appeal ruled in July 2003[20] that the Code should be observed by all to whom it was addressed unless they had good reason to depart from it in relation to an individual patient. They could not depart from it as a matter of policy. An appeal was made to the House of Lords.[21] which, by a majority of 3 to 2, decided that the policy pursued by the hospital in question was lawful. (It had a policy of providing fewer medical reviews than was set out in the Code). The Lords also said that the Code was guidance to which great weight must be given and from which hospitals should depart only where they had cogent reasons for doing so.[22]

The 1983 Act applies mainly to England and Wales (although there are provisions about cross-border arrangements). Reform of the equivalent Scottish law was made by the *Mental Health (Care and Treatment) (Scotland) Act 2003*,[23] which was frequently referred to as a more desirable model during the debates in the House of Lords.

C. Joint Committee on the *Draft Mental Health Bill 2004*

On 23 March 2006, the Government announced that it would be introducing a much shorter Bill than its 2004 Draft Bill and that the new Bill would amend rather than replace the 1983 Act.[24] The proposals in that statement form the basis of the current Bill. The Government attributed its change of mind partly to the critical report by the Joint Committee on the 2004 Draft Mental Health Bill, which contained a detailed examination of the issues raised by that Draft Bill as well as an account of some of the earlier controversies.[25]

Some of the most controversial aspects of the earliest proposals have now disappeared. In particular compulsory treatment in the community, which was originally one of the

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19 European Court of Human Rights judgement on HL v UK, 5 October 2004.

20 R (Munjaz) v. Mersey Care National Health Service Trust, 13 July 2003: http://www.bailii.org/ew/cases/EWCA/Civ/2003/1036.html

21 R v Ashworth Hospital Authority (now Mersey Care National Health Service Trust) (Appellants) ex parte Munjaz (FC) (Respondent)

22 http://www.publications.parliament.uk/pa/ld200506/ldjudgmt/jd051013/ash-1.htm

23 See Bibliography

24 See Section D below.

25 *Draft Mental Health Bill*, HL Paper 79 I-III and HC Paper 95 I-III of 2004-5: http://www.publications.parliament.uk/pa/jt/jtment.htm

most controversial aspects of the Government's proposals, is only to apply to people who have been through an initial period of detention and treatment in hospital. Large elements of the 2004 Draft Bill have been dropped, including some of the consolidation measures that it would have introduced.

Omissions include lengthy provisions on criminal justice, a major overhaul of the system of Mental Health Review Tribunals, including automatic referral to a Tribunal where a patient is detained for more than 28 days, and plans for a new specialist mental health independent advocacy service. Some changes are to be introduced by other means. The future of the Mental Health Act Commission, for example, is now bound up with the reforms of the Healthcare Commission and the Commission for Social Care Inspection, which are likely to be merged in 2008.

Despite newspaper headlines about a Government climbdown, some commentators argued that many of the most controversial aspects of the proposals remained, and in practice many of the concerns of the Joint Committee on the 2004 Draft Mental Health Bill have reappeared during the debates in the House of Lords. The Joint Committee published its report in March 2005, a year before the Government announced its decision to go ahead with a "streamlined" Bill rather than replace the 1983 Act entirely. The Committee made 107 recommendations. Those that it chose to highlight at the beginning of its report are listed below.

- **Principles should be on the face of the Bill**: "The primary purpose of mental health legislation must be to improve services and safeguards for patients and to reduce the stigma of mental disorder. To this end, the fundamental principles underpinning the legislation must be on the face of the Bill."
- **Exclusions from the broad definition of mental disorder are needed**: "We accept the merits of having a broad definition of mental disorder, but the Bill needs to have clear exclusions ensuring that the legislation cannot be inappropriately used as a means of social control."
- **Compulsion only where treatment of therapeutic benefit is available**: "In particular, we have proposed that the threshold for risk of harm to others should be raised and that compulsion should only be used where a treatment is available which would be of therapeutic benefit to the patient."
- **Compulsory treatment only where decision-making ability is impaired: "**Where a person's decision-making is unimpaired, he should be able to reject treatment."
- **Separate legislation should be introduced for people with dangerous and severe personality disorder (DSPD):** "We do not believe that this group [people with DSPD] should be dealt with by mental health legislation.."
- **Non-residential orders (compulsory treatment in the community) should be limited and accompanied by a duty on local and health authorities to provide care for patients subject to such order:** "The introduction of non-residential orders will regularise the current use of leave and guardianship provisions...The Bill should delineate clearly the clinically identifiable group of persons to whom such orders can be applied and it should limit and control the time that patients can be subjected to such orders. In addition, there should be a duty on health and local authorities to

provide adequate care for non-resident patients without placing undue burdens on families and carers."

- **Limit the use of adult wards for children and adolescents and require more use of specialists in child and adolescent mental health**: "We welcome the inclusion in the draft Bill of a section dedicated to children and adolescents and we welcome most of its provisions. We would, however, like to see the Bill limit and control the use of adult wards for the treatment of under 18s subject to compulsion, and to require the involvement of specialists in child and adolescent mental health in both the assessment of and the tribunal hearings for under 18s."
- **Introduce national training standards and monitoring for the proposed changes in professional roles:** "The draft Bill proposes several changes in professional roles. We broadly favour these changes, and believe that they are in line with modern interdisciplinary and team-based working practices. We recommend that the Bill should be amended so as to provide for the creation of national training standards and monitoring."

- **We welcome,** "in particular the new Mental Health Tribunals, the rights to an Independent Mental Health Advocate and the placing of care plans on a statutory footing. We have recommended the retention of the Mental Health Act Commission as the best vehicle for visiting and inspection."
- **We have major concerns about: "**the resources needed to implement the Bill. We lack confidence in the Government's models and underlying assumptions used to predict the funding and staff required to make the new provisions work. Without adequate staffing and funding, the new tribunal, for example, will fail to improve patients safeguards, and mental health could remain the "Cinderella service" of the NHS."[26]

D. Government Statement, 23 March 2006

The Written Statement and accompanying press notice issued in March 2006 said that the Government had taken into account concerns over the length and complexity of the 2004 draft Bill as well as pressures on parliamentary time, and was therefore making a commitment to introduce a shorter, streamlined Bill which would be easier for clinicians to use and less costly to implement. The statement is reproduced below:

> The Minister of State, Department of Health (Ms Rosie Winterton): I should like to set out the Government's plans for a Mental Health Bill.
>
> Mental health legislation is about the circumstances in which people with a mental disorder can be treated without their consent, in order to protect them and/or others from harm; and the processes that have to be followed if someone is to be treated without consent. The majority of people with a mental disorder will not require treatment under mental health legislation. At any point in time, one in six of the population has a common mental health problem. At 31 March 2004,

[26] *Draft Mental Health Bill*, HL Paper 79 I-III and HC Paper 95 I-III of 2004-5, March 2005: http://www.publications.parliament.uk/pa/jt/jtment.htm

there were about 14,000 patients who were being detained and treated in hospital for a mental disorder.

Through sustained investment and ongoing service reform, the mental health system is progressively achieving success in many areas. However, it is important that the present mental health legislation is amended to keep pace with changes in service delivery, to provide safeguards for patients and to prevent harm to individual patients and to the wider public.

We have spent the last seven years consulting on, discussing and redrafting the Mental Health Bill. The draft Bill achieves many of our intentions but we have been reviewing its length and complexity. We have listened to the Joint Committee and our stakeholders, and have looked again at the arguments about amending the Mental Health Act 1983.

As a result, we will introduce a shorter, streamlined Bill that amends the Act. It will reflect the impact of service modernisation and will provide legislation that is easier to understand and implement. It will also help deliver our other objectives: to promote patient safeguards and to protect patients and the public from harm.

The Bill to amend the 1983 Act will:

- introduce supervised treatment in the community for suitable patients following an initial period of detention and treatment in hospital. This will help ensure that patients comply with treatment and enable action to be taken to prevent relapse and readmission to hospital. The introduction of treatment in the community reflects modern service provision enabling patients to be treated according to their individual needs and circumstances;

- expand the skill base of professionals who are responsible for the treatment of patients treated without their consent;

- improve patient safeguards by taking order-making powers with regard to the Mental Health Review Tribunal. We are currently considering across Government the precise terms of the changes, and will continue to consult with stakeholders;

- reflect a widespread consensus and the views of the Joint Committee and will introduce a new, simplified single definition of mental disorder;

- keep, as recommended by the Joint Committee, the exclusion for drug and alcohol dependency, and preserve the effect of the Act as it relates to people with learning disabilities;

- replace the "treatability" test with a test that appropriate treatment must be available. Unlike the treatability test, the availability of appropriate treatment will be a requirement for all groups of patients, regardless of their particular diagnosis. This is important to ensure that patients are not brought under compulsory powers unless appropriate treatment is available;

- amend the current Act to remedy an European Court of Human Rights incompatibility in relation to the Nearest Relative. At the same time, we

> will bring the Act into line with the Civil Partnership Act 2004 in relation to the Nearest Relative provisions.
>
> The Bill will be used as the vehicle for introducing the Bournewood safeguards, through amending the Mental Capacity Act 2005. These safeguards are for people who lack capacity and are deprived of their liberty but do not receive mental health legislation safeguards.
>
> We will address safeguards for children treated on the basis of parental consent through the Children Act 1989. Children detained under the Mental Health Act will continue to receive the same safeguards as adults. We will also look at ways that we can continue to pursue other patient safeguards, such as advocacy, through other means.
>
> We shall publish very soon a report on the outcome of the public consultation on Bournewood and the key features of our Bournewood proposals. [27]

II The Bill

The Department of Health's website contains copious material relating to the present Bill, both as it was introduced in the House of Lords and as it appears before the Commons. This includes, among other things, the Bill itself, the Explanatory Notes, Regulatory Impact Assessment, Race Equality Impact Assessment and short briefings on each of the Government's main proposals. There are links to the 1983 Act and to the 1983 Act as if amended by the Bill, to the draft new Code of Practice, and to other relevant documents.[28]

This material, together with the lengthy debates in the House of Lords,[29] and the briefings produced by various interested organisations[30] provide a great deal of information for those wishing to study the controversies and the Government's proposals in detail. This Paper concentrates on providing an overview of the Bill. The Explanatory Notes provide a much more detailed explanation, with charts and diagrams to aid understanding where the provisions are complicated and have changed.[31]

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27 The Written Statement on 23 March 2006 by Rosie Winterton is available at: http://pubs1.tso.parliament.uk/pa/cm200506/cmhansrd/vo060323/wmstext/60323m01.htm#60323m01.html_sbhd3

28 These are available through the following link: http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Mentalhealth/DH_063423

29 The debates and various versions of the Bill are listed, with links, on the PIMS Bill Index pages: http://www.publications.parliament.uk/pa/pabills/200607/mental_health.htm

30 See the Responses section of this Paper for some examples

31 See, in particular pages 13, 21 and 29-30 of the Explanatory Notes to the Bill as brought from the Lords: http://www.publications.parliament.uk/pa/cm200607/cmbills/076/en/07076x--.htm

A. The Bill as introduced in the House of Lords

The Bill was introduced in the House of Lords on 16 November 2006. Below is a list of the main measures contained within the Bill at that time.[32] The clause references are to the Bill as it was then, that is, to The *Mental Health Bill* [HL] Bill 1 of 2006/7. The list is supplemented by the comments made by Lord Warner, who was then Minister at the Department of Health, during the Second Reading speech on 28 November 2006.[33] A number of organisations have produced their own summaries.[34] Provisions in thats Bill would:

Introduce a simplified single definition of mental disorder throughout the Act and abolish the current four separate categories of mental disorder (clauses 1-3).
Lord Warner, Second Reading: At present, a patient being treated under the Act often needs to be assigned to one of four separate categories of mental disorder. We wish to replace these with a simpler single definition of mental disorder under which a patient's needs and risks, not the label that happens to be applied to a person's mental disorder, determine when action is taken. This simpler single definition will also make the Act easier for clinicians to use and for others to understand. This will not alter the way in which the Act deals with learning disability. Similarly, alcohol and drug dependence will remain excluded from the definition of mental disorder, as they are now, but two other exclusions in the Act will be removed. The first relates to promiscuity or other immoral conduct, which is redundant. No one could now regard such behaviour as mental disorder. By contrast, the present exclusion for sexual deviancy is simply wrong. If a person has a clinically recognised mental disorder, the fact that the disorder manifests itself, for example, as voyeurism or paedophilia should not be an obstacle to using the Act where it is justified to protect the patient or other people.

Introduce a new requirement that appropriate treatment must be available if patients are to be subject to detention for treatment or to the new regime of supervised community treatment (clauses 4-5).
Lord Warner, Second Reading: We will also introduce a new requirement that appropriate treatment must be available for patients subject to detention in hospital for treatment or on supervised community treatment. This will reinforce the fundamental principle that detention and supervised community treatment must always be for a clinical purpose. The test replaces the more selective "treatability test", whose many drawbacks include contributing to a culture in which certain groups of patients are labelled untreatable and thereby are denied services. That may have been convenient for service providers, but it was not very useful to patients and was sometimes dangerous to the public.

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32 The list is drawn mainly from the summary guide to the Bill published on the Department of Health's website http://www.dh.gov.uk/assetRoot/04/14/04/99/04140499.pdf and also from the Explanatory Notes to the Bill introduced in the House of Lords: HL Bill 1-EN, 2006/7: http://www.publications.parliament.uk/pa/ld200607/ldbills/001/en/index_001.htm

33 HL Deb 28 November 2006 Lord Warner's speech was in 654-659

34 Two examples are: Mental Health Act Commission Policy Briefing for Commissioners, November 2006: http://www.mhac.org.uk/Pages/documents/policy_briefings/POLICY_BRIEFING_issue16_Nov06.pdf and The NHS Confederation Mental Health Bill 2006, House of Lords 4 February 2007 (produced before it was amended): http://www.nhsconfed.org/about/about-1863.cfm See also the Responses section of this Paper.

The appropriate treatment test is designed to ensure that no one will be brought or kept under compulsion unless suitable treatment is available for them. It will not be enough for treatment to exist in theory, which in itself is a considerable patient safeguard. The treatment must be not only available and appropriate to the medical condition but appropriate to the circumstances. For instance, factors such as how far the services are from the patient's home or whether those services are culturally appropriate will need to be considered. That is very much in line with the move across the NHS towards more tailored, individual patient-focused services. It is a change that links mental health very much to the mainstream of NHS reform and improvement.

Broaden the range of professionals who can take on key roles in the Mental Health Act. (clauses 8-20)
Lord Warner, Second Reading: Another shift across the NHS has been the modernising of medical careers, making sure that the right person is doing the right job to the benefit of patients. In line with this, we intend to broaden the range of professionals who can take on the key roles of responsible medical officer and approved social worker. The responsible medical officer role is being replaced with the role of responsible clinician. A patient's responsible clinician will have overall responsibility for their case and make key decisions, such as whether a patient should be discharged or go on supervised community treatment. Allowing the responsible clinician role to be taken on by a broader range of appropriately skilled and trained professionals will give hospitals the flexibility to select someone whose skills best meet the patient's treatment needs. Where a patient mainly needs treatment from a doctor, such as medication, a doctor will be the responsible clinician. But, for example, if a patient has a personality disorder and the treatment mostly involves psychological interventions, such as cognitive behavioural therapy, a psychologist may have the skills most appropriate to the role of responsible clinician for that patient.

The current approved social worker role is being replaced by the role of approved mental health professional. The functions of the role will remain largely unchanged, but the role will be opened up to a broader range of professionals, often working in the same integrated community mental health teams as approved social workers.

Amends the Nearest Relative (NR) provisions in order to remedy a Human Rights incompatibility (clauses 21-24).
Lord Warner, Second Reading: Two other important patient safeguards are being introduced. The first will give patients the ability to apply to the county court to displace the nearest relative if they believe they are unsuitable; for example, if the relationship with the patient is abusive. This is important as the nearest relative has various powers under the Mental Health Act such as being able to apply for or to block detention, to request a review of detention and to receive certain information about the patient. The court will be allowed to displace the nearest relative indefinitely, making this difficult time less arduous and complicated for all those involved. (The second safeguard that he mentioned relates to the Mental Capacity Act 2005 – see below.)

Introduce supervised treatment in the community which will be available for suitable patients following an initial period of detention and treatment in hospital. (clauses 25-29) The Explanatory Notes say that supervised treatment differs from after-care under supervision, which it will replace, in that it will allow patients who do not need

to continue receiving treatment in hospital to be discharged into the community, but with powers of recall to hospital if necessary. It is different from leave under section 17 of the 1983 Act, which remains suitable for a patient as a means to give shorter term leave from hospital, as part of the patient's overall management as a hospital patient.[35]

Lord Warner, Second Reading: Supervised community treatment is probably the key change in the Bill and is an area of some controversy. It is important not just from a patient and public safety angle but because clinical practice itself has changed. At present, most patients treated under the Mental Health Act are detained in hospital. That reflects the fact that, in 1983, most acute mental health services were provided in hospital. However the world has moved on and we now have a wide range of community-based mental health services, some of which I mentioned earlier. We also know that some form of compulsory community treatment is established in jurisdictions in New Zealand, Australia, Canada, Israel, Sweden, Belgium, Portugal and Scotland.

It is clear that there is now scope for some patients to be treated under compulsory powers but to live in the community, not in hospital. For suitable patients, supervised community treatment meets the need for a framework for their treatment and safe management in the community, instead of detention in hospital. That modern approach strikes a balance between individual autonomy and protection of the patient and the public.

I hope that we will not hear arguments in this House that we should go back to the future and reserve compulsion for detention in hospital. We have made it clear that, to be eligible for supervised community treatment, patients must have had an initial period of detention and treatment in hospital. This means that their medical condition and treatment needs will be well established before they go into the community. Criteria are set out in the Bill on whether a patient is suitable for supervised community treatment. It will be for clinicians, working with approved mental health professionals, to determine against those criteria whether a patient should be put on a community treatment order. There is no question of supervised community treatment being imposed on people who have not been detained in hospital first.

We know that some patients stop taking their medication or treatment once they leave hospital, and so relapse and end up being readmitted. This detrimental cycle is often referred to as the revolving door. Patients on supervised community treatment will benefit from a structure designed to promote safe community living. This will reduce the risk of relapse and re-detention. They will be asked to comply with conditions to help prevent relapse, such as living in a certain place, attending an out-patient clinic and agreeing to take medication under the direction of their responsible clinician.

If, despite all this, a patient’s mental health does deteriorate again, there will be scope to take action to prevent crisis. Under supervised community treatment, patients can be recalled to hospital, if they need to be, for treatment. This is important because the power of recall provides the means to tackle relapse, and to avoid its potentially adverse

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[35] EN paragraph 86: http://www.publications.parliament.uk/pa/ld200607/ldbills/001/en/07001x-a.htm#end

consequences for the patient or someone else. Recall to hospital allows patients to be treated quickly and to return to the community straightaway if it is clinically safe to do so.

I recognise that there were some concerns about our proposals for supervised community treatment, but we have tried to deal with them. I assure the House that it is not about forcing people to have treatment in the community. If a patient refuses consent to treatment, it can be given only on recall to hospital. Forcible treatment against a patient's will cannot be given in the community where the patient lacks the capacity to consent unless the treatment is immediately necessary—for example, to save the patient's life.

Supervised community treatment is a new, modern and effective way to manage the treatment of patients with serious mental health problems. It will allow patients, so far as possible, to live normal lives in the community. This will reduce the risk of social exclusion and stigma associated with detention in hospital for long periods of time or with repeated hospital admissions.

We have published a draft code of practice that provides guidance in more detail, and we are happy to have comments on how to improve it. Supervised community treatment will be suitable for a minority of patients who have already been detained in hospital. There will be clear criteria for eligibility, safeguards for patients, and strict provisions for review and appeal, exactly as they apply to detained patients.

Set maximum period before which hospital managers must refer civil patients to the Mental health Review Tribunal, and enable the Secretary of State for Health and Welsh Ministers to reduce the time before a patient's case is automatically referred to the Tribunal if the patient has not applied and no one has done so on their behalf (clauses 30-31).
Lord Warner, Second Reading: We are committed to improving patient safeguards and will do this by taking a power to allow the time to be reduced before a patient's case is referred to the mental health review tribunal. Of course, a patient can always apply for a tribunal hearing and this will not change their current rights, but it will improve the safety net for those who do not apply. Currently, patients who do not apply wait for six months before their case is referred to the tribunal. We want to reduce that, but we will not use this power until hospitals and tribunals have capacity to meet the reduced time limits. This responds to evidence provided to the Joint Committee.

Abolish finite restriction orders (clause 33).
There was no mention of this clause (which is a Home Office responsibility) on Second Reading and the clause was not debated in Committee.

Introduce safeguards into the *Mental Capacity Act 2005* in order to rectify the breach of the law identified by the European Court of Human Rights in its 5 October 2004 judgement in the Bournewood case. These relate to people with a mental health problem who lack capacity to consent to care or treatment. Where they are informal patients in a hospital or living in a care home they may be subject to "de facto compulsion" even if not detained under the Mental Health Act 1983. The Explanatory Notes say that it will be unlawful to deprive a person of his or her liberty unless an *authorisation* is in force or the deprivation follows from an order of the Court of Protection on personal welfare matter. The new provisions will apply to people

are suffering from a mental disorder within the meaning of the 1983 Act but they will not generally apply to those who are subject to the 1983 Act, or, unless they agree, to those who would meet the criteria for civil detention in the Act. They will only apply to adults who lack capacity to decide whether or not they should be a resident in the hospital or care home in question. [36]

Lord Warner, Second Reading: We will also make some amendments to the *Mental Capacity Act 2005* in response to the 2004 judgment of the European Court of Human Rights. The court found that a man had been unlawfully deprived of his liberty in Bournewood Hospital because he had not been admitted under a legal process which included safeguards against arbitrary detention, and he was not able to benefit from speedy access to a court to consider his case. The Bournewood safeguards will protect the human rights of people who are not able to decide about their care and who, for their own protection, need to be cared for in a hospital or care home in a way that deprives them of their liberty. This could apply, for example, to some people with severe learning disabilities or dementia. These safeguards will set up a legal process of independent assessment of each case for depriving the person of liberty. Each person will have a representative who is given the right to initiate a further review of their case or to apply to the Court of Protection on their behalf.

Miscellaneous: Other provisions include**:** Replacing the existing regional Tribunals with one for England and one for Wales; cross-border arrangements; delegation of powers of managers of NHS Foundation Trusts; extension of the disqualification on grounds of *mental illness* of Members of Parliament and Members of devolved assemblies to *mental disorder*, which is more broadly defined.

B. Government defeats in the House of Lords

The Bill was heavily criticised during its passage through the House of Lords by the Conservatives, Liberal Democrats and Cross Benchers, who often supported each other's amendments. The Bill was, as a result, amended in various ways, including amendments made by the Government in response to pressure and amendments supported by the Government though not introduced by it. Rosie Winterton, Minister at the Department of Health with responsibility for mental health, said that as a result of the amendments opposed by the Government: "the entire balance of the Bill has been altered".[37]

On six occasions changes were forced on the Government by a majority vote. These changes, together with some associated amendments, are summarised below. Other changes and issues are mentioned in the next section of this paper.

No detention without impaired decision-making:: A new clause, opposed by the Government would prevent patients from being detained in hospital unless their ability to

[36] Fuller details of the qualifying requirements and relevant procedures are set out in the Explanatory Notes: http://www.publications.parliament.uk/pa/ld200607/ldbills/001/en/07001x-c.htm

[37] See the press notice reproduced below in section E.

make decisions was significantly impaired due their mental disorder. This is now clause 4 of the Bill. It was introduced on a vote of 225 to 119 on 10 January 2007.

The amendment was designed to apply to section 2 and 3 detention but a later amendment on Report applied it to the conditions for Community Treatment Orders (now clause 32).[38] The requirement would be a new one. The definition of mental impairment is different from the definition of mental incapacity in that it would cover people who may have the ability to reason and make decisions but whose decisions are impaired because of their mental disorder.

The proponents of the new clause argued that other patients subject to any other form of medical treatment had the power to refuse treatment. This would bring mental health treatment into line. The Government opposed the clause on the ground that it was the needs of patients and the risk that their disorder posed to themselves and to others, not their decision-making ability, that must determine whether compulsion should be used. If the clause was introduced some people might go untreated and harm themselves or others.[39]

The Explanatory Notes to the Bill brought from the Lords say at paragraph 43:

> While there is no precedent for this provision in legislation in England and Wales a similar provision exists in the *Mental Health (Care and Treatment) (Scotland) Act 2003* (an Act of the Scottish Parliament). Volume 2 of the Code of Practice published by the Scottish Executive 1 to accompany that Act states (at paragraph 23 of Chapter 1):
>
> *1 Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 2 - Civil Compulsory Powers (Parts 5, 6, 7 & 20), Scottish Executive, September 21, 2005.*
>
> > "One difference between incapacity and significantly impaired decision-making ability arguably is that the latter is primarily a disorder of the mind in which a decision is made, resulting in the decision being made on the basis of reasoning coloured by a mental disorder. Incapacity, by contrast, broadly involves a disorder of brain and cognition which implies actual impairments or deficits which prevent or disrupt the decision-making process."

The following three amendments were passed on the first day of the Report Stage, Monday 19 February:

Exclusions from the definition of mental disorder: By a vote of 216 to 128 the Government's changes to the current exclusions in the Act were removed and replaced. The new version is now Clause 3 of the Bill.

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38 HL Deb 26 February 2007 c1417-1418.

39 HL Deb 10 January 2007 (Committee Stage) c228-251. The new clause was in the names of Baroness Barker, Earl Howe, Baroness Murphy and Lord Rix.

The 1983 Act excludes from the definition of mental disorder people suffering from mental disorder "by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs." The Government would have removed all of this and simply said that dependence on alcohol or drugs was not considered to be a disorder or disability of mind. In the Government's view because some of the existing exclusions were redundant, the only real change was the removal of the exclusion for sexual deviancy, which the Government believed was necessary.

The amended clause now says that a person is not be considered to have a mental disorder solely on the grounds of his substance misuse (including dependence on alcohol or drugs); his sexual identity or orientation; his commission, or likely commission, of illegal or disorderly acts; his cultural, religious or political beliefs.

The proponents of the change argued that because the Government Bill was using a broader definition of mental disorder than the existing one, it was necessary to have explicit exclusions to guard against the measure being used as a form of social control. The Government argued that it was absolutely not its intention to detain anyone except on the basis of his or her mental disorder and that the exclusions proposed by the Opposition were either redundant, for example, sexual orientation, as no-one would in practice be detained solely on those grounds, or would exclude people who might need help.[40] A debate on this topic was also held in Committee on a slightly different amendment but was not pressed to a vote.[41]

No detention for treatment unless the treatment is likely to have a therapeutic benefit:: By a vote of 186 to 115 an amendment was approved to ensure that no-one could be detained for treatment unless that treatment was "likely to alleviate or prevent a deterioration in his condition". Clause 5 now contains this additional condition, which applies to section 3 of the 1983 Act, related sections of the criminal justice provisions and the corresponding criteria for renewal and discharge. A number of other provisions in the Bill are also affected (including clauses 7 and 32).

The new condition is similar to the existing one in the 1983 Act but will apply more widely within the Act. The Government Bill would have replaced the existing condition with a condition relating to the availability of "appropriate treatment". The amendment passed in the Lords leaves "appropriate treatment" as a condition but qualifies it.

The Government proposed compromise amendments but these were not successful in stopping the amendment on what is often referred to as the "therapeutic benefit" condition. The dissenters argued that the Government's compromise still left open the possibility that someone could be detained simply for preventive purposes without any medical benefit. The Government argued that the Bill was not about detaining people without offering them treatment but that the existing conditions had led to a culture in

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40 HL Deb 19 February 2007 (Report Stage) c906-925. The amendment was in the names of Earl Howe, Baroness Barker and Baroness Murphy.

41 HL Deb 8 January 2007 (Committee) c72-90

which too many people, especially those with personality disorders, were labelled untreatable and therefore did not receive support.[42]

A fully qualified medical practitioner must be involved in the renewal of detention: By a vote of 147 to 108 a new clause was introduced into the Bill, designed to ensure that a fully qualified medical practitioner examine the patient and that both a Responsible Clinician and a medical practitioner agree before the renewal of detention. This is now clause 6 of the Bill. The issue of renewal also arose in Committee, where a slightly different amendment, requiring the involvement of two medical practitioners was discussed.[43]

The Government had proposed compromise amendments but they were unsuccessful. The Bill had proposed that responsibility for renewal should be placed with the patient's Responsible Clinician (a new category of professional to be created by the Bill, who could be a doctor but might be from another profession) and an Approved Mental Health Professional (also a new category of professional to draw on a wider range of skills than the existing Approved Social Worker). The present Act requires only one person to be responsible for renewal, the Responsible Medical Officer, who is normally a consultant psychiatrist.[44]

There were further defeats for the Government on the second day of the Report Stage, 26 February 2007*:*

Specific arrangements for under 18s: A new clause dealing with specific arrangements for children and young people, opposed by the Government, was approved by 201 – 126 and is now clause 24. The clause says that children must be admitted to age-appropriate settings; except in an emergency they must be assessed by a medical practitioner with specialist training in child or adolescent mental health and, except in an emergency, the Responsible Clinician must also be a specialist.

The Government agreed that major challenges in the field of child and adolescent mental health services existed, a particular problem being the use of adult wards for children, but it did not believe that it was appropriate to require specific services in legislation when the rest of NHS services were governed by a more general duty. It believed that the code of practice was the right way to indicate to the health service how those services should be provided.[45] This issue was also discussed in Committee.[46]

Several issues affecting children were raised at various stages of the debates. For example, at the Report stage the Government introduced an amendment to clarify that those aged 16 and 17 could decide whether to be admitted regardless of whether there

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42 HL Deb 19 February 2007 c925 -939. The amendment was in the names of Lord Carlile of Berriew, Earl Howe, Baroness Murphy and Baroness Meacher.

43 HL Deb 15 January 2007 c439-449

44 HL Deb 19 February c939-950. The amendment was proposed by Lord Carlile of Berriew, Earl Howe and Baroness Meacher.

45 HL Deb 26 February 2007 c1366-1378.The amendment was in the name of Lord Williamson of Horton, Baroness Murphy and Earl Howe.

46 HL Deb 15 January c546-562

was a person with parental responsibility for them (now clause 42 of the Bill) and said that it was willing to initiate discussions about the position of "Gillick competent"[47] children under age 16.[48] Advocacy services for children and young people were also an issue (see next section of this paper).

Restrictions on the use of Community Treatment Orders (CTOs): By a vote of 173-140 an amendment was approved stipulating that any decision to place a patient on a CTO must involve a medical practitioner. This amendment is now incorporated into the current version of the Bill, within clause 32, which begins the chapter on supervised community treatment and is about the making of community treatment orders.

Other restrictions were introduced (also now in clause 32), designed primarily to limit the application of CTOs to strictly defined "revolving door" patients. These included, among several others, that "the patient must, on at least one occasion prior to the current admission under section 3, have refused medical treatment and that refusal must have led to a significant relapse in their mental or physical condition justifying compulsory admission to hospital and also, during that admission, must have received compulsory medical treatment which alleviated or prevented a deterioration in their condition".

The proponents of the amendments argued that they were not opposing CTOs outright. The Government response was that, even so, there appeared to be a big gap between them and the Government about the benefits of CTOs. On the specific technical point, the Government argued in favour of its newly created *Responsible Clinician* (who may or may not be a doctor) being involved in the decision. The Government also pointed out that under the Bill's provisions the *Responsible Clinician* alone could not make a CTO; he had to have the agreement of an Approved Mental Health Practitioner [49]

Another amendment was pressed to a Division but was not successful. By 133 votes to 136 an amendment to remove the power to require a patient on a CTO to abstain from a particular conduct (for example, not to go down to the pub) was defeated.[50] Various other potential amendments were discussed, such as setting a maximum time limit for CTOs. The existing *after care under supervision* provisions that the Government had intended to repeal were reinstated and there was also a lengthy debate on *Community Treatment Orders* in Committee as part of a "clause stand part" debate. [51]

C. Other amendments and issues

Some of the other issues that prompted debate are summarised below. Issues that resulted in a change to the Bill (even if the debate was wider than the change) are listed first. Commitments are listed next but, apart from that, the issues are listed in no particular order.

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47 Children who have are deemed have the capacity to make decisions.

48 HL Deb 26 February 2007c1462-1466; see also HL Deb 15 January 2007c546-562

49 HL Deb 26 February 2007 c1406-1418. The amendment was in the name of Earl Howe, Lord Carlile, Baroness Murphy and Baroness Meacher.

50 HL Deb 26 February 2007 c1417-1424

51 HL Deb 17 January 2007 c695-713

a. Amendments (with related issues)

Fundamental Principles and Status of the Code of Practice

There were long debates on whether the 1983 Act should be guided by fundamental principles written onto the face of the Act. The status of the Code of Practice was another recurring theme in relation to this and in general. The Government responded to both these issues on Third Reading by introducing an amendment (now clause 10 of the Bill) to require those performing functions under the 1983 Act to have regard to the Code and to require the Secretary of State to include in the Code a statement of principles to inform decisions under the Act. The amendment then listed eight matters that must be addressed:

- respect for the patient's past and present wishes and feelings
- minimising restrictions on liberty
- involvement of patients in planning, developing and delivering care and treatment appropriate to them.
- avoidance of unlawful discrimination
- effectiveness of treatment
- views of carers and other interested parties
- patient well-being and safety, and
- public safety.

The Secretary of State also has to have regard to the desirability of ensuring effective use of resources and equitable use of services.[52]

The very first debate in Committee[53] was on an amendment to insert principles into the beginning of the 1983 Act. The Government was sympathetic but thought that it was not practically possible to add principles to an existing Act although it might have been possible if the Act had been replaced in its entirety. It argued that the Act already contained implicit principles[54] and that it would not make for clarity to add explicit ones. The Government undertook to explore the issue but made no promises about the outcome. The issue was debated on Report[55] when the Government again expressed sympathy but also doubts about causing confusion if principles were inserted into an Act that already contained principles. It agreed to introduce an amendment about principles at Third Reading although this would relate to the Code of Practice and not the Act.

The status of the Code of Practice was a recurring theme in relation to many issues as the Government's frequent response to problems raised was that the solution lay not in changing the law but in improving services, for which it considered the Code of Practice more appropriate than the Act itself. The opposing view was that even though there had to be "cogent reasons" for departing from the Code, it did not have the force of law and

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52 HL Deb 6 March 2007 c117-133

53 HL 8 January 2007 c11-53

54 The Government's list of what it sees as the implicit principles is in column 47 of the January 8, 2007 debate.

55 HL Deb 19 February c885-900

practitioners could depart from it. The issue of strengthening the status of the code came up in its own right as well. [56]

The amendment introduced on Third Reading was welcomed by Earl Howe, Conservative spokesman, although he said that he would have preferred the principles to be included in the Act. Baroness Barker (Lib Dem spokesperson) referred to the amendment as a compromise likely to satisfy no-one but said that, like Earl Howe, she accepted that this was all they were likely to get. Others, she said, were not happy. Lord Carlile, who was absent because he was unwell, had read the amendment and was firmly of the view that it offered no legal protection whatever.

Higher penalty for the offence of ill-treatment

Baroness Murphy introduced an amendment to increase from 2 years to 5 years the penalty for ill-treating a patient. It was supported by the Government and was agreed. [57]

Place of safety

Concerns raised in Committee about the overuse of police cells for the detention of mentally disordered people under the *place of safety* powers in the 1983 Act (for up to 72 hours). These concerns were supported by both the Police Federation and the Independent Police Complaints Commission. In response, the Government introduced an amendment to make it possible for someone to be moved from one *place of safety* to another without necessarily waiting 72 hours. The Government agreed that Police cells should be a last resort but said that the solution lay in good practice rather than over rigid regulation. It would, however consider the general issue of monitoring and see what could be done.[58]

Patient's consent to treatment (including Electro-convulsive Therapy)

There were several debates about increasing the safeguards relating to compulsory treatment once a patient has become subject to the *Mental Health Act*. There was, for example, an attempt to bring in an amendment to reduce from 3 months to 28 days the period following an order for compulsory treatment before a second medical opinion is required if the patient does not consent. It was strongly opposed by the Government, which did, however, introduce amendments at Report stage to enable patients to refuse ECT in non-emergency situations and in advance decisions (now in clauses 30-31). It also provided for additional treatments to be included.***[59]***

Approval criteria for mental health professionals

The Government introduced an amendment to require that the competencies required of an Approved Mental Health Professional should be set out in Regulations. These were made available in draft form in the House of Lords Library. (Local social services authorities will have the power to approve these professionals.)[60]

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56 HL Deb 15 January 2007 c111-120 and 27 February c1583-8

57 HL Deb 26 February 2007c1470; see also HL Deb 17 January 2007 c757

58 HL Deb 26 February 2007 c1466-1470; see also HL Deb 17 January 2007 c753-7 and 760-1

59 HL Deb 19 February c971-990; HL Deb 26 February c1395-1396 and c1449-1456; see also HL Deb 15 January 2007 c470-521

60 HL Deb 19 February 2007 c993-996; see also HL Deb 15 January 2007 c538-542

Conflicts of interest

Baroness Barker introduced an amendment, supported by the Government, to cover situations where a doctor might not provide medical recommendations because of his position in relation to the patient or another practitioner and to provide for a regulation-making power to extend such provisions to other professions in future.[61]

Cross border arrangement

There were Government amendments on cross border arrangements.[62]

The Bournewood Gap [63]

On Report the Government introduced a number of amendments, most of which were related to concerns that had been expressed at earlier stages of the debate. It also made a number of commitments. These included:

Initiating the authorisation process: In response to concerns that someone other than the hospital or care home should be able to initiate the authorisation process, the Government introduced an amendment to enable family, friends and carers to take action if they had not been able to get the care home or hospital to apply for authorisation. They would be able to apply to the supervisory body, which would appoint a *best interests* person to consider whether a person was in fact deprived of liberty.

Deprivation of liberty not authorised: The Government introduced an amendment to strengthen the arrangements for dealing with a case where deprivation of liberty is not authorised but the *best interests assessor* reports that the person is in fact being deprived of his or her liberty.

Training and skills of assessors: The Government introduced an amendment widening the regulatory powers in the Bill to enable the training and skills of assessors to be prescribed.

Affirmative procedure for Regulations: The Government also introduced an amendment to ensure that all Regulations relating to the deprivation of liberty would be included in one set of Regulations and would be subject to the affirmative procedure.

Initial authorisation period: The Government undertook to introduce an amendment when the Bill is in the House of Commons in response to concerns that the initial authorisation period of one year might be too long. The amendment would ensure that the *Mental Capacity Act* would contain a power to reduce the maximum period at a future date if monitoring convinced the Government that this was necessary.

Advocacy support: The Government undertook to make sure advocacy support available to families and friends during the authorisation process and beyond.

Other *Bournewood* issues raised included:

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61 HL Deb 26 February 2007 c1392-1393
62 HL Deb 26 February 2007 c1462

- No charges for accommodation while deprived of liberty (the Government did not accept this)
- Temporary incapacity (the Government said that this would be covered by the provisions that it was introducing)
- The opinion of a second doctor for someone who requires serious medical treatment (the Government response to this was that this was not an authorisation issue and that the necessary safeguards regarding treatment were already contained in the *Mental Capacity Act*)
- Other safeguards where unauthorised deprivation of liberty is taking place
- The distinction between medical treatment in the Mental Capacity Act and in the Mental Health Act (the Government undertook to look at the definitions in both Acts and to write to Lord Carlile)

b. Commitments

Independent Advocacy (including services for children and young people) The question of advocacy services was raised a number of times. On Report, the Government undertook to bring in proposals when the Bill was considered in the House of Commons. It said: "We wish to see tailored advocacy services, which will bring maximum benefit to all groups of patients, including children and young persons. The Government will continue to develop their proposals on how patients with mental disorder who are subject to the *Mental Health Act* can access appropriate advocacy services, and we will bring them back when the Bill is considered in the other place" (c1399). [64]

Mental Health Act Commission (including visitorial role for informal patients) In general the Government's response to queries about the role of the MHAC was that its role was being considered outside the framework of the *Mental Health Bill* reforms as part of the reorganisation of other regulatory bodies. However, it did undertake to explore making a Direction under existing powers that would enable the MHAC to have a visitorial role for people not detained under formal powers. [65]

63 HL Deb 27 February 2007 c1561-1583 ; HL Deb 19 February c967-971; and HL Deb 17 January c761-770

64 HL Deb 26 February c1396-1400 and HL Deb 26 February c1481-1484; see also HL Deb 17 January 2007 c688-695

65 HL Deb 26 February c1428-1431; see also HL Deb 17 January 2007 c727-738

c. Other issues

Nearest Relative:
There were attempts to give patients more choice over the *Nearest Relative* and regrets were expressed that the 2004 draft Bill's proposal to abandon the concept altogether in favour of a different system was no longer the Government's policy. But there were no changes.[66] There was also an attempt to enable the *Nearest Relative* to act for *restricted patients* but the Government argued that the provisions for *restricted patients* were intentionally different.

Learning Disability
There were attempts to remove learning disability from the definition of mental disorder altogether. (The Bill and the 1983 Act include it where it is associated with abnormally aggressive behaviour or seriously irresponsible behaviour). The Government did not agree but undertook to include guidance in the Code of Practice guidance about the difficulties of determining whether someone with learning disabilities who appeared aggressive or irresponsible was in fact suffering from a mental disorder or simply acting out of frustration. There was also an attempt to include autistic spectrum disorders within the definition of learning disability.[67]

Issues relating to the role of Approved Social Workers (in future Approved Mental Health Act Professionals)
Both in Committee and on Report issues were raised that were of concern to the British Association of Social Workers relating to current responsibilities of Approved Social Workers, which would, under provisions in the Bill, also apply to Approved Mental Health Act Professionals. In particular there was concern about the support they needed from Police and ambulance services and problems arising when hospital wards were completely full. Other issues were also raised, including rights of entry to premises and the extent to which the new Approved Mental Health Professionals would be independent.[68]

The Government was sympathetic to some the problems of e Approved Social Workers but opposed the amendment to place a duty on other bodies, such NHS Trusts, Primary Care Trusts, and the police to convey patients to hospital, on the grounds that this was an issue better dealt with by intervention at local level.[69]

Role of Tribunals An amendment was proposed relating to the composition of Tribunals (ethnic mix etc). The Government's response was that it was about to produce a strategic document on the future of the Tribunal Service more generally.[70]

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66 HL Deb 6 March 2007 c133-135; HL Deb 26 February c1400-1406; HL Deb 17 January c661-665
67 See HL Deb 19 February c903-906 for the amendment. The issues were also discussed during the debate on the definition of mental disorder, HL Deb 8 January 2007 c53 onwards.
68 HL Deb 17 January 2007 c747-750
69 HL Deb 26 February c1477-1481;
70 HL Deb 17 January c741-5

Dismissal of M.P.s with mental health problems: The Government argued that this was a matter for the House of Commons.[71]

Other issues raised included:

- Safeguards for people who lack capacity to apply to a Tribunal for a review[72]
- Care Planning[73]
- Criminal justice[74]
- Assessment for health and social care services [75]
- Use of seclusion[76]
- Required period of assessment for all and early Tribunal hearing[77]
- Advance decision and statement[78]
- Young carers[79]

D. Joint Committee on Human Rights: Mental Health Bill[80]

The report of the Joint Committee on Human Rights was completed at the end of January and published in February 2007 after the Bill had completed its Committee stage in the House of Lords but before Report and Third Reading. It may nevertheless have had an influence on earlier debates through its membership. The key features of the Bill introduced in the Lords from the committee's point of view were set out in its introduction.

> - It alters the statutory criteria for compulsory admission to psychiatric hospital by broadening the definition of mental disorder, and by removing the requirement that medical treatment in hospital must be likely to alleviate or prevent deterioration in the patient's condition, replacing it with a new test, that appropriate treatment must be available. This raises the question of the compatibility of the new compulsory admission procedures with the right to liberty in Article 5 ECHR.
> - It removes the exclusion in the Mental Health Act 1983 that a person shall not be treated as suffering from mental disorder by reason only of sexual deviancy.
> - It seeks to comply with the settlement in JT v United Kingdom,[81] relating to the right to respect for privacy under Article 8 ECHR, by conferring on the patient the right to challenge the suitability of his or her 'nearest relative' to act as such for the purposes of the Act.

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71 HL Deb 17 January 2007 c758-60
72 HL Deb 26 February 2007 c1460-1462; see also HL Deb 17 January 2007 c745-7
73 HL Deb 15 January 2007 c530-538; HL Deb 19 February 2007 c990-993
74 HL Deb 17 January c649-660HL Deb 26 February 2007 c1393-1393
75 HL Deb 26 February 2007 c1456-1459; for rights to services, see also HL Deb 10 January c263-280
76 HL Deb 26 February 2007 c1470-1481; see also HL Deb 17 January c661-682 and 747-750
77 HL Deb 15 January 2007 c449-454
78 HL Deb 15 January c523-530
79 HL Deb 17 January 2007 c682-688
80 Joint Committee on Human Rights HL Paper 40 and HC Paper 288 of 2006/7: http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/40/40.pdf
81 (2000) 30 E.H.R.R CD 77, [2001] 1FLR 909

- It introduces a Community Treatment Order with a view to imposing an effective obligation on patients to accept treatment for mental disorder while resident in the community. This raises issues under Article 8, and potentially under Article 5 ECHR.
- It alters the test for treatment without consent from one where the decision-maker is required to have regard to the likelihood that the treatment will alleviate or prevent deterioration in the patient's condition to the test that it is appropriate for the treatment to be given. This raises issues under Article 8 ECHR.
- It replaces the requirement that every detained patient have a responsible medical officer ("RMO") who must be a doctor in charge of their treatment and responsible for renewing detention, by conferring these functions on a responsible clinician ("RC") who need not be a doctor.
- It replaces the Approved Social Worker (currently the professional responsible for applying for detention under the Mental Health Act) with the Approved Mental Health Professional ("AMHP").
- It seeks to comply with the ruling of the European Court of Human Rights in HL v United Kingdom[82] by introducing a procedure for the detention of compliant mentally incapacitated adults who need to be deprived of their liberty in their own best interests. This will be achieved by amendments to the Mental Capacity Act 2005. This raises issues of compatibility with Article 5(1) and 5(4) ECHR.

The summary conclusions of the Joint Committee are set out below:

> In the Committee's view, the Bill raises nine main human rights compatibility issues and omits two means to enhance or promote human rights.
>
> In relation to detention on grounds of unsoundness of mind, the Committee considers that, given the bill's new, broad definition of mental disorder, it is desirable to restate on the face of the bill key non-discrimination principles so as to avoid discrimination on grounds of sexual orientation and sexual identity. In the Committee's view the Bill's provisions on procedures for lawful psychiatric detention appear broadly to comply with the case law on Article 5 (1) (e) of the Convention.
>
> As to conditions of compulsion, in the Committee's view there appears to be no Convention obstacle to replacing "treatability" with "availability of appropriate treatment" as a condition of detention. Nevertheless, the Committee is mindful of the strongly held view of psychiatrists that in any replacement of the "treatability" test the treatment available should be likely to be of therapeutic benefit to the patient.
>
> As regards renewal of detention, the Committee is concerned that, while initial detention would still be based on objective medical expertise, as required for compatibility with Article 5 ECHR, the bill proposes renewal of detention by the responsible clinician, who need not be a doctor, reporting to the managers of the hospital that the conditions justifying detention continue to be met. The Committee does not agree with the Government's wider definition of objective

[82] HL v United Kingdom (2004) 40 EHRR 761

medical expertise. The Committee is also concerned that under the bill a report renewing detention, not necessarily by a medical practitioner, is subject to no scrutiny by any higher authority other than the Mental Health Review Tribunal (MHRT) and takes the view that it may be difficult for responsible clinicians to provide the Tribunal with objective medical expertise.

In the Committee's view the bill's provisions for a patient to displace his nearest relative meet the terms noted by the European Court of Human Rights in a recent case. The Committee considers however that effective safeguards on the suitability of nearest relatives should be made more explicit on the face of the bill.
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The Committee considers that any procedure whereby hospital managers authorise Community Treatment Orders should be in the legislation not the Code of Practice so as to be compatible with the Convention requirement that interferences with private life must be in accordance with the law.

The Committee considers in relation to the right to seek review of conditions in a Community Treatment Order that the requirement that restrictions on conduct be proportionate and that conditions may not be imposed which collectively amount to a deprivation of liberty should be enshrined in the statute, and that a patient should be entitled to seek review of the conditions before a Mental Health Review Tribunal.

As regards treatment without consent, the Committee considers that the principal legitimate aim for which medical treatment may be imposed under Article 8(2) ECHR is health. It must also be in accordance with law. For this reason, in the Committee's view the full appropriateness test should be in the legislation rather than in a Code of Practice.

The Committee considers that forcible feeding should be subject to the same safeguards as apply to other invasive forms of treatment.

As regards the treatment of mentally incapacitated patients, the Committee is mindful of the Strasbourg Court's ruling that, where a compliant incapacitated person is to be deprived of his liberty, this must be done in accordance with a procedure prescribed by law. Since the bill's proposals to amend the Mental Capacity Act are detailed and complex, the Committee questions whether they will be readily understood by proprietors of residential care homes. In the Committee's opinion, to charge someone for accommodation in which they are deprived of their liberty potentially engages civil rights and obligations and therefore the right of access to a court to determine those rights under Article 6 of the Convention.

The Committee regrets the bill's omission of any provision for effective supervision and review of decisions to give treatment without consent for mental disorder to patients deprived of their liberty under mental capacity legislation, where the treatment involves psychotropic medication or other significant interferences with physical integrity. The Committee considers that where patients are so treated or are subject to restraint or seclusion there is need for some supervision and review by a second opinion system or by a visiting inspectoral body such as the Mental Health Act Commission.

Similarly the Committee urges the Government to make provision for sufficient safeguards to ensure that seclusion is used only when strictly necessary and that

individuals subject to it should have access to review at intervals so that it is brought to an end when no longer necessary.

E. Rosie Winterton, 1 March 2007

After the Bill had completed its stages in the House of Lords, Rosie Winterton, Minister at the Department of Health with responsibility for mental health, made a speech to the Local Government Association in which she condemned the changes made in the House of Lords and called for them to be reversed. The Department of Health's press notice about the speech is reproduced below:

Health Minister slams Lords over Mental Health Bill amendments

Health Minister Rosie Winterton today expressed her deep concern about the impact on patient and public protection that the amendments the House of Lords has made to the Government's Mental Health Bill.

Rosie Winterton told the Local Government Association conference on the Mental Health Bill in London :

"Every year, over 1,300 people in contact with mental health services take their own lives. Every year, mental health patients commit around 50 homicides. Often, these are preceded by a reluctance to continue taking the treatment that would keep them well.

"We believe the present law can deny treatment to those who are in urgent need of it. We want to modernise the law to remove these obstacles both for community-based and hospital treatment for the good of patients themselves and to better protect the public.

"But the Peers have seriously weakened our plans for better protection for patients and the public. I want to spell out the impact of the changes that the peers have made and the very real risks if they are not reversed."

The Lords have amended the Bill to:

- introduce a new treatability test that means patients with severe personality disorders will continue to be turned away from services because they are deemed 'untreatable';

- place restrictions on supervised community treatment so that far fewer people will benefit from living in the community. This means that patients will have to stay in hospital longer or be discharged without proper supervision, leaving patients untreated and families in distress; and

- introduce an 'impaired judgement' test so that if it cannot be shown that a patient's judgement is impaired, they cannot be detained - regardless of how much the patient needs treatment and however much they, and others, are at risk without it.

Rosie Winterton continued:

> "We have made decisions which we believe strike the right balance between getting treatment to those who need it, putting in place patient safeguards and minimising the risk to the public.
>
> "By choosing to ignore the strict conditions for detention already in place, downplaying the importance of the judgment of doctors and the implications of denying treatment for patients, the Lords have altered the entire balance of the Bill.
>
> "These are people with profound mental health needs, who, at times, will pose a serious risk. For the sake of mental health patients themselves, their families and the safety of the public, these changes must be overturned." [83]

Rosie Winterton's full speech is on the Department of Health website [84]

III Responses to the Bill

At the time of writing there are only a few briefings for the Second Reading of the Bill in the House of Commons. Reproduced below is the summary of the briefing from Mental Health Alliance, which has co-ordinated much of the opposition to the Bill. It is an organisation with 79 members, many of whom have produced their own briefings as well.[85]. Below that is a letter sent from the Zito Trust to the Independent about the Bill. The Zito Trust is one of the few organisations that has consistently supported measures along the lines of those proposed by the Government.

The views of the Mental Health Alliance on the Bournewood provisions, which amend the *Mental Incapacity Act 2005* are reproduced at the end.

Mental Health Alliance Briefing for Second Reading in the House of Commons

Executive Summary

The Mental Health Alliance believes that the Mental Health Bill as introduced in the House of Lords was deeply flawed and represented a missed opportunity to introduce a radically revised Mental Health Act fit for the 21st century. In doing this the Government ignored the recommendations of its own Expert Committee appointed in 1998 and the Joint Parliamentary Scrutiny Committee in 2004.

The amendments made to the Bill by the House of Lords, however, provide an opportunity for the Government to achieve mental health legislation that is ethical and enjoys the support of patients and their families, professionals and the public. We call on

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83 Department of Health Press Notice, Client ref 2007/0048; GNN ref 144598P: http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=267945&NewsAreaID=2&NavigatedFromDepartment=False

84 http://www.dh.gov.uk/en/News/Speeches/DH_072442

85 For example the British Medical Association has produced a briefing for the Second Reading in the House of Commons, which is available on its website: http://www.bma.org.uk/ap.nsf/Content/MentalHealthBill

the Government not to squander this opportunity and turn back the clock by reversing these well considered changes to the Bill.

The six key changes made by the House of Lords

1. Exclusions

The Government's original Bill removed most of the exclusions from the 1983 Act which ensure that specific behaviours and preferences are not seen as mental disorders. We believe that exclusions are essential to guard against the inappropriate use of mental health legislation. We therefore welcome the Lords decision to add exclusions to ensure that people are not detained solely because of substance misuse, sexual identity or orientation, involvement in illegal or disorderly acts or cultural, religious or political beliefs.

2. Impaired decision making

The Alliance welcomes the Lords amendment which ensures that people with full decision making ability cannot be forced to have treatment imposed upon them against their will. This would bring the 1983 Act in line with the Scottish Mental Health Act. People who are physically ill and have capacity are not detained in hospital against their will because they refuse to take the treatment that should improve their condition; nor should people with mental illness. Nothing in this provision would "expand the right to suicide" or prevent the treatment of patients who are a risk to others – if a mental disordered person is suicidal or a danger to others as a result of their condition, their decision making is impaired.

3. The treatability test

The Alliance believes that all compulsory treatment should have a health benefit for the patient and that the purpose of mental health legislation should not be to effect the preventative detention of those who cannot benefit from treatment. It is therefore crucial that the House of Lords amendment to reintroduce a treatability test into the 1983 Act is not overturned – this would provide that a person can only be detained if treatment is available which is likely to alleviate or prevent a deterioration of his condition. This provision would not prevent people with a personality disorder – for whom effective treatments are available - from receiving treatment.

4. Renewal of detention

We welcome the amendment passed by the House of Lords to require a medical practitioner to examine the patient and agree to the detention before a renewal of detention can occur. This will ensure compliance with the Human Rights Act, as interpreted in case law, which requires that a decision to renew a detention order is based on 'objective medical evidence of a mental disorder'. We would like the Bill to go further and require two professionals – one of who must be a medical expert - to agree a renewal in every case.

5. Community Treatment Orders

If new compulsory community powers are to be introduced - and many Alliance members oppose this - they should be for a tightly defined group and be accompanied by stronger safeguards. We support the new eligibility criteria for CTOs agreed by the House of Lords – which will limit them to genuine 'revolving door patients' with a history of relapsing after discharge from hospital and who are a danger to others. This is precisely the group of patients the Government says it want this provision to cover. We are also concerned by the excessive scope of the restrictions that can be imposed on a patient's lifestyle and behaviour – and believe that patients should be allowed to appeal against them.

6. Children and young people

We welcome the House of Lords amendments to the Bill which would place health authorities under a duty to admit children to an age appropriate setting and to provide specialist assessment and supervision for detained children. We also welcome the Government's amendment to the Bill to allow 16 and 17-year-olds to override the wishes of their parents if they want to refuse treatment – although we would like this extended to 'Gillick competent' children under 16.

Missed opportunities in the Bill

The amendments made by the House of Lords have improved the Bill significantly but it still needs additional changes to provide for a modern Mental Health Act. The Bill that gets passed could remain in use for up to 30 years and must reflect the needs and expectations we all have of 21st century health care. We believe the Government must take this opportunity to modernise other aspects of the 1983 Act.

1. The nearest relative

The patient's 'nearest relative' has important powers in decisions as to whether they are to be detained or discharged. The Bill makes a marginal improvement to the system by which 'nearest relatives' are identified and if necessary displaced. The Alliance believes the individual patient should be able to nominate the person who can best represent their interests, as is the case in Scotland. We welcome the undertaking given by the Government to reconsider this issue and hope to see progress shortly.

2. Advance decisions

The Bill makes no provision for advance decisions or statements which would give patients the right to give directions about their future treatment – and it is therefore likely that any advance decisions or statements made under the Mental Capacity Act 2005 would be over-ridden if the person becomes subject to compulsory powers. This discriminates against people with mental disorders and we recommend that the Bill should allow people to make advance decisions and statements which must be taken into account by – but not binding on – decision makers determining the provision of medical treatment under the 1983 Act.

3. The right to assessment

Many instances of compulsion could be avoided if patients, and their carers, received services before their illness has deteriorated to crisis point. It is a recurring theme in the small number of tragic cases where violent crimes are committed that services turn people away when they ask for help. We therefore believe that the 1983 Act should – inline with the Scottish Mental Health Act – establish a duty on services to assess and meet the needs of people with mental health problems.

4. Right to advocacy

The Alliance supports amending the 1983 Act to ensure that all patients subject to compulsory powers have a statutory right to an independent mental health advocate. This was one of the few welcome aspects of the Government's 2004 Draft Bill but was later dropped. We welcome the Government's commitment to further consider this issue but we look forward to seeing their detailed proposals, which have not yet been published.

5. Places of safety

We support the Government amendment to the Bill which will allow people to be transferred between places of safety. This will ensure that mentally distressed people detained in police stations can be transferred to a therapeutic environment more speedily than they are now. However the Bill needs further changes to ensure that police stations are only ever used as a place of safety as a last resort.

6. Guiding principles

We are disappointed that despite the widespread consensus in the House of Lords the Government still refuses to include a clear set of overarching principles on the face of the 1983 Act – which would guide professionals and tribunals in reaching decisions. We believe that the Government's 'concession' on this issue – which would require the Health Secretary to include certain principles in the Code of Practice – does not go far enough.

7. Consent to treatment

We welcome the Government's amendment to the Bill which will ensure that patients with capacity cannot be forcibly given ECT – however we do not agree such a refusal should be overridden in cases of 'emergency'. We also believe that the Bill should give patients more say in other aspects of their medical treatment – they should have their wishes respected unless there is good reason to override them.

8. BME issues

The Bill also needs further changes to ensure that the 1983 Act tackles discrimination and promotes race equality. The Government's own statistics highlight staggering ethnic inequalities in the use of mental health services. To prevent this from happening in the future the Bill must include: principles of non-discrimination and respect for diversity on

its face; a right to advocacy; and restrictions on the use of police cells as places of safety.

9. Criminal justice system

The Alliance is concerned that prisoners with mental health problems are still not getting the specialist medical treatment they need. Despite the policy of diversion of offenders suffering from mental disorder from the penal to the hospital system, the high numbers of such persons amongst sentenced prison populations has been consistently well documented. We believe that the Bill must ensure that people with mental health problems in the criminal justice system are transferred to hospital at the earliest possible opportunity.

10. Safeguards for people who lack capacity (Bournewood patients)

The Mental Health Alliance supports the safeguards introduced in the Bill for people who lack the capacity to give informed consent to decisions made over their care. We also believe that the safeguards could be further strengthened to give more protection to these vulnerable people – for example where a person is detained in a care home they should not have to pay their accommodation costs and there should be a right to a second medical opinion for any serious medical treatment provided while the person is detained.

Zito Trust

Letter to the Independent published 7 March 2007

Policy disarray on mental illness

Sir: Jeremy Laurance says the mental health bill is "designed to introduce tough controls on people suffering from mental illness in the wake of the case of Michael Stone" (8 March) when, in fact, the bill is actually designed to make sure that therapeutic relationships between clinical teams and patients potentially at risk in the community are maintained for everyone's benefit.

However, recent House of Lords amendments to community treatment orders have the shocking consequence of leaving suicidal people to their own devices and will raise the stakes for those who are at risk of violence to others. And they will also ensure that people with personality disorders will continue to be denied treatment, thereby piling additional pressures on an already beleaguered prison system.

It is also ironic that the Conservatives, led by spokesman Tim Loughton, should oppose these essential reforms. It was after all their policies in the late 1980s and early 1990s which led to the breakdown of community-based mental-health services, leading to significant loss of life and misery to hundreds of families. Presumably they have a better

policy for restoring public faith in our mental health services. If so, could they let us know what it is?

MICHAEL HOWLETT, DIRECTOR, JAYNE ZITO, PATRON [86]

Bournewood Provisions: Extract from the Mental Health Alliance Briefing for the Second Reading in the House of Commons

10. Safeguards for people who lack mental capacity (Bournewood patients)

The Mental Health Bill proposes a new legal framework that will be inserted into the Mental Capacity Act 2005 to allow people in hospitals or care homes and who lack capacity, to be deprived of their liberty if it is considered to be in their 'best interests'. The changes are a response to the 'Bournewood judgement' , which concerned an autistic man who lacked decision making capacity and was detained in hospital under the common law (with no legal safeguards). In accordance with established clinical practice the Mental Health Act was not used because the person was not actively objecting to detention. In 2004 the European Court of Human Rights held that the common law was not enough for these patients: it was too vague and had too few safeguards to comply with the Convention.

The new proposals will allow people who lack mental capacity to be detained in a hospital or a care home. The 'authorisations' will be for up to a year and the detained person will have a right to appeal to the Court of Protection.

The Mental Health Alliance supports the safeguards introduced in the Bill for people who lack the capacity to give informed consent to decisions made over their care. The Making Decisions Alliance (a consortium of 40 charities set up to campaign for new legislation on mental capacity and to support the implementation of the Mental Capacity Act) shares our views on these proposals. We also welcome the flexible and co-operative approach adopted by the Government on this issue – which has led to a number of important concessions that we have called for and fully support. These include:

- an enabling power to allow the maximum length of authorisations to be reduced if monitoring of the operation of the safeguards shows this is necessary
- a requirement that the supervisory authority inform all interested parties when an unlawful detention is taking place
- allowing third parties to request an assessment of whether a person is being deprived of their liberty
- a commitment to introduce improved advocacy safeguards for Bournewood patients when the Bill reaches the Commons

The Alliance also believes that the safeguards could be further strengthened to give more protection to these vulnerable people. For example:

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[86] http://www.zitotrust.co.uk/

- Where a person is detained in a care home they should not have to pay their accommodation costs. The recent report of the Joint Committee on Human Rights supported this by pointing out it would be discriminatory if a person deprived of liberty in their own best interests in a hospital will not be charged for the detention whereas a person detained in their own best interests in a care home will have to pay.

- There should be a right to a second medical opinion for any serious medical treatment provided while the person is detained. The Joint Committee on Human Rights report also identified this area as an omission that would have promoted or enhanced human rights. They argue for "effective supervision and review of decisions to give treatment without consent for mental disorder where that involves psychotropic medication or other significant interferences with physical integrity, such as Electro Convulsive Therapy."

IV Bibliography

Numerous sources have been mentioned throughout this Research Paper. In addition to these, the following are mentioned here

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88 This is available on the Department of Health's website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072730

89 This is available from the King's Fund website: http://www.kingsfund.org.uk/resources/publications/communitybased.html

Inquiries into homicides

The Department of Health published in February 2007 a list of independent investigation reports commissioned by local health authorities since 1994 about homicides by people who had been in touch with mental health services. The list has been deposited in the Library.[90] Two of the relatively recent inquiries, published in 2006 are listed below with internet links as they attracted a particular amount of press comment and have sometimes been seen as relevant to the current Bill:

- *Report of the independent inquiry into the care and treatment of Michael Stone*, September 2006, published by the South East Coast Strategic health authority, Kent county Council, Kent Probation Area[91] and Joint agencies response to the recommendations of the independent inquiry into the care, treatment and supervisions of Michael Stone, published by South East Coast Strategic Health Authority et al September 2006[92]
- *Report of the independent inquiry into the care and treatment of John Barrett,* November 2006, published by NHS London, commissioned by South West London Strategic Health Authority[93]

Key documents in the development of Government Policy before March 2006

This list covers key documents in the development of Government policy before March 2006 (the point at which the shape of the present Bill was announced).

- **July 1998:** Frank Dobson, then Secretary of State for Health, announced that he was setting up a review of the Mental Health Act 1983. [94]
- **July 1999**: The Department of Health and Home Office jointly published a consultation document, *Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development*.[95]
- **November 1999:** The Department of Health published the report of the review of the *Mental Health Act 1983*. [96] The review (by an expert committee under the chairmanship of Genevra Richardson, Professor of Public Law at Queen Mary College, London) had been announced by Frank Dobson in July 1988. The report was published at the same time as the Government's Green Paper and a Government-commissioned review of research.

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90 Deposited Paper Number 07/476

91 http://www.southeastcoast.nhs.uk/news/MS-Report-21.09.06.pdf

92 http://www.southeastcoast.nhs.uk/news/127462Response.pdf

93 http://www.london.nhs.uk/resourcelib/SL%20Confidential.pdf

94 Written Answer HC Deb 29 July 1998 c383-4W and Department of Health Press Notice, "Frank Dobson Outlines Third Way For Mental Health," 29 July 1998: http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4024509&chk=G4JMRG

95 Home Office, Department of Health, *Managing People with Severe Personality Disorder, : Proposals for Policy Development*: http://www.homeoffice.gov.uk/docs/persdis.pdf See also the press notice issued 19 July 1999, Home Office 221/99 issued by both Departments, " Managing dangerous people with severe personality disorders: consultation document published", available on the Library's Press database: http://hcl5.hclibrary.parliament.uk:81/weblink/html/press_results_frameset.html

96 Department of Health, Report of the Expert Committee, *Review of the Mental Health Act 1983*, November 1999

- **November 1999:** The Government Green Paper on *Reform of the Mental Health Act 1983* was published for consultation with a draft regulatory Impact Assessment.[97]
- **November 1999:** The review of research relating to the *Mental Health Act 1983* was published: This was the report of a study commissioned by the Department of Health from King's College School of Medicine and Dentistry, which brought together research relating to the Act, including the Act's problem areas and trends in the use of the Act over time. [98]
- **March 2000:** The Home Affairs Select Committee published a report, *Managing dangerous people with severe personality disorder*.[99]
- **May 2000:** The Government's response to the Home Affairs Committee's report, *Managing Dangerous People with Severe Personality Disorder* was published.[100]
- **July 2000:** The Health Select Committee Report on Provision of NHS Mental Health Services was published: The report covered the delivery of mental health services generally but contained a section on the review of the *Mental Health Act 1983.* [101]
- **October 2000**: The Department of Health published its response to the Health Committee's report on mental health services.[102]
- **November 2000:** The Department of Health published a summary of the responses to the Green Paper published by the Department of Health.[103]
- **December 2000:** The Government White Paper on reforming the *Mental Health Act* was published[104] : This was published in two volumes jointly by the Department of Health and by the Home Office, thus bringing together the two strands of policy, one on review of the 1983 Act in general and one of dangerous people with severe personality disorder.
- **June 2002:** The Department of Health published three volumes containing respectively the Draft Bill, its Explanatory Notes and a Consultation Document. [105]

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97 Department of Health, Reform *of the Mental Health Act 1983: Proposals for consultation*, Cm 4480, November 1999 (Green Paper): http://www.archive.official-documents.co.uk/document/cm44/4480/4480.htm

98 Department of Health, A systematic review of research relating to the Mental Health Act (1983), Sharon Wall, Rachel Churchill et al c/o St George's Hospital Medical School , London: http://www.dh.gov.uk/assetRoot/04/06/66/77/04066677.pdf

99 Home Affairs Select Committee, *Managing Dangerous People with Severe Personality Disorder*, HC 42 of 1999-2000: http://pubs1.tso.parliament.uk/pa/cm199900/cmselect/cmhaff/42/4202.htm and associated press notice: http://mirror.parliament.uk/commons/selcom90/hmapnt8.htm

100 Government Reply published as the Committee's Third Special Report, Session 1999-2000, HC 505: http://pubs1.tso.parliament.uk/pa/cm199900/cmselect/cmhaff/505/50502.htm

101 Fourth Report of the Health Committee Session 1999-2000, *Provision of NHS Mental Health Services*, HC 373 - I and II http://pubs1.tso.parliament.uk/pa/cm199900/cmselect/cmhealth/373/37302.htm

102 Department of Health, *The Government's Response to the Health Select Committee's Report into Mental Health Services,* October 2000, Cm 4888 http://www.dh.gov.uk/assetRoot/04/01/94/58/04019458.pdf

103 Department of Health, Reform of the Mental Health Act 1983, Summary of consultation responses, November 2000: http://www.dh.gov.uk/assetRoot/04/06/66/70/04066670.pdf

104 Department of Health, Reforming the Mental Health Act, Part 1: The new legal framework and Part 2 High Risk Patients, Cm 5016-1 and 11: http://www.publications.doh.gov.uk/mentalhealth/whitepaper2000.htm

105 Department of Health, Draft Mental Health Bill, Cm 5538-1, Draft Mental Health Bill Explanatory Notes, CM 5538-11, Mental Health Bill Consultation Document, CM 5538, June 2002

The Explanatory Notes included a Partial Regulatory Impact Assessment, which was later expanded. The expanded version was issued for consultation.[106]

- **November 2002:** Joint Committee on Human Rights Report on the *Draft Mental Health Bill*: was published. [107]
- **September 2004** The Government published for consultation another *Draft Mental Health Bill* and Explanatory Notes[108]
- **March 2005** The House of Lords and House of Commons Joint Committee on the *Draft Mental Health Bill* published its report on the draft Bill. [109]
- **July 2005** The Government's response to the report of the Joint Committee on the *Draft Mental Health Bill* 2004 was published[110]

V Statistics

A. Prevalence of mental disorders

About one-tenth of adults worldwide – an estimated 450 million people – are affected by mental disorders at any one time. The Office for National Statistics divides disorders into three categories:

- neurotic disorders – a category comprising depression, anxiety disorders and obsessive compulsive disorder;
- personality disorders – in which there are severe disturbances of a person's character, thought patterns and behaviour; and
- psychoses – which are severe mental disorders characterized by loss of contact with reality.[111]

The prevalence of mental disorders in Great Britain is estimated from surveys. The most recent survey of adults aged 16 to 74 years living in private households took place in 2000:

- one in six (16%) were assessed as having a neurotic disorder in the week before the survey;
- one in 22 (4%) were assessed in clinical interview as having a personality disorder; and

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106 Partial Regulatory Impact Assessment (RIA) – Issues for Consultation, available from the Department of Health's website: http://www.dh.gov.uk/assetRoot/04/05/40/13/04054013.pdf

107 House of Lords, House of Commons, Joint Committee on Human Rights, Draft Mental Health Bill, HL Paper 181, HC 1294 of 2001-02, 11 November 2002: http://pubs1.tso.parliament.uk/pa/jt200102/jtselect/jtrights/181/181.pdf

108 Department of Health, Draft Mental Health Bill and Explanatory Notes 2004, Cm 6305-I and II: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4088910

109 HL Paper 79 I-III and HC Paper 95 I-III, with reports and annexes: http://www.publications.parliament.uk/pa/jt/jtment.htm

110 Cm 6624: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4115267

111 ONS, *Focus on Health*, 2006 edition, p110

- one in 200 (1%) were assessed, following a clinical interview, as having a probable psychotic disorder.[112]

Applying these proportions to the 2007 adult population in England and Wales suggests that, of those adults aged 16-74 living in private households:

- about 6.5 million have a neurotic disorder;
- about 1.7 million have a personality disorder; and
- about 0.2 million have a probable psychotic disorder.[113]

However, these estimates should be treated with caution. There are numerous problems in trying to identify people who suffer from mental disorders from surveys. The comparative rarity of some disorders, particularly psychotic disorders, means that sample sizes are small and results are therefore subject to considerable uncertainty. In addition, the severity of some mental disorders means that a simple survey of private households is likely to give only a partial picture of prevalence. Many people with such disorders do not live in private households. Official surveys have therefore covered other settings where prevalence is thought to be higher: institutions, prisons and among the homeless.[114]

[112] ONS, *Psychiatric morbidity among adults living in private households, 2000*, 2001, Tables 2.9-2.11, 2.27: http://www.statistics.gov.uk/downloads/theme_health/psychmorb.pdf
[113] Based on Government Actuary Department population projections for 2007.
[114] http://www.data-archive.ac.uk/findingData/pmsTitles.asp

B. Patients detained under the Mental Health Act 1983

Table 1 shows that a total of 27,779 patients were admitted to NHS facilities and independent hospitals under the Mental Health Act 1983 and other legislation in England and Wales in 2005/06. Of these, 26,928 were under Part II of the Act; 1,758 were via court and prison disposals under the Act; and 93 were under other legislation.

Table 1: Formal admissions to NHS facilities (including high security psychiatric hospitals) and independent hospitals registered to detain patients under the Mental Health Act 1983 and other legislation: England & Wales 2005/06

	England	Wales	Total
Total formal admissions (excluding Place of Safety detentions)	27,353	1,426	28,779
Under Mental Health Act 1983:			
Part II patients: Total	25,618	1,310	26,928
2 (assessment with or without treatment)	15,265	736	16,001
3 (to hospital for treatment/from supervised discharge)	9,147	407	9,554
4 (for assessment in emergency)	1,206	67	1,273
Court and prison disposals: Total	1,664	94	1,758
35 (remanded to hospital for report)	132	7	139
36 (remanded to hospital for treatment)	17	-	17
37 (convicted person sent to hospital for treatment with section 41 restriction)	322	33	355
37 (convicted person sent to hospital for treatment without section 41 restriction)	322	21	343
45A (sentenced person given a hospital drection with section 41 restriction)	1	-	1
47 & 48 (prisoner transferred to hospital with section 49 restriction)	634	27	661
47 & 48 (prisoner transferred to hospital without section 49 restriction	70	6	76
Other sections - 38, 44, 46	166	-	166
Previous legislation (Fifth Schedule) & Other Acts	71	22	93

Sources: NHS Information Centre, I*npatients Formally Detained in Hospital under the Mental Health Act 1983, England: 2005-06* , 29 March 2007, Table 1
National Assembly for Wales, *Admission of Patients to Mental Health Facilities in Wales, 2005-06* , 18 October 2006, Table 4.1

C. Homicides committed by people with mental illness

Table 2 details the number of offences currently recorded as homicide in which the apparent circumstance has been classed as an “irrational act carried out by an apparently insane or disturbed subject”. Of the 748 homicides recorded in 2005/06, 25 were categorised in this way; down from 36 in 2004/05 and 40 in 2003/04.

Table 2: Offences currently[1] recorded as homicide where apparent primary circumstance is described as "irrational act carried out by an apparently insane or disturbed subject": England and Wales

	2001/02	2002/03	2003/04	2004/05	2005/06
Aquaintance					
Irrational act	21	29	26	26	14
Total	407	400	410	424	324
Stranger					
Irrational act	11	13	14	10	11
Total	396	552	378	369	422
All relationships					
Irrational act	32	42	40	36	25
Total	803	952	788	793	746

Note: [1] As at 9 October 2006; figures are subject to revision as cases are dealt with by the police and the courts, or as further information becomes available.
Source: Home Office Statistical Bulletin, H*omicides, Firearm Offences and Intimate Violence 2005/2006* , 25 January 2007, Table 1.06

However, as only one circumstance can be recorded per case, these figures do not include all those homicides committed by a suspect with mental health problems (for example, the principal apparent reason could be recorded on the database as arson or loss of temper). In addition, where no suspect has been found, it is not always possible to establish the circumstances in which a homicide was committed or the reason for its commission.

Table 3 details the offences carried out by restricted patients admitted to hospital under mental health legislation. In the calendar year 2004, 102 patients had been convicted of, or charged with, murder in England and Wales: a further 52 patients had been convicted of, or charged with, other homicide.

Table 3: Restricted patients admitted to hospital by offence: England and Wales

	2000	2001	2002	2003	2004
Violence against the person					
Murder	62	67	61	87	102
Other homicide	35	48	36	51	53
Other violence	221	236	248	260	323
Sexual offences	72	78	80	77	94
Burglary	85	67	60	74	88
Robbery	82	96	91	112	127
Theft and handling stolen goods	11	17	16	22	16
Fraud and forgery	2	-	5	-	1
Criminal damage					
Arson	82	90	86	99	116
Other	54	48	67	48	75
Other indictable offences and summary offences	262	241	253	255	325
All offences	968	988	1,003	1,079	1,320

Source: Home Office Statistical Bulletin, *Statistics of Mentally Disordered Offenders 2004* , 16 December 2005, Table 10

Table 4 shows the total population of restricted patients detained under mental health legislation in England and Wales, broken down by offence. As at 31 December 2004, 249 detained patients had been convicted of murder and a further 420 had been convicted of other homicide.

Table 4: Restricted patients detained in hospital by offence: England and Wales as at 31 December 2004

Violence against the person	
Murder	249
Other homicide	420
Other violence	944
Sexual offences	403
Burglary	85
Robbery	184
Theft and handling stolen goods	20
Fraud and forgery	-
Criminal damage	
Arson	429
Other	100
Other indictable offences and summary offences	445
All offences	3,279

Source: Home Office Statistical Bulletin, *Statistics of Mentally Disordered Offenders 2004* , 16 December 2005, Table 13

Further analysis of homicides carried out by people with mental disorders is provided in the University of Manchester's *National confidential inquiry into suicide and homicide by people with mental illness*.[115]

D. Assaults on NHS staff

Table 5 shows that there were 41,345 incidents of physical assault against NHS staff working in mental health and learning disability settings in 2005/06, representing 200 assaults per 1,000 staff members – a rate far exceeding any occurring elsewhere in the NHS.

Table 5: Number of reported physical assaults on NHS staff: England 2005/06

	Total assaults	Assaults per 1,000 staff
Mental health/learning disability trusts	41,345	200
Acute and foundation hospitals	11,100	15
Primary care trusts	5,145	15
Ambulance trusts	1,104	35
All NHS staff	58,695	43

Source: NHS Security Management Service, *Physical Assault Statistics 2005/06* , 1 November 2006

[115] The University of Manchester, *Avoidable deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness*, December 2006:
http://www.medicine.manchester.ac.uk/suicideprevention/nci/Useful/avoidable_deaths_full_report.pdf