The Mental Health (Patients in the Community) Bill [Bill 122 of 1994/95]

Research Paper 95/71

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In August 1993, the Health Secretary, Mrs. Bottomley, announced her intention to introduce the power of "supervised discharge" for certain patients discharged from detention under the *Mental Health Act 1983*. Part I of this Research Paper gives the background to the announcement while Parts II and III discuss the provisions of the *Mental Health (Patients in the Community) Bill* which both introduces the power of supervised discharge and amends the current provisions covering absence from hospital. Although an analysis of the successes and failures of the policy of care in the community for people with mental health problems is beyond the scope of this paper, the appendix summarises briefly some of the recent reports on this subject.

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Introduction

The current legislation governing the care of people suffering from mental disorder is found in the *Mental Health Act 1983* for England and Wales and the *Mental Health (Scotland) Act 1984* for Scotland. Both Acts, in prescribed circumstances, allow for the compulsory detention and treatment in hospital of people suffering from mental disorder, and make provision for patients' discharge and their subsequent after-care in the community. The Acts also give the Mental Health Act Commission (in England and Wales) and the Mental Welfare Commission (in Scotland) the duty of overseeing the welfare of detained patients.

Following concern that a certain number of patients relapse very quickly after their discharge from detention under the 1983 or 1984 Act, the Government has proposed a new power of "supervised discharge" which aims to ensure that vulnerable discharged patients remain in touch with mental health services in the community. This paper looks first at the background to this decision, including a discussion of alternative proposals put forward by the Royal College of Psychiatrists and a description of other measures which have been taken over the past 18 months with the aim of preventing discharged patients from "slipping through the net". It then summarises the Bill's provisions clause by clause and considers some of the arguments put forward during the Bill's passage through the Lords.

Part I Background

A Mental health patients in the community: is a change in the law necessary?

Considerable public and media concern has been generated recently by a number of violent incidents involving mental health patients. Two well publicised examples are the killing of Jonathan Zito by Christopher Clunis, a discharged psychiatric patient, on 17 December 1992, and the incident two weeks later when Mr. Ben Silcock, a sufferer from schizophrenia, climbed into the lions' enclosure at London zoo and was injured by a lioness. This apparent failure in some cases to provide adequate care and supervision in the community for people with mental health problems has led to concerns both for the safety of the individual suffering from mental illness and for the safety of the general public. However, although it is incidents such as these which have generated the recent public debate on how well "community care" is working for those with mental health problems, the professional debate on how to deal with "revolving door patients" (those who are treated with apparent success in hospital, but who relapse once they are back in the community and have to be compulsorily readmitted) has been in existence for a long time.

The *Mental Health Act 1983* is primarily concerned with patients who need to be detained for treatment in a hospital, but even at the time the Act was passed, those detained under its provisions formed only a small minority of all in-patients, and an even smaller minority of all those suffering from mental illness[1]. Between 1981 and 1991, in line with the policy of caring for people wherever possible in the community, the number of mental illness beds in hospitals in England fell from 85,000 to 50,000 while in the same period day hospital places increased from 15,300 to 22,500[2]. Given this shift in emphasis from hospital care to care in the community, it is perhaps not surprising that a need has been felt for some sort of legal measure to oblige patients to follow a treatment plan in the community. Proposals for compulsory supervision or treatment in the community have been made by organisations such as the British Association of Social Workers (1979) and the Royal College of Psychiatrists (1987), but were not found to be generally acceptable.

The Royal College of Psychiatrists published a new set of proposals on 12 January 1993, putting forward the idea of "community supervision orders" or CSOs. According to these proposals, patients who have been detained under section 3 or section 37 of the Mental Health Act could later be subject to compulsory supervision in the community. CSOs would only

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[1]Dept of Health, "*Legal powers on the care of mentally ill people in the community: report of the internal review*", August 1993, p.5

[2]Dept of Health, op cit, p.16

apply to patients who agreed in advance to accept treatment and supervision; if the terms of the order were broken, the patient could be recalled to hospital for treatment. In the first half of 1993, the Health Select Committee considered the merits of CSOs, with particular reference to the Royal College's recommendations, and decided that they were "fundamentally flawed". The Committee felt that the idea of the patient "consenting" in advance to a CSO raised too many ethical questions: "consent under the threat of duress cannot be judged to be true consent ... Effectively a patient is being invited to sign away their right to refuse medication or other treatment at that time and in the future"[3]. The Committee also expressed concern that the Royal College's proposal was centred too heavily on the use of medication as treatment: "we believe that to enthrone compulsory medication by statute to this central position raises grave doubts about the right the state has to control the bodies of its citizens".

At the time of the incidents involving Ben Silcock and Christopher Clunis, the Department of Health was already considering the need for "a community supervision order or some other measure" to safeguard people with a serious mental disorder living in the community.[4] On 13 January 1993, Mrs Bottomley announced a review of the legal powers covering mentally ill people. Department of Health officials were asked to look at whether new legal powers were required to ensure that people with mental health problems, living in the community, got the care they needed and whether the legal powers currently available were being used to their best effect. In particular, they were asked to consider these issues in the light of the Royal College's proposals for CSOs which had been published the day before.

This internal review team published its report[5] in August and, like the Health Select Committee, it had doubts over CSOs. It expressed concern that the proposed grounds for recall to hospital appeared to "set a lower threshold for compulsory admission to and detention in hospital than the present sections 2 and 3 of the 1983 Act (otherwise new grounds would presumably not be needed)" and that such a provision might contravene the UK's obligations under the European Convention on Human Rights[6]. In considering the use of existing powers, the review team looked particularly at the power of "guardianship", under which a person's guardian (usually the local authority social services department, although it can also be a private individual) can require them to live in a specified place, attend for medical treatment, occupation, education or training and give access to a doctor, approved social worker or other person. (It should be noted that a guardian can require the patient to "attend for treatment" but cannot actually require them to accept the treatment.) Guardianship is currently relatively little used and the review team, commenting that the reasons for this were unclear, stated that they would like to see "active consideration" given to its wider use.

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[3]Health Select Committee, "*Community supervision orders*", HC 667-I 1992/93 p.v

[4]Health Select Committee, op cit, p.xxii

[5]Dept of Health, "*Legal powers on the care of mentally ill people in the community*", August 1993

[6]Dept of Health, op cit, p.27

However, they did not see the greater use of guardianship, even with extended powers, as being an alternative to a new power, stating:

> "But we cannot see guardianship offering a ready answer to the problems of the patients with whom we have been concerned. They are, in particular, a group whose *health* care needs are of central importance, and this suggests that local authorities may not be best placed (and may find it difficult) to take the lead in their care."[7]

Concluding that existing powers, even if used to their full extent, were not fully adequate to deal with "revolving door" patients, the review team went on to recommend two different changes to the Mental Health Act: the extension of the authorised leave of absence from detention from six months to one year (which would involve amending section 17 of the Act) and a new power of "supervised discharge".

As a result of the internal review, on 12 August 1993, Mrs. Bottomley announced a "ten-point plan" for developing successful and safe community care. The first point on the plan included the review team's proposals: the new power of "supervised discharge" and the extension from six months to one year for the period during which patients given "extended leave" under existing arrangements can be recalled to hospital. The full ten points are:

> "1. Strengthened powers to supervise the care of patients detained under the 1983 Mental Health Act who need special support after they leave hospital. These comprise:
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> (a) the new power of supervised discharge; and
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> (b) extending from six months to one year the period during which patients given extended leave under existing arrangements can be recalled to hospital.
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> 2. Publication of the Department of Health team's report of its review of the 1983 Mental Health Act.
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> 3. Publication of an improved version of the Code of Practice, which spells out clearly the criteria for compulsory admission under the 1983 Act.
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> 4. Fresh guidance to ensure that psychiatric patients are not discharged from hospital inappropriately, and that those who leave get the right support from the different agencies.

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[7]Dept of Health, op cit, p.25

5. Better training for key workers in their duties under the care programme approach, including the new Code of Practice and the new guidance.

6. Encouraging the development of better information systems, including special supervision registers of patients who may be most at risk and need most support.

7. A review by the Clinical Standards Advisory Group [CSAG] of standards of care for people with schizophrenia.

8. An agreed work programme for the Government's Mental Health Task Force, which supports health authorities in moving to locally-based care.

9. Ensuring the health authority and GP fund-holder purchasing plans cover the essential needs for mental health services.

10. The London Implementation Group [LIG] will take forward an action programme to help improve mental health services in the capital, identifying and spreading best practice."[8]

Primary legislation is needed for the new power of supervised discharge and for the extension of the period under section 17 of the 1983 Act that a patient is granted leave of absence from hospital while still being liable to detention. Other elements of the ten point plan, such as the guidance on discharge from hospital and the introduction of supervision registers, do not require changes in primary legislation and have already been implemented. Below, more detail is given on the main parts of the plan, together with the proposal, announced separately, to amend section 18(4) of the 1983 Act.

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[8]Dept of Health press notice, 93/908, 12 August 1993

B Supervised discharge

In the press notice announcing the plan[9], Mrs. Bottomley described the power as follows:

> "Under supervised discharge, patients would be subject to conditions, including a treatment plan negotiated with them and their carers, and a requirement to attend for treatment. A named key worker would be immediately responsible for that patient's care. He or she must ensure that the procedures agreed in advance are followed and that decisive action is taken if the patient does not co-operate.
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> The right would exist for the patient to appeal against the conditions of his or her discharge to a Mental Health Review Tribunal. However, as with all community care, patients and their carers must - and will - be closely involved with determining their treatment plan. What is important is that patients and their carers are clear about what their treatment in the community involves.
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> Failure to comply with the conditions would lead to an immediate review of the case. If necessary, the patient could be recalled to hospital under the existing provisions of the Mental Health Act."

The review team's report emphasises strongly that the use of a power such as supervised discharge must be considered in the general context of the services available. It makes clear that a supervised discharge order should be part of a multidisciplinary approach to care, should support a programme of treatment negotiated with the patient and should not unnecesssarily limit the patient's freedom of choice. It should also be very carefully defined and applied so that orders are not applied unnecessarily, do not discriminate against particular ethnic groups and specific orders are as unrestrictive as possible for the individual. In particular, the review team states the need to acknowledge that if an order is in force, then there should be a moral obligation towards that patient to ensure adequate services to support them:

> "It must be recognised that the use of the power implies a reciprocal obligation on the statutory services to provide the support the patient needs."[10]

The review team envisaged that around 3,000 people a year might be considered suitable for supervised discharge.[11]

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[9]Dept of Health press notice, 93/908, 12 August 1993

[10]Dept of Health, "*Legal powers on the care of mentally ill people in the community*", August 1993, p.26

[11]Dept of Health, op cit, p.9

C Extending the period for which detained patients can have leave

Under section 17 of the 1983 Act, a patient who is liable to be detained in hospital can be given leave of absence for up to six months. At any point during this six months, the medical officer responsible for the patient's care (the "responsible medical officer" or RMO) can recall the patient to hospital if they believe that this is necesssary for the patient's health or safety or for the protection of other people. After a patient has been on authorised leave in this way for more than six months, they are no longer liable to recall, and could only be detained in hospital again if a fresh application is made under the appropriate section of the Act. The proposal made by the review team, and accepted by Mrs. Bottomley in her ten point plan, is that this period should be extended up to a year. The review team also recommended that patients given leave in this way should be subject to the "Care Programme Approach". This approach, introduced on 1 April 1991, requires health and social services authorities to draw up individual care programmes both for all in-patients who are being discharged from mental illness hospitals and for all new patients accepted by the specialist psychiatric services. These programmes should include suitable arrangements for meeting the patient's health, social care and accommodation needs, together with the appointment of a "key worker" to keep in close touch with the patient and monitor their treatment.[12]

D Guidance on discharge

On 12 January 1994, Mrs. Bottomley issued for consultation draft guidance on the discharge of mentally disordered people from hospital. The final version of the circular, "Guidance on the discharge of mentally disordered people and their continuing care in the community"[13] was issued on 12 May. This guidance makes clear that those discharging a patient have the duty to consider both the safety of the patient and the protection of other people, stating that:

> "This guidance seeks to ensure:
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> - that psychiatric patients are discharged only when and if they are ready to leave hospital
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> - that any risk to the public or to patients themselves is minimal and is managed effectively
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> - that when patients are discharged they get the support and supervision they need from the responsible agencies."

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[12]Details of the Care Programme Approach are given in the Dept of Health circular HC(90)23

[13]Dept of Health circular HSG(94)27

The circular states explictly that "no patient should be discharged from hospital unless and until those taking the decision are satisfied that he or she can live safely in the community and that proper treatment, supervision, support and care are available" and goes on to remind health authorities of existing guidance on hospital discharge. The "care programme approach" (see above) should be applied to all mentally ill people, and health and local authorities have a further statutory duty, under section 117 of the 1983 Act, to provide after-care services for patients who have been detained in hospital under section 3 (detention for treatment) or section 37 (detention in hospital on the order of a court). The circular gives advice on assessing the risk posed by potentially violent patients when considering whether they could be discharged, and also includes information about supervised discharge and supervision registers.

The announcement of the new guidance was greeted with some scepticism by groups representing mentally ill people who felt that it would have little effect if the pressure on hospital beds did not ease. The National Schizophrenia Fellowship dismissed it as "a waste of time given the run-down of hospital beds. The number of available beds often determines the length of stay in hospital".[14] In a similar vein, Marjorie Wallace, chief executive of the mental health organisation SANE, is quoted as saying that the new measures would help "only if the Government halted or reversed its programme for closing psychiatric beds and hospitals".[15] The Health Select Committee, which reported before the final version of the guidance was produced, welcomed the draft guidance, but went on to say that "it is quite clear that the draft guidance by itself will not be sufficient to deal with these problems". It recommended that:

> "the Department of Health offer specific instructions to purchasers of mental health services to require providers fully to implement within a period of one year: the Care Programme Approach; adequate hospital discharge procedures; clear local operational policies on the management of acute beds; and annual reports by providers on the numbers of service contacts by patients with serious mental ilness and by other patients."[16]

A further concern about the guidance was expressed by Dr. Nigel Eastman of St. George's Hospital Medical School at a recent conference on mental health law.[17] He suggested that there was a lack of congruence between the guidance on discharge and the criteria which

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[14]National Schizophrenia Fellowship, 7th Parliamentary Briefing, January 1994

[15]"Rules for Care in Community tightened", *The Guardian*, 13 Jan 1994, p.10

[16]Health Select Committee, "*Better off in the community? The care of people who are seriously mentally ill*", HC 102-1, 1993/94, p.xiii

[17] IBC Legal Studies and Services Ltd in association with the Law Society's Mental Health & Disability Committee, "*Mental health law: discharge from hospital and care in the community for mentally ill people: conference documentation*", 11 November 1994

Mental Health Review Tribunals [MHRTs] must follow when considering whether to discharge a patient. Under section 72(1) of the *Mental Health Act 1983*, MHRTs *have* to discharge patients if they are no longer suffering from a disorder to the degree that detention in hospital for medical treatment is necessary, or if it is no longer necessary for their own health or safety or for the protection of other people that they should receive such treatment. Dr. Eastman therefore foresaw circumstances when a MHRT would have to discharge a patient because one of these criteria was met, even if appropriate support and supervision from the "responsible agencies" in the community were not forthcoming.

E Supervision registers

Guidance on the introduction of supervision registers was issued on 16 February 1994, with the aim of making it easier for staff to keep track of discharged patients.[18] The guidance requires health authorities to introduce registers which identify those mental health patients who might be at a significant risk of harming themselves or others in some foreseeable circumstance (for example if they were to cease to take medication, or if a relationship were to break up). Such factors should be noted on the register, so that professional staff caring for that person would be able to spot the warning signs in advance of a relapse. Further guidance on registers, including advice on which patients should be included, was published on 10 October, within a draft guide on interagency co-operation between those working in the mental health field.[19]

Since the guidance on supervision registers was issued, some professional and voluntary sector organisations, such as the Royal College of Psychiatrists and the charity MIND, have expressed concern about the civil liberties implications of such registers. According to press reports, MIND are concerned both at the potential cost of the registers (which they and the Royal College of Psychiatrists estimate at £77 million) and at the possible breaches of patient confidentiality which could follow from them.[20] They also commented that the money spent on introducing registers "would be better spent on community care".[21] Fiona Caldicott, the president of the Royal College of Psychiatrists, stated that the criteria for inclusion on the register were too broad and the numbers of patients involved would be considerably higher than intended.[22] After the further guidance was issued in October, the registrar of the Royal College was quoted as saying: "We cannot see how they are going to protect the public ...

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[18]Dept of Health circular HSG(94)5, "*Introduction of supervision registers for mentally ill people from 1 April 1994*"

[19]Dept of Health, "*Guide to arrangements for inter-agency co-operation for the protection of severely mentally ill people"*, 1994

[20]"Hospitals jib at registering discharged mental patients", *The Guardian*, 14 July 1994, p.2

[21]"Scrap registers for the mentally ill, says lobby", *Health Service Journal*, 13 October 1994, p.4

[22]"Fears over listing of mentally ill at risk", *The Independent*, 12 September 1994, p.5

You could say they will be a complete waste of time."[23] The National Schizophrenia Fellowship was more positive, but still expressed concerns at the cost: "Good in theory, but there are problems. This will cost money - no additional resources have been promised."[24]

In response to these criticisms, David King, the Leader of the Mental Health Task Force in the Department of Health, pointed out that:

> "The Government has never pretended that supervision registers on their own are a panacea for the problems of caring for severely mentally ill people in the community. Rather registers are a means by which services can identify the *most* in need and give them the appropriate priority for care and follow-up."[25]

There have been press reports suggesting that many health authorities have delayed introducing registers, despite the Department of Health deadline of 1 October 1994.[26] However, in the press notice launching the guide to inter-agency working, Mrs. Bottomley stated that "the vast majority" of health authorities have now introduced them.[27]

F Amendment of Section 18(4)

At present, under section 18(4) of the *Mental Health Act 1983*, someone detained under the Act (other than those detained under a "restricted" hospital order from a court) is no longer liable to detention if they go absent without leave for 28 days. This provision has its origins in the *Lunacy Act 1890* and was based on the principle that if a patient were able to cope outside hospital for 28 days, then they had been wrongly detained in the first place. On 16 March this year, the Parliamentary Under-Secretary for Health, Mr. Bowis, announced that the Department would be consulting on possible amendments for this provision. The discussion document produced by the Department states that:

> "On the face of it a provision which allows a patient who is lawfully detained under the Act to overturn its authority simply by walking out of the hospital and staying out for 28 days has little to commend it today. It dates from a period long before the introduction of modern forms of medication. It is possible for patients treated with long-acting phenothiazines to remain in

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[23]"Scrap registers for mentally ill, say psychiatrists", *The Daily Telegraph*, 11 October 1994, p.14

[24]National Schizophrenia Fellowship, 7th Parliamentary Briefing, January 1994

[25]"Reasons to register mentally ill", Letter to *The Independent*, 15 October 1994, p.12

[26]for example, "Mental register plan is delayed", *The Guardian*, 10 October 1994, p.2

[27]Dept of Health press notice 94/454, 9 October 1994

> remission for 28 days or even longer. In the case of patients subject to hospital orders there is understandable public concern at their being able to frustrate the intentions of the court."[28]

The paper goes on to suggest four possible ways in which the Act could be amended, all based on the assumption that although the 28 day rule is unsatisfactory, there should still be some finite limit on the liability of an absent patient to be returned to hospital. The four options outlined in the paper are as follows:

- **"Option 1**

> Allow patients to be returned at any time up to the end of the current period of detention, or 28 days after absconding, whichever is the later. As a variant of this it would be possible to consider adopting a period other than 28 days.

- **Option 2**

> As in option 1, but with a proviso that if the patient were returned more than 28 days (or other specified period) after absconding the responsible medical office would have to reassess his or her detention in the way provided by section 20(3). The authority for detention would then lapse unless the conditions of section 20(4) were met. A period of a week (after the patient's return) could be provided for carrying out the assessment, in line with the existing section 21.
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> [Sections 20(3) and 20(4) require the responsible medical officer, towards the end of a patient's period of detention, to consider whether the period of detention needs to be renewed.]

- **Option 3**

> As in option 2, a patient who was returned more than 28 days after going absent could then be detained for reassessment, but any further detention would have to follow the same procedure as for someone admitted from the community. That is, there would have to be a fresh application made in accordance with section 2 or 3 by an approved social worker supported by the two required medical recommendations (the period allowed for assessment might need to be longer than the week proposed under option 2).

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[28]Deposited paper No. 10781

- **Option 4**

  Remove the 28-day time limit only for patients detained under a hospital order (following option 1, 2 or 3), keeping the present position for those detained under section 3 [that is, "civil" patients, as opposed to those detained under an order from a court]. This would reflect the particular concern recorded in the above discussion about patients being able to frustrate the intentions of the court."[29]

The discussion paper invited comments on these options, or on any other possible alternatives.

[29]Deposited Paper No. 10781

Part II The Bill

The *Mental Health (Patients in the Community) Bill*[30] was introduced into the House of Lords on 15 February 1995. Its Second Reading was on 16 March 1995, the Committee Stage on 4 and 6 April 1995, the Report Stage on 1 May 1995 and the Third Reading on 11 May 1995. An informal meeting between the Department of Health and peers was also held between the Second Reading and the Committee Stage, but a public record of the proceedings is not available. The Bill was read for the first time in the Commons on 11 May and published as HL Bill 122; at the time of writing no date has yet been set for Second Reading in the Commons.

The Bill covers three main issues: the introduction of a power of "supervised discharge"; the extension from six months to one year of the period during which patients given leave can be recalled to hospital (or, in the case of Scotland, the *reduction* to 12 months of the period during which patients may be recalled); and the amendment of the provision under which the power to detain patients lapses if they have been absent without leave for more than 28 days. As the provisions vary to some degree between England and Wales and Scotland, they have been summarised separately, with amendments introduced during the Lords stages highlighted in bold.

A England and Wales

1. Supervised discharge or "after-care under supervision"

Clause 1 of the Bill would introduce the concept of "after-care under supervision". The mechanism for introducing after-care under supervision would consist in inserting additional sections into the *Mental Health Act 1983* as sections 25A-J.

The proposed **section 25A** sets out who will be liable to receive after-care under supervision and broadly what "after-care under supervision" means. A patient who is liable to be detained for treatment under section 3 of the 1983 Act and who is over the age of 16 could be liable to be supervised under this section if:

> "(a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment;

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[30]HL Bill 31 of 1994/95

> (b) there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons, or of the patient being seriously exploited, if he were not to receive the after-care services to be provided for him under section 117 below after he leaves hospital; and
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> (c) his being subject to after-care under supervision is likely to help him to secure that he receives the after-care services to be so provided." [s.25A(4)]

Section 117 of the 1983 Act requires District Health Authorities[31] and social services departments to provide after-care services for individuals discharged from detention in hospital; the new power of "after-care under supervision" is therefore closely tied in with current duties to provide services.

Under paragraph 6 of Schedule 1 to the Bill, after-care under supervision could also apply to patients detained under section 37 (ie those detained under a hospital order from a court) and section 47 (those transferred from prison to hospital) of the 1983 Act. It does not apply to "restricted" patients, that is those under a hospital order or transfer order who are also subject to special restrictions. Nor can voluntary patients be subject to after-care under supervision. However, a Government amendment at the Report stage in the Lords clarified that **patients granted leave of absence from hospital under section 17 of the 1983 Act could be made subject to after-care under supervision once their liability to detention ended** [s.25A(9)].

Section 25A also sets out who will make the application for after-care under supervision (the "responsible medical officer" in charge of the patient's treatment while detained under the 1983 Act) and to whom it will be made (the Health Authority who will be responsible for providing the section 117 after-care services). Once a Health Authority has accepted a supervision application, it must inform the patient, any informal carer and **(**unless the patient has requested otherwise) the patient's nearest relative. **The patient must be informed both orally and in writing, and the information must include, in particular, what rights the patient has to apply to a Mental Health Review Tribunal; the nearest relative must also be informed in writing.** The way in which the informal carer should be informed is not specified.

Section 25B sets out in some detail how an application for after-care under supervision (known as a "supervision application") should be made. The patient, one or more people professionally concerned with the patient's medical treatment in hospital (for example a

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[31]"District Health Authorities" should become "Health Authorities" from April 1996, under the provisions of the Health Authorities Bill presently proceeding through Parliament; the term Health Authority is therefore used in the actual text of this Bill.

nurse), one or more people who will be professionally concerned with the after-care services (for example a social worker), any informal carer likely to be involved in looking after the patient **and (unless the patient requests otherwise) the patient's nearest relative** must be consulted before the application is made. The application must be supported by the recommendation of another doctor and of an approved social worker. It must include details of the after-care services to be provided under section 117, details of the requirements to be imposed on the patient (details of the possible requirements being set out in section 25D) and written statements both from the doctor who will be responsible for the patient after s/he leaves hospital (the "community responsible medical officer") and from the "supervisor" who will ensure that the patient receives the after-care services. Definitions of "community responsible medical officer" and "supervisor" are given in paragraph 4 of Schedule 1 of the Bill. When the responsible medical officer makes the application, again the patient, any informal carer and (unless the patient requests otherwise) the patient's nearest relative must be informed; **the patient should be informed both orally and in writing and the nearest relative should be informed in writing.**

Section 25C makes supplementary provisions for supervision applications, including the requirement that the responsible medical officer and the doctor supporting the application must agree on the kind of mental disorder from which the patient is suffering, and the power of the supporting doctor and approved social worker to visit the patient and to inspect their records when deciding whether to recommend after-care under supervision.

Section 25D defines the powers which the "responsible after-care bodies" (that is the Health Authority and social services authority responsible for providing after-care services) have to ensure that after-care services are indeed received by the patient. These powers include requiring the patient to live in a specified place, to attend specified places at specified times for medical treatment, occupation, education or training, and to allow access to the supervisor, doctor, approved social worker or other persons authorised by the supervisor. They also enable the supervisor to authorise some-one to convey the patient to the place where they are required to live or attend. Although most of these powers are already available under the guardianship arrangements set out in sections 7-10 of the 1983 Act, the power to convey the patient, other than in a limited degree to the place where s/he is required to reside, is new. As mentioned earlier, under section 25B, the powers which will apply to the particular patient must be set out in the supervision application.

Section 25E allows for the review of the after-care services provided under supervision. Where a patient refuses to receive any or all of the services or does not comply with the requirements laid down by the after-care bodies, these services and requirements will be reviewed. The responsible bodies should also consider whether the patient should cease to be subject to after-care under supervision, or whether re-admission to hospital for treatment might be appropriate. In the latter case, an approved social worker should be informed. The Bill does *not* allow for any form of automatic re-admission to hospital, and so the normal

procedures for admission under the 1983 Act would be followed. If the services or requirements are to be modified in any way, the responsible bodies must first consult the patient, the informal carer and (unless the patient requests otherwise) the patient's nearest relative, and then inform them of any changes. They must also be informed if there is any change in the doctor in charge of the patient's treatment (the "community responsible medical officer") or the supervisor. Slight amendments were made to this section at the Report stage in the Lords **to allow modifications to be made to the after-care services before the patient leaves hospital, should this be deemed necessary**. In cases such as these, the same process of consulting and informing the appropriate people would be followed as in cases where the services are modified at a later stage. If at any stage the community responsible medical officer or supervisor changes, then the patient, any informal carer and (unless the patient requests otherwise) the nearest relative should be informed; **the patient must be informed both orally and in writing and the nearest relative must be informed in writing**.

Section 25F allows the community responsible medical officer to make a report to the Health Authority if s/he believes that the patient is suffering from a form of mental disorder different from that specified on the supervision application. The supervision application will then have effect as if the latter form of mental disorder were originally specified in it. Before making a report of this kind, the community responsible medical officer must consult another medical practitioner concerned with the patient's treatment, unless there is no such practitioner. If the report is made, the patient and (unless the patient requests otherwise) the nearest relative should be informed, **with the same requirements as to information in writing as in earlier sections**.

Section 25G sets out the duration of after-care under supervision. Initially this will be for six months from the date when the Health Authority accepts the supervision application. The period of supervision can then be renewed for a further six months and then for one year at a time. The section also sets out the procedures for renewal: within two months of the date when supervision would otherwise end, the community responsible medical officer must examine the patient, and if the patient still meets the necessary criteria, must supply a report to the after-care bodies. The period of supervision will then be renewed. Before supplying the report, the community responsible medical officer must consult the patient, the supervisor, other people concerned in the patient's care on a professional basis, any informal carer **and (unless the patient requests otherwise) the nearest relative**. If after-care under supervision is to be renewed, then the patient, informal carer and (unless the patient requests otherwise) the nearest relative must be informed; **the patient must be informed orally and in writing, including, in particular, what rights s/he has to apply to a Mental Health Review Tribunal, and the nearest relative must be informed in writing.**

Section 25H covers the ending of after-care under supervision. The community responsible medical officer may put an end to supervision at any time. Before doing so, however, s/he must consult the patient, the supervisor, other people concerned professionally with the patient's care, any informal carer and **(unless the patient requests otherwise) the nearest relative**. Patients will also cease to be subject to supervision if they are received into guardianship or if they admitted into hospital under the 1983 Act, other than under an emergency application. Where after-care under supervision has come to an end, the patient, informal carer and (unless the patient requests otherwise) the nearest relative should be informed **with the same requirements as to information in writing as in earlier sections**.

Section 25I, covering patients subject to after-care under supervision who are detained in custody (ie in prison on remand or after conviction), was introduced at Third Reading in the Lords, although some of its provisions were earlier contained in section 25H. Where a patient is detained in custody, s/he remains technically subject to after-care under supervision but is not required to receive the after-care services provided under section 117 of the 1983 Act, and nor is s/he required to comply with the requirements stipulated in the supervision application (that is, living in a certain place, attending at specific places for treatment or occupation etc). I**f the patient is in custody for less than 6 months, but during that time, or within 28 days of being released, the period of after-care under supervision is due to come to an end, then the period can be extended to last until 28 days after release from custody. During this extension period, the community responsible medical officer can, if necessary, submit the reports required by section 25G to enable the period of after-care under supervision to be renewed.**

Section 25J, making provision for patients moving from Scotland to England or Wales, was also introduced during the Lords Third Reading. **Powers are given to the Secretary of State to make regulations modifying the provisions in sections 25A to 25I so that supervision applications can be made for patients subject to community care orders in Scotland. This will enable patients to move from Scotland to England or Wales while still remaining subject to the provisions of a community care order or after-care under supervision.**

Schedule 1 of the Bill, introduced by clause 1(2), expands the role of Mental Health Review Tribunals, to enable them to review cases of patients subject to after-care under supervision (para 7). Either the patient or the patient's nearest relative may make an application to the Tribunal, which is given the power to direct that the patient should not be subject to supervision. The Secretary of State may also refer a case to the Tribunal at any time (para 8). In cases where the patient has appealed to the Tribunal against detention under the Act and the Tribunal does not recommend that the patient should be discharged, it can recommend instead that the responsible medical officer should consider making a supervision application for the patient (para 10).

The Schedule also makes a number of consequential amendments to the 1983 Act. These include definitions of "community responsible medical officer" and "supervisor" which were amended at Report stage in the Lords: **the community responsible medical officer is required to be approved under section 12 of the 1983 Act as "having special experience in the diagnosis or treatment of mental disorder"; and, whilst the supervisor is not required to hold a specific professional qualification, the definition ensures that s/he is professionally concerned with the after-care services provided and is not, for example, the informal carer** [paras 4 & 15].

2. Absence without leave

Clause 2 of the Bill covers the absence without leave of patients detained in hospital or subject to guardianship under the 1983 Act. It would replace section 18(4) of the 1983 Act, according to which patients who go absent without leave for more than 28 days are no longer liable to detention, with a new section 18(4). Under this new section, patients can be taken into custody and returned to hospital or their place of guardianship, either within the six months from the first day of absence, or up to the end of the period of their detention, whichever is the longer.

Section 21 of the 1983 Act would also be replaced by new sections 21, 21A and 21B. These extend the patient's period of detention by up to one week after his/her return, in cases where less than a week of the original period of detention remains. During this extension, the responsible medical officer is able to examine the patient and if necessary arrange for the detention to be renewed. In cases where the patient has been absent for more than 28 days but more than one week of their period of detention remains, the responsible medical officer must reassess the patient to see if s/he should still be detained. If a report from the reponsible medical officer requesting renewal of the power to detain the patient is not made within a week of the patient's return from unauthorised absence, then the patient ceases to be liable for detention.

These provisions appear to match closely with option 2 outlined in the Department of Health's consultation paper on the amendment of section 18(4). The consultation paper is discussed earlier, on pages 10-12.

Other amendments to the 1983 Act, set out in clause 2 of this Bill, would include the right to appeal to the Mental Health Review Tribunal when the authority to detain a patient is renewed after his or her return from unauthorised leave.

3. Leave of absence from hospital

Under current provisions, where patients liable to be detained under the 1983 Act are given leave of absence, they can only be recalled to hospital within the first six months of their absence. **Clause 3** of the Bill would change this provision, so that no time limit for recall is stipulated. In practice, this would mean that patients could be recalled during a period of up to a year, as no authority to detain can last more than a year without renewal. The provisions for "restricted patients" who can only be granted leave of absence or discharged with the consent of the Secretary of State are slightly different; the power of the Home Secretary to recall the restricted patient at any time is unaffected, but an amendment introduced at the Committee Stage in the Lords **extends the power of the responsible medical officer to recall a restricted patient given leave by the Home Secretary from 6 months to 12 months** in line with the arrangements for non-restricted patients.

B Scotland

1. Community care orders

Clause 4 of the Bill would introduce the power of supervised discharge for Scotland; in this case the power is described as a "community care order". The clause would insert a number of new sections into the *Mental Health (Scotland) Act 1984* (cap 36) as sections 35A-35K. As shown below, the powers proposed in Scotland vary to some degree from those proposed for England and Wales.

Section 35A sets out how a responsible medical officer can apply to the sheriff for a "community care order" to be applied to a patient who has been subject to detention under the 1984 Act. An application for an order can be made for any patient liable to be detained under section 18 of the 1984 Act (that is "civil" patients); under paragraph 5 of Schedule 2 to the Bill, an order could also apply to "hospital order" patients (those detained under order from a court) or patients transferred from prison. However, as in England and Wales, orders cannot apply to patients diverted or transferred from hospital who are also subject to special restrictions. Nor can they apply to voluntary patients, to patients detained under the emergency provisions (s.24 of the 1984 Act) or to those detained under the short term provisions following an emergency admission (s.26 of the 1984 Act). The aim of the order is to ensure that, after discharge from hospital, the patient receives medical treatment together with the after-care services provided by the local authority under section 8 of the Act.

The application is made to the sheriff in the same way as for applications for admission and detention in hospital (as set down in sections 21 and 113 of the 1984 Act). The sheriff can

then decide to make the community care order subject to the conditions specified in the application, make the order subject to different conditions, or refuse the application altogether. The community care order must specify who will be the "special medical officer" in charge of the patient's medical treatment while the order is in force, the name of the "after-care officer" responsible for co-ordinating the provision of after-care services and the conditions to which the patient is to be subject. The sheriff can also defer making the order until satisfactory arrangements for medical treatment and after-care services for the patient have been made. Where the sheriff has not yet determined the order, or has deferred making it, the patient's liability to be detained can be extended until either the sheriff has refused the application or the community care order has come into force.

Once the order has been made, a copy should be sent within 7 days to the patient, the patient's nearest relative (unless the patient objects), the Mental Welfare Commission, the special medical officer and the after-care officer. It is the duty of the after-care officer to explain to the patient, both orally and in writing, the purpose and effect of the order, the patient's right of appeal to the sheriff under section 35F and the patient's right to make representations to the Mental Welfare Commission. The after-care officer should also send a copy of any written explanation to the nearest relative, unless the patient objects.

Section 35B sets out how the application for a community care order should be made. It requires certain individuals to be consulted by the responsible medical officer before making an application: the patient; **the patient's nearest relative (unless the patient objects)**; those principally involved in the patient's medical treatment in hospital; the proposed special medical officer and others who will be concerned in the patient's medical treatment after discharge; the proposed after-care officer; others likely to have a continuing professional involvement with the patient's after-care; and any informal carer. The application must include the conditions which the responsible medical officer thinks should be included in the order, the names of the special medical officer and the after-care officer, and the proposed period over which the order should have effect. This differs from the proposals for England and Wales, where the possible requirements which could be made on a person subject to after-care under supervision are listed in the proposed section 25D; the nature of the conditions which could be included in the Scottish community care order is *not* stipulated and is left for the sheriff to determine. In theory, this means that the order could include the provision that the patient must take their medication. In practice, however, there would be no mechanism for forcing the patient actually to do so; the patient could only be recalled to hospital for reassessment under section 35G if the appropriate conditions set out in that section were met. Before making the application, the responsible medical officer must also "take such steps as are reasonably practical" to inform the patient's nearest relative (unless the patient objects) of their right to be heard by the sheriff when the latter is considering the application.

The community care application must be accompanied by two medical recommendations and a report from the person who will be the after-care officer. The medical recommendations must state that the following conditions are met:

> "(a) that the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment, but that the grounds set out in section 17(1) of this Act for admission and detention in a hospital do not apply to the patient; and
>
> (b) that the patient requires to be subject to a community care order -
> (i) with a view to ensuring that he receives medical treatment and the after-care services to be provided for him under section 8 of this Act; and
> (ii) in the interests of his health or safety or with a view to the protection of other persons." [s.35B(7)]

The requirement was added at the Lords Report Stage that **the two medical recommendations must agree on the form of mental disorder (either mental illness or mental handicap) from which the patient is suffering.**

The after-care officer's report must give details of the patient's social circumstances, the after-care services to be provided and any care other than medical treatment or after-care services which will be arranged. It must also confirm the view expressed in the medical recommendations that the patient needs to be subject to an order to ensure that services are received and in the interests of his/her own health or safety or the protection of others.

Section 35C is concerned with the duration of a community care order. The original order can have effect for up to six months; it can then be renewed for a further six months and thereafter for a year at a time. The section also sets out how the process of renewal should be carried out. If the special medical officer considers that the conditions for a community care order are still met, s/he can renew the order by sending a report to the Mental Welfare Commission. Before doing so, the special medical officer must examine the patient and consult **the patient, the patient's nearest relative (unless the patient objects)**, the after-care officer, others professionally involved with the patient's care and any informal carer. If the order is to be renewed, the special medical officer must then notify the patient, the nearest relative (unless the patient objects) and the after-care officer. **The after-care officer is responsible for ensuring that the patient is informed (both orally and in writing) of the purpose and effect of the order, their right of appeal to the sheriff under section 35F and their right to make representations to the Mental Welfare Commission. The after-care officer should also send a copy of any written explanation to the nearest relative, unless the patient objects.**

Section 35D sets out how the community care order can be varied, either by adding further conditions, or removing or amending existing conditions. In order for the order to be varied, the special medical officer must consult the patient, **the patient's nearest relative (unless the patient objects)**, other people involved in their medical treatment, the after-care officer, others involved professionally in the patient's after-care, and any informal carer. The application is then made to the sheriff who has the power to approve it. Where the patient objects, the sheriff cannot approve the application without holding a hearing. If the variations are approved, the patient, **the nearest relative (unless the patient objects), the Mental Welfare Commission** and the patient's after-care officer must be informed. The same requirements about how the patient and their nearest relative should be informed apply as in section **35C** (see above).

Section 35E, covering the change of the special medical officer or after-care officer, was inserted at the Lords Report Stage. **Before there is any change in the special medical officer, the existing special medical officer must consult the patient, the patient's nearest relative (if the patient does not object), other persons involved in the patient's medical treatment, including the proposed new special medical officer, the after-care officer, others involved professionally with the patient's after-care and any informal carer. Similarly, if the after-care officer is to change, the current after-care officer must consult all these individuals, including, in this case, the proposed new after-care officer. Within seven days of the change, the patient, their nearest relative (unless the patient objects), the Mental Welfare Commission and the patient's after-care officer (or special medical officer, as appropriate) must be informed.**

Section 35F gives any patient subject to a renewed community care order the right to appeal to the sheriff for the order to be revoked (but there is no right of appeal during the first period of a community care order). If the sheriff is satisfied both that the patient no longer needs to be the subject of the order with a view to ensuring that medical treatment and after-care services are provided, and that the order is not necessary for the patient's health or safety or the protection of others, then s/he must revoke it. If the sheriff is not satisfied on both these counts, s/he will affirm the order with or without amendments.

Section 35G sets out the grounds on which a patient subject to a community care order may be recalled to hospital for reassessment. A patient can be admitted to hospital for up to 7 days if their special medical officer, after consultation, believes that their mental condition has deteriorated and is likely to "give grounds for serious concern" regarding their health or safety or the protection of others. The persons to be consulted are **the patient's nearest relative (unless the patient objects)**, others involved in the patient's medical care, the after-care officer, others professionally concerned with the after-care and any informal carer. Before the patient can be readmitted, both the special medical officer and another medical practitioner must examine the patient and agree that their mental disorder is such that it is appropriate for them to be admitted for assessment for at least a limited period and that detention in hospital

is necessary in the interests of their own health or safety or for the protection of others. The after-care officer must also consent to the patient's readmission. Details of the reports and the direction requiring the patient to be admitted to hospital should be sent to the nearest relative (unless the patient objects), the Mental Welfare Commission, the managers of the hospital and the after-care officer. Following an amendment at the Lords Report Stage, **this provision cannot immediately be re-used**; if further detention is required after 7 days, then an application to the sheriff must be made for detention under the existing provisions of section 18 of the 1984 Act.

Section 35H makes further provisions for the patient's reassessment. Where a patient is detained in hospital under section 35G, both the responsible medical officer and another medical practitioner (at least one of whom must be approved as having special experience in mental disorder) must examine the patient and submit a report. Copies of the reports must be sent to the Mental Welfare Commission. If the reports conclude that the criteria for a community care order are met (ie those set out in section 35B(7) of the Act), then the patient must be discharged again as soon as possible, subject to the same community care order as before. Where, however, the reports conclude that the necessary criteria for admission to hospital are met (ie those set out in section 17(1) of the 1984 Act), then an application to the sheriff for admission to hospital should be made. When such an application is made, the patient may be detained for up to a further 21 days, pending the sheriff's decision. Within the 7 days specified in section 35G(7), either the patient must be discharged, or an application must be made to the sheriff for their admission to hospital. Otherwise the patient will cease to be liable either to be detained in hospital or subject to a community care order. Likewise, if the sheriff has not approved the application for admission within the 21 days, the patient will cease to be liable either to be detained or to be subject to a community care order.

Section 35I allows the special medical officer, after consultation, to revoke the community care order at any time. The persons to be consulted are **the patient, the nearest relative (if the patient does not object)**, other persons involved in the medical treatment, the after-care officer, others professionally involved in the after-care and any informal carer. Before revoking the order, the special medical officer must be satisfied both that the order is not necessary to ensure that the patient receives medical treatment and after-care services and that the patient does not need to be subject to the order in the interests of their own health or safety or for the protection of others. The Mental Welfare Commission is also empowered to revoke the order if they are similarly satisfied; unlike the special medical officer, they are not required to consult anyone before doing so.

Section 35J, covering patients subject to a community care order who are detained in custody (ie in prison on remand or after conviction), was introduced in the Lords Third Reading. **While the patient is detained in custody, the period of the community care order will continue to run, but the conditions stipulated in the order will not apply. If the patient is in custody for less than 6 months, but during that time (or within 28 days of being**

released) the period of after-care under supervision is due to come to an end, then the period can be extended to last until 28 days after release from custody. During this extension period, the community responsible medical officer can, if necessary, submit the reports required by section 35C to enable the period of after-care under supervision to be renewed.

Section 35K, making provision for patients subject to aftercare under supervision in England or Wales, was also introduced at Third Reading in the Lords. **A community care application may be made in respect of a patient who is subject to after-care under supervision in England or Wales and who wishes to move to Scotland; the Secretary of State is empowered to make regulations determining how the provisions in section 35A to 35J should be modified for this purpose.**

Clause 4 would also introduce **Schedule 2** to the Bill which makes consequential amendments to the 1984 Act. These include extending the protective duties of the Mental Welfare Commission for Scotland to cover patients subject to community care orders.

2. Absence without leave

Clause 5 of the Bill seeks to amend the provisions in the 1984 Act for patients going absent without leave either from hospital or from guardianship in Scotland. They closely mirror the proposals for England and Wales, set out in clause 2.

3. Leave of absence from hospital

Clause 6 would amend section 27 of the 1984 Act which allows the responsible medical officer to grant leave of absence to a patient for specified periods of not more than 6 months. At present, there is no limit on the number of consecutive periods of leave which can be given, so in practice leave can be granted on an open-ended basis. Under the amendment, the total period of leave of absence granted should not exceed 12 months.

Clause 7 give the short title, commencement date (**which was changed from 1 January 1995 to 1 April 1996 at Report stage**) and extent.

Part III Comments on the Bill

This section will first look at the general reactions to the proposals in the Bill, both from political parties and from groups representing patients and professionals concerned with mental health, and will then go on to consider the more detailed critiques. Criticisms or suggestions which have been accepted by the Government, with amendments subsequently passed during the Lords stages, are covered in Part C of this section.

A General responses

The aims of the Bill were set out by the Parliamentary Under-Secretary of State for Health, Baroness Cumberlege, in the Second Reading debate on the Bill in the Lords:

> "There is a very small minority of severely mentally ill people who on discharge from hospital fail to take their medication or comply with agreements reached in terms of their continuing care. Then they can become a risk to themselves, their families and the public. That risk is not acceptable and policy and practice have to work to minimise it. The Government have brought forward this Bill to address this important issue."[32]

Neither Labour nor the Liberal Democrats have expressed opposition to the principles behind the Bill, although spokespersons for both parties made it clear that the details would be closely scrutinised. In the debate in the Commons on the Queen's Speech, Labour health spokesperson, Margaret Beckett, stated that:

> "We shall also want to give much thought and scrutiny to the Government's proposals for supervision orders for the small number of patients whose violent behaviour makes them a danger to the public. That is a proposal about which, as the Secretary of State will know, those in the field are expressing considerable anxiety.
>
> Our concern will be not just for the specific proposals in the legislation, but for the background against which they will be implemented ... I give the Secretary of State fair warning: while we will look constructively at whatever proposals the Government make, we shall expect and demand evidence that,

[32]HL Deb, 16 March 1995, c.934

> outside the legislation itself, the Government are taking action to address the issues."[33]

Baroness Robson of Kiddington, Liberal Democrat spokesperson for health in the Lords, welcomed the Bill, though not without reservations:

> "We on these Benches very much welcome the aims of the present Bill. We are pleased that the Government have recognised the need for reform of the current Mental Health Act. But that does not by any means mean that we approve of every detail of the Bill. We have deep reservations about many of its details. However, it gives us the opportunity to discuss the problem in detail and we hope to improve the Bill by introducing amendments at a later stage."[34]

The responses to the announcement of legislation from organisations representing users and providers of mental health services have been more mixed. The Royal College of Psychiatrists and the mental health organisations SANE and the National Schizophrenia Fellowship [NSF] all welcomed the Bill in principle. SANE described the proposals as "a step in the right direction" while regretting that supervised discharge would only be available to a limited number of those suffering from severe mental illness[35]; the Royal College welcomed the proposed new power though expressing the view that "legal powers can never be a substitute for properly planned and delivered services"[36] and NSF "supported the Bill in principle" while expressing specific concerns over funding and the position of "nearest relatives"[37].

Other organisations, however, have either expressed opposition to the principles behind the Bill or stated that the powers proposed will not solve the problems identified. The mental health charity MIND has stated that it "rejects any proposal for new powers over mentally ill people discharged from hospital into the community"; it believes that the proposed powers would operate in a discriminatory way, increase stigma, increase pressure on people to take potentially dangerous medication and undermine relationships between patients and carers[38]. The Royal College of Nurses has stated that the Bill "offers false reassurance to patients and the public" and "risks driving patients away for fear of being forced to comply with

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[33]HC Deb, 22 November 1994, cc 480-481

[34]HL Deb, 16 March 1995, c.944

[35]SANE press notice 16 November 1994

[36]Royal College of Psychiatrists press notice, November 1994

[37]NSF briefing, 1 April 1995

[38]MIND press notice, 15 November 1994

unacceptable treatment regimes"[39]. On the Scottish part of the Bill, the National Schizophrenia Fellowship (Scotland) says that "the proposals in the Bill should be dropped" and that "they do nothing for the safe care of individuals with chronic psychotic illnesses such as schizophrenia"[40]. The Scottish Association for Mental Health feels that the legal changes proposed "are not an adequate response to the needs of seriously mentally ill people living in the community" and that there is a need for research into good practice in this area to be commissioned[41].

B Detailed critiques

1. The relationship between after-care under supervision and guardianship

One of the first criticisms made by Baroness Jay, speaking for Labour in the Second Reading in the Lords, was that the Bill appeared to offer very little that was not already available under the guardianship provisions of the *Mental Health Act 1983*. She suggested that, apart from the power to "take and convey", existing guardianship orders could achieve the same results as the proposed after-care under supervision, and that surely it would be easier simply to amend the 1983 Act to give guardianship the necessary extra power. A number of mental health organisations, including MIND and NSF Scotland, also commented on the similarity of the proposals to guardianship. Responding to the debate for the Government, Lord Fraser of Carmyllie stated the use of guardianship would not always be appropriate for people suffering from mental illness:

> "Guardianship is essentially an arrangement which is oriented towards social care. I believe that these sets of provisions, whether they apply in England, Wales or Scotland, are based separately; they are centred upon the health service; they are rooted in the care programme approach. A separate identifiable health-led provision is made. I believe that that is the right way to approach the matter. We are not persuaded that simply by adding a power to convey - I believe that it is accepted that it would be necessary in any event if guardianship were relied upon - would be an acceptable way forward."[42]

Baroness Jay pressed the question again at the Report stage, with amendments which would enable health authorities, as well as social services departments, to accept guardianship applications, and which would add the power to "take and convey" to the guardianship

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[39]RCN parliamentary briefing, 8 March 1995

[40]NSF (Scotland) briefing for HL 2nd Reading, n.d.

[41]Scottish Association for Mental Health briefing paper, March 1995

[42]HL Deb, 16 March 1995, c.979

provisions. While accepting that there may be scope for improving the general use of guardianship, Baroness Miller of Hendon for the Government said that guardianship was "there for a different type of patient - one with perhaps a lower risk factor and fewer medical needs - than the patient we think would benefit from supervised discharge"[43], and that changing guardianship to be more like supervised discharge would only cause confusion. However, she promised that the Government would certainly look at the issue again when it had had chance to analyse the results of a recent consultation exercise on guardianship and when it was in a position to see how supervised discharge was working in practice.

2. Costs and resources

A recurrent theme, both in the Second Reading Debate and in the responses to the Bill produced by concerned organisations, was the question of resources. In her speech opening the Second Reading Debate, Baroness Cumberlege, the Parliamentary Under-Secretary of State for Health, stated that:

> "We do not believe that [after-care under supervision] will impose extra cost because it does not introduce new requirements. Rather, it gives legal backing to what is already recognised as good practice."[44]

This view has given rise to considerable concern among those who believe that mental health services are already under-funded and that therefore additional funding would do far more than a new power to improve community care services for the mentally ill. Quite apart from the question of the adequacy of current funding, concern has also been expressed that for after-care under supervision to work without adversely affecting other mental health services, extra resources will be necessary. At Second Reading, Baroness Jay of Paddington was not convinced by Baroness Cumberlege's statement, saying:

> "And yet we were told this afternoon by the Minister that this Bill will not give rise to any additional costs. There will be no need for extra staff. Instead, apparently, a dreadful situation will be improved solely by a new statutory supervising system. There will be no additional resources for health authorities or social services departments."[45]

Baroness Robson of Kiddington for the Liberal Democrats expressed the concern that the new power of after-care under supervision, if not accompanied by an increase in resources, would lead to other groups of mentally ill patients suffering:

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[43]HL Deb, 1 May 1995, c.1263

[44]HL Deb, 16 March 1995, c.936

[45]HL Deb, 16 March 1995, c.940

> "Concentrating resources on one client group will inevitably lead to fewer resources being available to the vast majority of mentally ill people who already receive inadequate support in the community, and consequently may lead to an increase in the need for supervised discharge powers."[46]

Organisations concerned with mental health patients also repeatedly raise this issue. The Royal College of Psychiatrists, while welcoming the general thrust of the legislation, says that "it would be wrong to draft legislation, with careful recognition of patients' civil rights, and not at the same time ensure community resourcing sufficient to ensure their rights to treatment and proper supervision"[36]. The Royal College of Nurses states that the Bill "fails to provide sufficient resources and training, particularly for community psychiatric nurses, to implement the proposals", and calls for greater attention to be paid to the need for improved aftercare services.[39] MIND suggests that "a framework of coercion is no substitute for adequate services" and that "better community care services can be achieved only through setting national minimum standards for local mental health services".[47] MIND also draws attention to the *Community Care (Rights to Mental Health Services) Bill*[48], a Private Members' Bill drafted by MIND and presented by Tessa Jowell MP, which aims to establish rights to particular services for those suffering from mental illness; MIND feels that the rights proposed in this Bill would do far more to assist those in need of help. In response to comments during Second Reading on current funding levels and their adequacy, Lord Fraser of Carmyllie stated that health authority spending on mental illness services had increased by 40% since 1979.[49]

3. Adequacy of the current system

It has been suggested both that, on the one hand, it is current *services*, rather than the *law* which are inadequate as far as patients in the community are concerned, and that, on the other hand, the shift in emphasis from hospital care to community-based care requires an overhaul of the entire mental health legislation. Baroness Jay made both these points at Second Reading:

> "The overall problem is clearly inadequate services, not inadequate laws. The chairman of the Law Commission recently said that the law in this area has grown up piecemeal and is 'now out of date and full of gaps'. But the solution must be to conduct a thorough review and reform of the Mental Health Act 1983 and to make our legislation, which was originally designed for hospital

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[46]HL Deb, 16 March 1995, c.945

[47]MIND briefing, n.d.

[48]Bill 37 of 1994/95; no day named for Second Reading

[49]HL Deb, 16 March 1995, c.975

> services, more relevant to community care. The Bill before us today is trying to patch up a crisis; but that crisis needs different long-term solutions."[50]

Calls for an overall review of the 1983 Act have also been made by the Mental Health Act Commission and by the authors of the report, "*The falling shadow*", on the death of the occupational therapist Georgina Robinson (Louis Blom-Cooper, Helen Hally and Elaine Murphy). The Mental Health Act Commission submitted a memorandum to the Secretary of State for Health on 30 September 1993, setting out their reasons for seeking such a review; the conclusion of the memorandum stated that:

> "The incremental distancing of mental health services from those which pertained in the 1970s, and for which Parliament was appropriately legislating in the early 1980s, is such as to call for legislation, to match the substantially changed environment of mental health services, in the facilities for care and treatment, psychiatric practices and public expectation of the services for the mentally disordered."[51]

The view that the change in emphasis to community services from institutional care requires a concomitant change in legislation was echoed in *The falling shadow*:

> "The time has come to jettison an Act which neither protects the public effectively, nor provides the care which seriously mentally disordered people require to achieve a more fulfilled and happier life. There has been a ministerial commitment to a review of mental health law "sooner or later". We think the review should start now."[52]

Lord Fraser of Carmyllie responded to calls for a fundamental review of the Mental Health Acts at the end of the Second Reading debate, stating:

> "I wish to conclude by acknowledging the case for considering whether the Acts still reflect current practice. But there is no clear evidence at present, I believe, to conclude that they fail to meet present day needs or that there is as yet any emerging consensus about how the position might be changed. Our view is that we wish to take stock of the new powers that we propose should be introduced in the Bill before considering any further fundamental changes."[53]

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[50]HL Deb, 16 March 1995, c. 944

[51]reproduced in The Mental Health Act Commission, *"Fifth Biennial Report 1991-93"*, 1993, p.106

[52]Louis Blom Cooper et al, "*The falling shadow: one patient's mental health care 1978-1993*", 1995, p.200

[53]HL Deb, 16 March 1995, c.979

4. Civil liberties

There has been considerable disagreement as to whether the provisions in the proposed Bill would contravene the European Convention on Human Rights. MIND, in their briefing paper for the Second Reading in the Lords[47], suggested that the provisions risk contravening Articles 5 (right to liberty), 8 (right to respect for private life) and 14 (right to exercise these rights free from discrimination on grounds of race, gender, sexual orientation, class or any other status) of the Convention. The last point is picked up by the Royal College of Nursing which suggests that patients from black and ethnic minority groups are already over-represented among those detained under the current powers of the 1983 Act, and that the Bill would only serve to reinforce such discrimination[39]. These points were urged by Lord Ennals during the Second Reading debate, but strongly criticised by Lord Mottistone who suggested that "the enthusiasm for civil liberties at the centre of MIND does nothing but harm, rather than good, to the cause of mentally ill people"[54]. A similar point was made by Lord Milverton later in the debate, stating:

> "Like my noble friend Lord Mottistone, if it is decided that a mental patient should be returned to hospital for some further treatment, I cannot see how the Bill in any way infringes that person's liberty. I believe that we are really going mad about the word "liberty" in every way. The Bill is aimed at trying to help such people. If one is trying to help someone, does that mean that you are taking away that person's liberty?"[55]

The Government has several times reiterated that it has taken legal advice and has been assured that there is no conflict between the provisions of the Bill and the UK's obligations under the European Convention[56].

5. Trust between patients and professional carers

Concern has been expressed over the possible impact of the Bill's provisions on the therapeutic relationship between patients and those caring for them. In particular, it has been suggested that the power to oblige a patient to live at a particular address and attend other places for treatment or occupation, backed up by the power to "take and convey", may undermine a trusting relationship between a patient and their doctor, nurse or social worker. Lord Ennals, for instance, in the Second Reading debate quoted a letter from a consultant psychiatrist, describing the benefits of developing a long-term trusting relationship with patients and stating:

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[54]HL Deb, 16 March 1995, c.964

[55]HL Deb, 16 March 1995, c.971

[56]eg HL Deb, 4 April 1995, c.154

> "It is difficult to build up trusting relationships when the patient/user perceives that all of the power rests with the psychiatrist."[57]

In response to this concern, Lord Fraser of Carmyllie emphasised that it would "clearly be very unsatisfactory" if therapeutic relationships were damaged, but that the Government was not convinced that this would be the case:

> "Ultimately, the effectiveness of the treatment and care given under the provisions of the Bill will depend on the co-operation of the patient. That is why the principle of consulting the patient is so firmly enshrined. We believe that with the patients whose needs the Bill addresses a measure of legal backing is nevertheless justified, but we do not see that as undermining the principle that treatment relies primarily on co-operation. We would certainly not wish to damage that relationship."[58]

6. The power to take and convey

As well as concerns that the power to take and convey could be intimidatory and could damage a therapeutic relationship, the effectiveness of the power has also been questioned. In the Committee Stage of the Bill, Baroness Jay quoted from a letter from the Mental After Care Association suggesting that the power is excessive for what it may be able to achieve:

> "As this significant new power lies at the heart of the Bill, we are keen to learn [what Ministers] hope to achieve by this measure. How, in practice, will this new power ensure that patients comply with aftercare arrangements? If a patient fails to arrive at a day-centre or training course, will the Community Psychiatric Nurse be expected to convey the individual there? Or will the power to delegated to another agency, for example the police? Whatever the case, is the attendance at a place of "occupation, education or training" considered so important as to necessitate [these] far-reaching legal powers?"[59]

She went on to suggest that the main purpose of the power might be to take patients to their place of treatment and hence induce them to take medication, even though the actual power to oblige them to accept medication against their will is not within the scope of the Bill.

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[57]HL Deb, 16 March 1995, c.963

[58]HL Deb, 16 March 1995, c.977

[59]quoted in HL Deb, 4 April 1995, c.152

In response, Baroness Cumberlege stated that while the Government envisaged that the power would only be used rarely, it gave "useful backing to the care team, for example where there is a temporary reluctance to co-operate."[60] She went on to say that she did not feel that the power would be misused "because to do so would be so obviously self-defeating".

7. Compulsory medication

The question of compulsory medication in the community was raised several times during the Lords debates on the Bill, although this power had explicitly been rejected by the Department of Health in its review of the legal powers governing mentally ill people. In the Second Reading debate, Lord Mottistone suggested that "the Bill would be much more useful for the sufferers and the public if a measure of compulsory medication had been included within it"[61], although at Report stage he stated that the advice he had received from the National Schizophrenia Fellowship suggested that this would not be workable[62]. Also at the Report stage Baroness Jay moved a probing amendment allowing compulsory medication, suggesting that the proposals as drafted fell between two stools by giving the power to take and convey but refusing the power to treat:

> "First, they offend those whose primary concern is to protect the civil rights of the patient; and secondly, they do not fulfil the wishes of many clinicians who would like to have powers to treat patients on supervision orders with medication."[63]

Baroness Cumberlege, however, reiterated the Government's view that compulsory medication in the community was not appropriate, and felt that there was no contradiction between this approach and granting the power to take and convey:

> "We feel that compulsory medication in the community has no place in our proposals. The requirements placed on a patient may include where he should atttend for treatment. There will be a power to convey him there if absolutely necessary. But the idea of compulsory medication goes against the basic philosophy of the Bill."[64]

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[60]HL Deb, 4 April 1995, c.154

[61]HL Deb, 16 March 1995, c.965

[62]HL Deb, 1 May 1995, c.1250

[63]HL Deb, 1 May 1995, c.1248

[64]HL Deb, 1 May 1995, c.1251

8. The role of the Mental Health Act Commission

Baroness Jay tabled amendments at Committee, Report and Third Reading stages, attempting to extend the remit of the Mental Health Act Commission (which currently has the statutory duty of keeping under review the use of the 1983 Act as it relates to detained patients) so that it would also have the duty of monitoring patients subject to after-care in the community. In particular, she drew attention to the fact that under Schedule 2 of the Bill the Mental Welfare Commission in Scotland would have this power. The Mental Health Act Commission itself, in its public position paper, suggested that "the powers of control and compulsion included in the Bill (whatever the frequency of their use in practice) in the Commission's opinion, warrant consideration being given to the extension of its remit to patients under supervised after-care."[65] Baroness Cumberlege's doubts about this proposal were summarised at Third Reading:

> "As I explained then in responding to the earlier amendments, we have reservations about this on two counts. The first is the question of priorities for the allocation of the finite resources at the commission's command. It seems to us that detained patients, having been deprived of their liberty, have a uniquely powerful claim on the commission's protection and that any extension of its remit to other groups certainly ought not to be at their expense. The second reservation has to do with timing. The commission is at present undergoing a major reorganisation of its structure and we think that that needs to be allowed to settle down before any widening of its remit could be considered. That does not mean that the commission will have no *locus* at all in reviewing the use of the new power. Given its general responsibility to protect the rights of patients liable to be detained, it will be able to review the procedures for making a supervision application since the patient at that point must be liable to be detained."[66]

9. Absence of leave from hospital

The provisions in the Bill dealing with absence without leave from hospital and the extension from six months to 12 months of the period in England and Wales during which a patient given leave of absence can be recalled to hospital (clauses 2 and 3) generated relatively little debate. Lord Rea for Labour stated in the Second Reading that "we have no great quarrels with Clauses 2 and 3", although he added that "there are resource implications there which

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[65]Mental Health Act Commission, "*Mental Health (Patients in the Community) Bill: public position paper*", April 1995, para 3.1

[66]HL Deb, 11 May 1995, c.187

are not addressed"[67]. One point which was discussed briefly at Report stage was the appropriateness of the time limits proposed during which a patient absent without leave from hospital could be taken back into detention; Baroness Jay expressed some concern that if a patient went absent without leave near the end of their period of detention, the new provisions could result in their being taken back to hospital more than 5 months after the original authority to detain had expired.[68] A similar point was made by the Mental Health Act Commission who felt that the six month rule could be "unfair in some cases", and suggested that a more equitable provision would be to enable a patient to be retaken either during the period of their liability to detention or for 28 days after they have gone absent without leave, whichever were the greater.[69] In response to Baroness Jay's amendment, Baroness Cumberlege pointed out that there would be the safeguard that patients absent for more than 28 days could only be re-detained for more than a week if the responsible medical officer so recommended. She also stated her belief that setting an appropriate time limit involved "a careful balancing act taking account both of the civil rights of patients and their safety and that of the public", and that the Government was "confident that the provisions in Clause 2 as they currently stand have got this balance right."[70]

There was also little debate over the question of absence without leave from hospital in Scotland. However, the Scottish provision dealing with the period during which a patient given official leave of absence can be recalled to hospital was rather more controversial. In England and Wales, the current maximum period of absence from hospital which can be granted is 6 months; after this the patient cannot be recalled to hospital without beginning again with the "sectioning" procedures. Since the "Hallstrom" judgement[71] in 1986, which clarified the meaning of the 1983 Act in this respect, hospitals have not been able to recall patients to hospital just before the six months were up in order simply to renew the period of leave. However, in Scotland until now, hospitals have been able to keep renewing the period of absence; patients could therefore be indefinitely "on leave", with the hospital having the power to recall them without having to begin at the beginning with the sectioning procedures. Although the effect of the Bill is to bring the English/Welsh and Scottish provisions in line with a maximum of 12 months of leave of absence, the impact is clearly very different in the different countries: in England and Wales the change *extends* current practice, while in Scotland it *restricts* it. In the Second Reading debate, Lord Campbell of Croy expressed his concern at the proposal to change the present system, despite the fact that it has been suggested that the present system could be open to legal challenge:

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[67]HL Deb, 16 March 1995, c.974

[68]HL Deb, 1 May 1995, cc 1263-1264

[69]Mental Health Act Commission, "*Mental Health (Patients in the Community) Bill: public position paper*", April 1995, para 2.9

[70]HL Deb, 1 May 1995, cc 1264-5

[71]*R. v. Hallstrom, ex p.W.; R. v. Gardner, ex p. L.* [1986] 2 W.L.R. 883; [1986] 2 All E.R. 306

> "I must tell your Lordships that those proposals have met with some disappointment among the organisations concerned north of the Border. The present indefinite leave of absence from the hospital which has worked extremely well is now to be reduced to one year. Some of us have known that leave of absence from hospital without time limit might be challenged legally. That has not happened so far. As it is an accepted system, operating well in Scotland, we had hoped that the Bill might make a simple change in the legislation and remove the possibility of a legal challenge."[72]

Similar views were expressed by the National Schizophrenia Fellowship (Scotland)[40], while the Scottish Association for Mental Health welcomed the proposal to limit leave of absence to one year, though suggesting that any change in the law should be delayed pending the completion of research by the Mental Welfare Commission for Scotland in this area[41].

In response to these comments, Lord Fraser of Carmyllie agreed that the present system appeared to be working adequately, but emphasised the need to ensure that practice was beyond legal challenge:

> "It was believed that we should simply leave that arrangement in place because it was working well. It would be fair to say that, generally speaking, the arrangement has worked well. However, proper concern has been expressed that we should ensure that what is undertaken in relation to the mentally ill should be beyond legal challenge. As I recall, in opening my noble friend indicated that we have been made aware from a decision in the Scottish courts that to allow leave of absence without end is ultimately illogical and threatens to be opened up to legal challenge. So far as concerns Scotland, we have restricted the provision to 12 months. By the same token, to ensure that we march in step in England, the period has been extended from six months to 12 months. That would seem about right so far as we can best judge."[73]

C Lords' amendments

A considerable number of amendments to the Bill were made during the Lords' stages. Some of these were merely technical amendments, correcting minor errors in drafting or the unforeseen effects of the Bill on other parts of the Mental Health Acts. However, a number were tabled by the Government at the Report and Third Reading stages in response to arguments put forward by peers at the Committee and Report stages. These were summarised by Baroness Cumberlege at the end of the Third Reading in the Lords:

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[72]HL Deb, 16 March 1995, c.949

[73]HL Deb, 16 March 1995, c.978

> "In his unfailingly courteous but effective way, my noble friend Lord Mottistone persuaded us by the force of his argument of the importance of consulting the patient's nearest relative. He was joined by my noble friend Lord Haig and the noble Baroness, Lady Jay, in arguing the case for the community responsible medical officer to be someone approved by my right honourable friend the Secretary of State. The noble Lords, Lord Carter and Lord Rea, put forward a persuasive case for requiring information, including that about mental health review tribunal rights, to be given to patients both orally and in writing. I confess that I enjoyed being able to surprise your Lordships just a little by going even further than we had been asked to do ... In relation to the Scottish provisions of the Bill, we are grateful to the noble Lord, Lord Carmichael of Kelvingrove, for his intervention on the subject of the immediate re-use of the period of reassessment in hospital. We have now made it clear on the face of the Bill that rolling periods of reassessment in hospital are not to be permitted ... We are particularly grateful for the noble Earl's [Lord Mar and Kellie] intervention on the subject of those community care order patients whose order expires when they are in prison. As a result, we have now addressed that group of people not only in Scotland but also in England and Wales."[74]

Other amendments made during the Lords stages included the requirement that the supervisor should be professionally involved in the patient's care (that is, the informal carer cannot be nominated as the supervisor), provisions covering the change of special medical officer or after-care officer in Scotland, and provisions enabling patients to move from England or Wales to Scotland, or vice-versa, without losing touch with mental health services. The amendments passed are highlighted in bold in Part II of this paper which goes through the Bill clause by clause.

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[74]HL Deb, 11 May 1995, cc 189-190

Appendix: Reports on mental health services

A considerable number of reports on community care for people suffering from mental illness have been produced over the past year. Some of the main ones are briefly summarised below.

1. In February 1994, the "*Report of the Inquiry into the Care and Treatment of Christopher Clunis*"[75] was published, after Christopher Clunis, a discharged psychiatric patient, killed Jonathan Zito in December 1992. The report serves to highlight a number of areas of concern over the policy of care in the community for people with mental health problems. It expressed the view that Mr. Clunis' case could not be blamed on just one failure: "We do not single out just one person, service or agency for particular blame. In our view the problem was cumulative; it was one failure or missed opportunity on top of another"[76]. Similarly, the authors emphasise that they do not feel the Christopher Clunis case is an exception; rather they say that "we are very concerned that these failures may well be reproduced all over the country, in particular in poor inner city areas". In the view of the authors, therefore, the conclusions of the report have a wider relevance than one particular situation.

The report highlights a number of failures in the care Mr. Clunis received, including poor liaison between different agencies, the failure to plan or monitor aftercare after he had been detained under the *Mental Health Act 1983*, the failure to provide "assertive" care and to act upon warning signals, and the failure to provide qualified social workers to assess new referrals and provide supervision. The report also comments on the lack of beds in London, both in regional secure units and in general psychiatric wards, and the shortage of accommodation which would provide a supportive environment for discharged patients who might otherwise have to return to hospital. The report's authors make wide-ranging recommendations on how aftercare should be planned when a patient is discharged. These include specific recommendations for very seriously mentally ill patients who, like Christopher Clunis, may be a danger to themselves and to the public. Emphasising that they "have no wish to return to the days of the locked, impersonal, dehumanising and undignified institutional care", they propose such seriously ill patients should form a "Special Supervision Group" cared for by a specialist multi-disciplinary team, who would be able to make a very rapid response in any crisis. Mrs. Bottomley welcomed the report, stating that:

> "This report is essential reading for everybody involved in caring for mentally ill people in the community. It shows just how serious can be the

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[75]North East Thames and South East Thames Regional Health Authorities, "*Report of the Inquiry into the Care and Treatment of Christopher Clunis*", 1994

[76] North East Thames and South East Thames Regional Health Authorities, op cit, p.105

> consequences when the most elementary rules of co-operation and co-ordination between the different agencies are not strictly adhered to."[77]

She felt that the main themes and recommendations of the report had been anticipated by the measures taken as part of the ten-point plan, but said that "we shall, of course, urgently consider any further action which needs to be taken nationally in light of the Report's recommendations".

2. In March 1994, the Health Select Committee published a further report on mental health services: "*Better off in the community? The care of people who are seriously mentally ill*".[78] The Committee concluded that "levels of performance nationwide are highly uneven" and recommended that the Department of Health should issue instructions on minimum acceptable levels of provision for 24 hour staffed community houses, day staffed residential care, day centre and day hospital places and community-based multi-disciplinary teams. It also highlighted concerns over inter-departmental co-ordination, resource allocation, the priority given to mental health services by purchasing authorities and inadequacies of the data available. In its response to the Committee's recommendations[79], the Government acknowledged that "while there are undoubtedly many areas of good practice, there are also areas where things are not going so well", but claimed that significant progress was being made.

3. In August 1994, the Confidential Inquiry into homicides and suicides by mentally ill people produced "*A preliminary report on homicide*" (known as the Boyd Report). This Inquiry was set up in 1991 to investigate homicides and suicides by people either under the care of, or recently discharged from, the special psychiatric services, in order to try to reduce such incidents in the future. The preliminary report looked at 22 homicides out of 34 committed in the three year period between 1991 and 1993, and emphasised that they needed to be wary of jumping to conclusions on such a small sample. However, the authors felt certain findings stood out, including the infrequency of homicides among in-patients and among those during the first year after discharge from specialist care. They also noted that the evidence of 60% of the cases studied suggested that the proposed power of supervised discharge would be useful, provided it was matched by the necessary resources.

4. The day after the Boyd report was published, the National Schizophrenia Fellowship launched a report "*£500 million more*" highlighting where they felt more money should be

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[77]Dept of Health press notice, 94/102, 24 February 1994

[78]Health Select Committee, "*Better off in the community? The care of people who are seriously mentally ill*", HC 102 1993/94

[79]"*Government response to the first report of the Health Committee "Better off in the community? The care of people who are seriously mentally ill": session 1993-94 (102-I)*", Cm 2588

spent to improve mental health services. Their proposals included increasing the numbers of social workers and psychiatrists, acute beds, secure beds and supported accommodation.

5. In September, the Royal College of Psychiatrists publicised a survey carried out by the College in June; according to press reports, 12 inner London mental units were running at an average capacity of 111%, 84 patients diagnosed as needing hospital treatment were turned away and 24 were discharged prematurely to make room for others.[80] The college carried out a follow-up survey six months later which suggested that the position was still much the same. A summary of both reports was published in April 1995.[81]

6. In the same month, the Mental Health Foundation produced a report "*Creating community care*", calling for a Cabinet committee to be set up to co-ordinate all the departments involved in community care, better co-operation between health and local authorities, more resources devoted by health and local authorities to community care services, a national network of community mental health teams and a greater role for GPs. Shortly afterwards, the Government announced an extra £4.4 million to expand secure units for severely mentally ill people.

7. Also in September, the Mental Health Task Force reported on mental health services in London.[82] The Task Force made a number of recommendations to improve services, including better collaboration between health and local authorities; addressing pressures on acute psychiatric services by giving priority to severely mentally ill people, improving bed management and in some areas increasing the number of available beds; reviewing hospital closure plans to ensure that adequate community services were in place before hospitals closed; and developing the care programme approach and supervision registers to coordinate and monitor the care delivered to severely mentally ill people. A follow up report to this was published in April 1995[83] in which it was stated that "good progress" had been made "both in services on the ground and in making changes to the infrastructure through which decisions on future services will be made". Examples of improvement cited included better collaboration between statutory authorities, revised timetables for long stay hospital closure, an increase in the number of acute psychiatric beds and greater involvement of people from racial and cultural minorities.

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[80]"Psychiatrists despair over beds", *The Guardian*, 16.9.94, p.7

[81]Royal College of Psychiatrists, "*Monitoring inner London mental illness services*", April 1995

[82]Dept of Health, "*Priorities for Action*", 1994

[83]NHS Executive, "*Mental Health Task Force London project: follow up report*", April 1995

8. The Audit Commission published "*Finding a place: a review of mental health services for adults"* in October 1994. The report expressed concern about the allocation of resources, suggesting that needs vary enormously between districts, that most resources are still tied up in hospitals and that considerable resources could be released by reviewing the skill-mix of community-based staff and by rationalising the balance of supported accommodation. It further suggested that resources could be much better targeted to need and services could be better managed. The Department of Health felt that the report was "rather unbalanced" and that much work had already been carried out to address issues identified by the Audit Commission.[84]

9. In November 1994, "*The Report of the Independent Panel of Inquiry examining the case of Michael Buchanan*"[85] was published. This inquiry had been set up after Michael Buchanan, a former patient of Shenley Hospital, was convicted of manslaughter for killing a retired policeman in September 1992, only 17 days after he had been discharged from hospital. The inquiry team concluded that he was inappropriately discharged to a hostel not resourced to deal with his behavioural disturbances; that the community psychiatric nurse who discharged him from his caseload as soon as he had vanished had made the wrong decision (while acknowledging that the nurse's caseload was too high); and that there had been a lack of effective social work support. Their recommendations included better co-ordination between the professionals involved in discharging patients, appropriate supportive accommodation to be available after discharge and a review of the caseloads of community psychiatric nurses. In response to the report, the Department of Health pointed out that the incident happened more than two years ago, before the latest initiatives to tighten up community care, and that "Government plans for a more rigorous approach to community care for patients released from psychiatric hospital have again been fully vindicated."[86]

10. "*The falling shadow*"[87], which examined the fatal stabbing of the occupational therapist Georgina Robinson by Andrew Robinson in the Edith Morgan Centre in Torbay, was published in January 1995. The authors of the report highlighted a number of areas of mismanagement at the Edith Morgan Centre: the unauthorised absence of Andrew Robinson from the Centre during the week before the attack (during which time he bought a knife), this absence being possible because of a lax policy at the Centre; his second absence authorised by a nurse, in breach of section 17 of the *Mental Health Act 1983* which only allows the responsible medical officer to give such permission; and the failure to find the knife in the days between his return from leave and the attack. The authors conclude that "had Andrew

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[84]Dept of Health press notice 94/490, 26 October 1994

[85]North West London Mental Health NHS Trust, "*The Report of the Independent Panel of Inquiry examining the case of Michael Buchanan*", 1994

[86]Dept of Health press notice H94/502, 3 November 1994

[87]Louis Blom-Cooper et all, "*The falling shadow: one patient's mental health care 1978-1993*", 1995

Robinson been denied - as he should have been - both the freedom to go to Torquay on 25 August and to wander around in London and Torquay for three days, from 28-31 August, Georgina almost certainly would not have been fatally assaulted by Andrew on 1 September 1993".

However, the authors also stated their belief that "much of the maladministration and malpractices derived from a fundamentally flawed statutory framework" and went on to make suggestions on how a new Mental Health Act could be constructed. They suggested that detention in a secure place, while necessary for some, should not be regarded as a precondition of treatment; many people could successfully be treated in their own homes. Emphasising that these were only "initial thoughts", they suggested a power for the compulsory care of mentally disordered people which would require the person to live in a designated place (such as their own home), be provided with particular services under a care plan agreed by health and local authorities and attend a specified place for specified treatment. A major difference between this suggestion and the proposed community supervision order discussed earlier in this paper is the fact that the authors distinguish clearly between the place where the patient might live, such as their own home, and the place where they attend for treatment, such as a health centre or day hospital. John Bowis, the Parliamentary Secretary at the Department of Health welcomed the report, noting there were important lessons to be learned from the tragedy. In response to the call for major changes in mental health legislation he stated that "once we have more experience of implementing the new arrangements for supervised discharge, we shall certainly need to look at the more general legal framework for care of mentally ill people."[88]

11. In January 1995, the Zito Trust published "*Learning the lessons*", which summarised the reports of mental health inquiries between 1969 and 1994 and then brought together selected recommendations common to a number of the inquiry reports. The report's author, Dave Sheppard, expressed concern that many practitioners seemed to be unaware of some of these inquiries and their recommendations, and that it was the exception rather than the rule for statutory authorities to ensure that the implications of report recommendations for local practice were properly considered.

12. Finally, in February 1995, the Matthew Trust published "*Victims of Care: a commentary on the care of the mentally ill in the community*". This report described the personal stories both of mentally ill people whom the Trust had been able to help financially and those whom it had been unable to assist. Describing its report as "a snapshot of deprivation", the Trust stated that since the publication of the White Paper "*Caring for People*" in 1988 it had received a four-fold increase in grant applications. While agreeing that the shift in emphasis to care in the community had brought "potential benefits" for the mentally ill, the report felt that there were also "special pitfalls" and concluded that "the sweeping change in the

[88]Dept of Health press notice 95/20

management of care appears to be putting vulnerable people even more at risk". In a debate in the House of Lords on the report[89], the Parliamentary Under-Secretary of State for Health, Baroness Cumberlege, stated that it was "a useful contribution to our understanding of mental illness" and that the Department would "certainly consider its findings carefully". She also expressed the view that anecdotal evidence often raised more questions than it solved, and, on the question of funding, assured the House that the Government was committed to giving priority to mental health services.

13. During the past year, the Government has also published a considerable amount of guidance on mental health services. The guidance on supervision registers, discharge from hospital and inter-agency working has been mentioned earlier in this paper. Other guidance issued includes a revised version of the Health of the Nation "Key Area Handbook" on mental illness[90] and a series of booklets from the Mental Health Task Force: advice on purchasing services for people with severe mental health problems[91], advice on providing appropriate service for black users of mental health services[92], guidance on listening to service users[93] and advice on minimising "transitional costs" when shifting from hospital-based to community services[94].

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[89]HL Deb, 20 April 1995, c.644

[90]Dept of Health, "*The Health of the Nation Key Area Handbook: mental illness*", 1994

[91]Dept of Health, "*Local systems of support: a framework for purchasing for people with severe mental health problems*", 1994

[92]Dept of Health, "*Black mental health dialogue - a dialogue for change*", 1994

[93]Dept of Health, "*Advocacy - a code of practice*", 1994 and Dept of Health, "*Guidelines for a local charter for users of mental health services*", 1994

[94]NHS Executive, "*Transitional costs - the case for better management*", 1994