



Mental Health Act 2007 Consultations Report

Report on the consultation exercises on the draft revised Code of Practice and secondary legislation

**Mental Health Act 2007
Consultations Report**

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Report on the consultations exercises on the draft revised Code of Practice and the secondary legislation

Prepared by the Mental Health Act Implementation Team

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INTRODUCTION

This report covers the consultation exercises conducted from 24 October 2007 to 24 January 2008 on the draft revised Code of Practice to the Mental Health Act 1983 and on the secondary legislation to be made in the light of the Mental Health Act 2007. It details the process, analyses the responses received and explains which comments were accepted and which discarded and why.

BACKGROUND

The Mental Health Act 2007 (the 2007 Act) received Royal Assent on 19 July 2007 and amongst other things made several important changes to the Mental Health Act 1983 (the 1983 Act).

Section 118(1) of the 1983 Act requires the Secretary of State to revise from time to time a Code of Practice (the Code). The current Code has been in operation since 1999 and the changes introduced by the 2007 Act were the catalyst for its revision.

A number of the amendments made to 1983 Act give the Secretary of State specific powers to make secondary legislation on matters which are necessary to give effect to the changes introduced by the 2007 Act. This was the authority for the regulations and directions issued for consultation. At the same time, the opportunity was taken to review the existing secondary legislation under the 1983 Act and invite comments on possible changes.

The draft Code and secondary legislation were not a surprise. A draft illustrative revised Code had been published when the Mental Health Bill 2006 was introduced in November 2006 and was the result of working with key stakeholders. It continued to be refined during the Parliamentary passage of the 2007 Act. Similarly, key elements of the draft secondary legislation had been drawn up with stakeholders. These were placed on the Department's website during the passage of the Act, as were statements of intent on regulations for supervised community treatment and mutual recognition and the order for transitional arrangements for after-care under supervision.

THE CONSULTATION EXERCISES

The Consultations followed a clear format founded on the principles of the Cabinet Office code of practice. A full version can be found at

www.cabinetoffice.gov.uk/regulation/Consultation/Code/htm

On 24 October 2007 the Department of Health published two consultation documents; copies are archived at :

www.dh.gov.uk/en/Consultations/Closedconsultations/index.htm.

One document accompanied the draft revised Code and invited comments on style and content and views on specific questions. The aim was to elicit views on what the Department considered important elements of the guidance, but respondents were not excluded from commenting on anything else. The other document sought views on proposals for the secondary legislation. Again specific issues had been highlighted where views were particularly welcomed, but no elements of the legislation were exempt from comment. The documents were produced in both electronic and paper format and easy-read versions were published. Key stakeholders were alerted by e-mail to start of the consultations which ran for 13 weeks and closed on 24 January.

Supporting the exercises were a series of 14 workshops held at locations throughout England; two each in Nottingham, Birmingham, London, Taunton, Cambridge, Newcastle and Manchester. Run in partnership with the Care Services Improvement Partnership (CSIP), these were either open to everyone with an interest in mental health legislation, or targeted at specific interest groups. The feedback from the workshops was included in the overall consultation responses.

The Government would like to thank all those who responded. 160 responses on the Code and 40 on the secondary legislation were received from a wide range of groups, organisations and individuals and these are detailed at appendices 1 and 2.

This report does not address any responses which: were comments on the 2007 Act itself, rather than the Code; sought to re-introduce through the Code provisions which fell during the passage of the 2007 Act; were outwith the scope of the Code or secondary legislation; or referred to drafting errors that were corrected in the copy editing process

THE CONSULTATION QUESTIONS

Code of Practice

The Code consultation document asked eight specific questions.

1. Do you have any comments on the style and tone of the draft Code? Do you think it is suitable for the people who will use it?

There was a very large range of responses to this question. Some respondents welcomed the updating of the style and tone and the language and felt that both professional and non-professionals would be able to access it. Others thought the style was reasonable and clear and the language appropriate to professional users, but that non-professionals might have difficulty understanding it. And one or two respondents implied that no one would be able to understand it, let alone use it. Because the Code had been written for professionals but with the aim of being accessible to service users, carers and others, some people suggested it was

trying to appeal to too broad an audience and as a result had been weakened. A common criticism was the length. Several respondents noted that it was much longer than the current Code and felt that the size and complexity might deter practitioners, making it less of a useful and accessible everyday tool.

2. Do you have any comments on the structure of the draft Code? Can you suggest ways in which it could be improved?

Respondents championed a variety of formats: A5; A4; loose leaf; both paper and e-versions; summaries; chapters produced individually. But there was majority support for everything being in one well-structured document rather than scattered across a range of sources. More cross-referencing was requested by several respondents as a helpful tool to navigation. Flow-charts and patient pathways were also suggested by a number of people. Some people recommended copying some aspects of the style of the Mental Capacity Act 2005 (MCA) Code of Practice, in particular the summary at the beginning of each chapter.

3. Do you think that the Code has identified all the areas in which equality is a major issue? If not, what changes would you make?

Most of those who specifically responded to this question thought the issue of equality had been well addressed and in a more meaningful way than in the current Code, although there were some calls for a separate chapter. There was support from some respondents for more references to disability in some areas. Some said the needs of transgender people had to be acknowledged and sexual orientation should be more prominent. Some respondents thought that there should be a requirement to take social factors into account. Cross-references to discrimination legislation and the Human Rights Act 1998 were felt by some respondents to be vital.

4. Is there material that the Code ought to cover that is missing from the draft? If so, what is missing and how should it be addressed in the Code?

A number of respondents suggested that there was too little guidance on the rights and roles of carers, family members and others with an interest in a patient's care. Several felt that the advocacy chapter was lacking in detail. There were calls for the Code to be binding on the police and ambulance services. Some respondents also asked for a summary of duties of each professional and guidance on their roles and on the duties of employers.

5. Is there material in the draft Code that could be cut down or left out completely – or covered in other guidance?

Some respondents suggested that the introduction was a candidate for deletion, or at least for pruning. A number said that links to other legislation, guidance and information sources were vital, but that repeating large chunks of other material was a waste of time. There were conflicting views on the use of case studies: they were welcomed; they were also welcomed,

but only as an annex or a separate document; they had no place in a code of practice and should be confined to training materials; they were too simplistic to be useful. Some respondents recommended that guidance of a clinical or general nature, rather than specifically about the Act should be removed and in particular, that the chapters on psychological treatments, people with learning disabilities and people with personality disorders should go.

6. What do you think of the guiding principles in the draft Code? How could they be improved?

Among the people who responded specifically to this question, there was universal welcome for the inclusion of principles as a valuable way of helping practitioners use the legislation and code. However some respondents thought their importance and significance had been lost by putting them in separately and argued for them to head each chapter. Others thought their position at the start of the Code emphasised their importance. For further details, please see the summary of responses to chapter 1 below.

7. Looking at each chapter in turn, will the material in the draft Code help people make decisions under the Mental Health Act 1983? If not, what changes would you wish to see?

Most respondents who specifically responded to this question felt that the Code would achieve its objectives and enable professionals to work with the Act. Some called for clearer guidance to help people make decisions and for good practice examples on the interface with other legislation – especially the MCA.

8. What are the practical implications of the draft Code for professional staff and those who manage and commission services?

The two main answers to this question were “training“ and “money”. There appeared to be a general belief shared by the people who specifically addressed this question that the 2007 Act was not on everyone’s radar and a higher priority had to be encouraged. There were calls for increased Government funding.

Government response

Although the Code is primarily addressed to professionals who have specific duties under the 1983 Act, we have tried to make it as accessible as possible to non-professionals. It cannot and does not address every aspect of the legislation, but we have tried to ensure key issues are covered. In structuring the Code we have responded to views expressed in the written consultation and comments made in the workshops and have paid particular attention to the structure and format to increase the ease with which those who use the Code can navigate it. We have done this by: clear indexing; highlighting the cross-references within and between chapters; and a detailed glossary of terms used. A number of respondents raised the issue of the size of the Code and it was noted that the size and portability of the existing Code was valued. In updating the Code to reflect changes in the legislation and developments in policy

and practice it has inevitably become a lengthier document than previous editions. But we hope it is a more comprehensive one and we have designed the layout to maintain the portability valued by those who use it. The use of case scenarios elicited a mixed response. We have addressed this by maintaining the scenarios, which reflect the importance of the principles in the Code, but we have taken them from the body of the text and placed them at the end of selected chapters. Comments relating to particular areas of the Code have been dealt with in those parts of this report.

Comments on individual chapters

Chapter 1: the statement of guiding principles

Around 30 written responses commented on this chapter, which was also extensively discussed in consultation workshops. Some people argued that the principles in the Code should follow more closely the list in the 2007 Act of matters to be covered. A number of people commented on the order in which the principles were presented. Some people commented specifically on whether each of the principles was welcome. In general, these comments were more favourable about the respect and participation principles than about the purpose and resources principles. There was a variety of specific suggestions for changes to the wording of the principles and of other points that might be covered. Themes which recurred in several responses were that the purpose principle was unduly negative and put too much emphasis on mental disorder as a source of harm and that the resources principle risked undermining the others, by making everything else subject to the availability of resources.

Government response

We have revised the chapter in the light of comments and made a number of changes to the principles themselves, largely to clarify their meaning. Although noting that quite a few people felt the first principle (the purpose principle) was too negative, we continue to believe it is correct. The 1983 Act is, primarily, a framework within which clinicians and others can intervene compulsorily. The justification for that intervention is the minimisation of the harm done by mental disorder. While that intervention should also aim to maximise benefits to patients and others, that is not and should not be the starting point for compulsory intervention.

Chapter 2: communication

Around 30 written responses commented on this chapter, in addition to comments made at the consultation workshops. There was strong support for hearing the views of family and carers. The use of friends as interpreters was deprecated by several respondents. Significant detail in guidance was sought by some: for example, risks and benefits of drug treatment; how to provide translation services in emergency situations; what policies hospitals should have; multi-agency arrangements.

Government response

We have revised the chapter in the light of comments and combined it with what was in chapter 18 – information for patients and nearest relatives. We have amended it to make clear that relatives and friends can be used only exceptionally as interpreters and to strengthen family and carer involvement. We have strengthened the need to provide information orally and in writing and to ensure that information is provided in a way that is accessible to the patient. Some of the level of detail requested by respondents was more appropriate to local guidance and protocols and therefore was not incorporated.

Chapter 3: mental disorder

Around 35 written responses commented on this chapter, in addition to comments made at the consultation workshops. There were mixed views about the inclusion of a list of examples of mental disorder. Some thought it helpful, others thought it might mislead people into thinking that it was an exhaustive list. Some had suggestions for the order in which the conditions should be listed. There was a variety of specific comments on the wording of the chapter. Some issues recurred in several people's comments. A number of people found the drafting in relation to alcohol and drug dependence confusing: it was not clear whether or not it was a mental disorder. Several people questioned whether acute intoxication was a mental disorder within the meaning of the 1983 Act and several argued that it should never be the basis of detention. A number of people commented on the reference to sexual preference not being a mental disorder: some thought it a helpful reference, some thought the opposite. A number of people questioned whether behaviour which was a form of communication should therefore not be regarded as abnormally aggressive or seriously irresponsible behaviour. A number of people wanted more guidance on the meaning of those terms.

Government response

We have revised the chapter in the light of comments, largely to remove any ambiguities or lack of clarity. We have kept the illustrative list of conditions, but there is now a clear statement that it is not intended to be exhaustive. We have revised the material on alcohol and drug dependence to make it easier to read. We continue, however, to believe that acute intoxication and dependence are different disorders and that the former remains a mental disorder for the purposes of the 1983 Act even if, in practice, it is rarely likely to be the basis for a justified intervention under the 1983 Act.

Chapter 4: assessment and examination prior to applications for admission to hospital

Around 55 written responses commented on this chapter, which was also extensively discussed in consultation workshops. There were a large number of comments and suggestions on matters of detail, although a number of issues recurred in several responses. A number of people argued that the guidance on when to use section 2 rather than section 3 and vice versa both in the draft and the current Code was legally incorrect and should be changed.

Some people commented that it was helpful for the chapter to give guidance on the relationship between detention and the new deprivation of liberty safeguards in the MCA, although others found the guidance unclear, confusing or incomplete. Several people questioned why the chapter no longer stated that approved mental health professionals (AMHPs) should always be responsible for coordinating assessments. A number of people questioned the meaning or the adequacy of the term “social care perspective” which AMHPs are intended to bring to assessments. Several people also questioned why AMHPs needed to inform patients and other people present at assessments of name of the local social services authority on whose behalf they are acting. Several people commented that it was essential, not merely good practice that doctors should discuss cases with the potential applicant. A number of people wanted the chapter to be more prescriptive about the role that the police would play in assessments. A number of respondents argued that doctors involved in assessments should not have any responsibility for securing a hospital bed where that was what their assessment indicated was necessary, but that this should fall either to AMHPs or to National Health Service (NHS) bodies instead. Those people who commented on the guidance about avoidance of de facto detention of informal patients were largely critical of it. Most suggested that the guidance was self-contradictory, because it would not be possible to inform patients of the effects of being detained without implicitly threatening them with detention.

Government response

We have extensively revised the chapter in the light of comments and made a large number of detailed changes. We have simplified the guidance on the distinction between section 2 and section 3, but we continue to believe the guidance in the current version of the Code to be essentially correct. We have retained the statement that AMHPs have responsibility for coordinating assessments unless it is agreed otherwise locally. We believe that is a matter for local decision. We also continue to believe that doctors involved in assessing patients have a responsibility for taking steps to secure a hospital bed where necessary - again, unless different local arrangements have been agreed. We have removed the guidance about avoidance of de facto detention of informal patients.

Chapter 5: emergency applications for admission

Fewer than 15 written responses commented on this chapter, which was not much discussed at the consultation workshops. Comments were largely suggestions on the detail of the wording, although one professional body suggested replacing references to “undesirable delay” with “unacceptable delay” and another professional body commented that the chapter did not acknowledge what it saw as the adverse impact of the European Working Time Directive on arranging round the clock clinical cover in rural areas.

Government response

We have made a number of small changes to this chapter in the light of comments. The term “undesirable delay” has been retained because that is the term used in the 2007 Act.

Chapter 6: appropriate medical treatment

Around 35 written responses commented on this chapter, in addition to comments made at the consultation workshops. Several people commented that the chapter as a whole, or specific parts of it were hard to understand. There were several requests for clarification or for further guidance on specific points; for example, how long psychological treatments might remain appropriate if the patient was not willing to engage. A number of people commented that it was unclear who the chapter meant by “decision-makers”. Several respondents argued that the chapter was self-contradictory because, on the one hand it said that simply detaining someone in a hospital could not be medical treatment, but, on the other hand, gave an example of appropriate medical treatment which amounted to no more than (or little more than) preventative detention. Some respondents argued that the distinction made in the draft between the purpose of treatment and the likelihood of it having a particular outcome was incorrect. For example, one professional association argued that treatment can only be for a purpose if it is reasonably foreseeable that the purpose will be achieved. Several respondents questioned the statement that the alternative to providing medical treatment might be a prison sentence.

Government response

We have revised the chapter in the light of comments, largely to clarify material which people found confusing. However, we continue to believe that the guidance in the draft was essentially correct and do not agree that it was in any way self-contradictory. We have not attempted to be more prescriptive about what can and cannot constitute appropriate medical treatment, as that can only be determined on the facts of any given patient’s case.

Chapter 7: conflicts of interest

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents criticised it as being too lengthy and discursive and continuing previous ambiguity when clarity was sought. Some thought that the chapter should be more prescriptive, requiring a practitioner to withdraw if their ability to make objective decision was compromised. However there was a counter opinion that it was not necessary to withdraw immediately, but guidance and advice had to be sought. Questions were raised about various scenarios involving AMHPs and their independence generally: acting as an Appropriate Adult under the Police and Criminal Evidence Act 1984 (PACE); being junior to a doctor; being independent of the receiving organisation. Existing local arrangements were criticised as not doing enough to prevent approved social workers (ASW) from undue pressure currently. A clarification of “undue pressure” was sought to ensure distinction from robust professional disagreement and guidance on what would be acceptable for a relationship between assessing doctors, bearing in mind the benefits of prior knowledge and previous acquaintance against a fresh assessment and lack of preconceptions. The non-application of conflicts of interest to supervised community treatment (SCT) was seen by some respondents as a major flaw. Some respondents also suggested that the guidance was too hospital

focused; community and SCT issues had to be strengthened and clarified. The contrast with the MCA deprivation of liberty (DOL) safeguards regulations was noticed and there were calls for both drafts to be harmonised so that the only differences reflected different powers not different authors. Diagrams and charts of what was acceptable and schematic presentations of conflicts were proposed as a helpful aid.

Government response

We have extensively revised the chapter in the light of comments and the changes made to the relevant regulations. We have rationalised the guidance on conflicts of interest, although it is a complex area and some detail is necessary. We have set out what is required by legislation, although some degree of professional judgement on potential conflicts will continue to be needed and guidance makes reference to this. Although this is not covered by the regulations, we have given guidance on SCT and potential conflicts of interest.

Chapter 8: the role of the nearest relative

Around 30 written responses commented on this chapter, in addition to extensive comments made at the consultation workshops. This was criticised by some respondents as containing very little on the role and functions of the nearest relative (NR) and the Welsh code was cited as giving better information. More guidance on the role and responsibilities of the AMHP was sought by several people and on the need to stress local social services authority (LSSA) support. While accepting that NR was often confused with next of kin, there was a call for cross-referencing to others who might be involved in a patient's care.

Government response

We have revised the chapter in the light of comments. The roles and rights of the NR are set out in legislation. The Code makes it clear that hospital managers are responsible for ensuring that detained patients and patients on supervised community treatment and their NRs have been informed about their legal situation and rights. We have made appropriate cross-referencing; for example in chapter 4 on the role of the AMHP in respect of NRs. We have separated out the material on donees of lasting power of attorney ("attornies") and deputies appointed under the MCA and made it into a chapter of its own.

Chapter 9: places of safety and police powers

Around 35 written responses commented on this chapter, in addition to extensive comments made at the consultation workshops. Respondents made a variety of detailed comments and suggestions on specific points. Some respondents thought that the chapter should have an introduction reinforcing that the powers should be used with regard for the dignity and respect of the person concerned, minimising distress and using minimum force. It was also vital to give a clear explanation of the process. There were calls for cross-referencing to PACE procedures and codes of practice under other legislation. There was some concern that the Code was not binding on the police and training for the police and ambulance services was advocated.

Respondents requested additional guidance on a wide range of issues; for AMHPs on alternative legal options; on the meaning of reasonable force - with case examples of good practice; on who was responsible for custody during transfer and for transport; what to do in cases of disagreement; and on how quickly assessment should take place. The references to local policies and protocols were disliked by several respondents; they were seen as exacerbating existing variations and lack of co-operation. A number of people called for stronger guidance to emphasise that the use of a police cell was the last resort in an emergency and that the power was a medical emergency power not a police one. There were concerns about possible abuse of power; strong safeguards were important, as was the continuing social care perspective. There were also calls for robust monitoring with proper records and statutory documentation.

Government response

We have revised the chapter in the light of comments. We do not believe that the Code can give detailed advice to the police or to the ambulance services because the legislation that underpins it – section 118 of the 1983 Act – does not enable it to do so. However, as in the consultation version, the revised Code makes it clear that the police and ambulance services should be parties to locally agreed policies governing the use of the place of safety powers. The section on the rights of persons detained in a place of safety refers to PACE procedures. We continue to believe that operational policy should not be directed from the centre and that jointly agreed local policies are the way forward. The Code now stresses that such policies should set out response times for attending a police station, and define responsibilities for dealing with people under the influence of alcohol or drugs or who are violent and for arranging access to accident and emergency facilities and for record-keeping. We have also clarified responsibility for arranging transport to a place of safety in section 135 cases. We have made a number of changes to clarify when the authority to detain a person ends and when a transfer to another place of safety may take place.

Chapter 10: conveyance of patients

Around 30 written responses commented on this chapter, in addition to comments made at the consultation workshops. Comments included a variety of specific suggestions for the wording of the chapter and for other points that might be included. A number of themes were raised by several different respondents. Several respondents wanted the chapter to be more prescriptive about when and how the police should be involved in conveying patients. A number of respondents argued that leaving these issues to local agreement did not work. Similarly, several respondents wanted more prescriptive guidance on the role of ambulance services. A number of respondents suggested there should be more guidance on the use of restraint and sedation and awareness of physical distress and physical health issues.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes. We do not believe that the Code can or should give prescriptive guidance about the role of

ambulance services or the police, but the revised draft emphasises more strongly the need for these matters to be discussed and agreed locally.

Chapter 11: holding powers

Around 25 written responses commented on this chapter, which was not much discussed at the consultation workshops. Comments were mostly on matters of detail. They included requests for further guidance on a number of issues, including: the definition of “in-patient”; arrangements in non-mental health hospitals; the meaning of “junior doctor” and “senior psychiatrist”; the way in which responsible clinicians could ensure that their deputies had appropriate training and experience and when it might be appropriate to use powers under the MCA instead. One respondent pointed out that the chapter did not reflect the latest case law on how reports could be furnished to the hospital managers. Another respondent regretted the omission of the guidance in the current code on the steps to be taken if the clinician in charge of the patient’s treatment has not arrived within four hours of the use of section 5(4); the respondent argued that this advice was interpreted as setting a target time which should be reduced.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes and additions. In general, the chapter has been revised to be less prescriptive about specific operational matters. We believe that is better left to local decision.

Chapter 12: receipt and scrutiny of documents

Around 25 written responses commented on this chapter, in addition to comments made at the consultation workshops. The issue raised most frequently in the comments was the absence of any arrangements in the 2007 Act for the rectification of documents relating to supervised community. There were a variety of other comments on the detail of the chapter, including some suggestions that the Code should spell out the cases in which errors in documents can or cannot be rectified. Several respondents suggested that the chapter should make clearer that it is only significant errors which would invalidate documents, not those which are *de minimis*.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes and additions. We have included further guidance on SCT documentation, emphasising the importance of ensuring it is correct before it is acted on, but the Code cannot allow what is not permitted by the legislation.

Chapter 13: allocating a responsible clinician

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents saw this as representing a major shift in clinical practice so detailed guidance was requested. Some suggested that frequent changes of the responsible clinician (RC) would result in a loss of direction and the clinical team not working together, resulting in a lack of care for the patient. There were calls for clarity about various roles, especially in respect of prescribing and on the autonomy of partners in the care team. The issue of a patient rejecting an RC was raised and guidance sought on how to handle such incidents and requests for a change of RC. Some respondents suggested that disagreements between the RC and another team member would also require guidance. The proposal that hospital managers should keep the appropriateness of RC under review drew a variety of responses. Some thought it was unnecessary. Some were unclear how it would be done. Some queried what powers hospital managers would have and whether they would simply monitor, make suggestions, or even make changes. There was a firm view from some respondents that local protocols were not rigorous enough to ensure the appropriate person acted as RC and that central guidance was needed if variations were to be avoided.

Government response

We have revised the chapter in the light of comments. It now reflects the importance of continuity of care and service user engagement, as well as the appropriateness of the RC. We have given guidance on circumstances where the RC does not lead all aspects of care - eg medication - and how disputes may be resolved. We do not think it appropriate to provide detailed central guidance for hospital managers on allocation of RCs.

Chapter 14: safe and therapeutic responses to disturbed behaviour

Around 30 written responses commented on this chapter, in addition to comments made at the consultation workshops. This chapter was criticised by some respondents as being muddled, repetitious and needing a complete re-write. The case example was poor and terms were unhelpfully loose in meaning. Some respondents queried the chapter's value; most of the contents were already addressed by National Standards and National Institute for Health and Clinical Excellence (NICE) guidance. It resembled a nursing manual and was too detailed for service users and carers. But others welcomed it as well thought-out and covering most of the important points well, reflecting a shift towards safe and therapeutic management of aggression and establishing a prevention culture. It was more comprehensive than the current Code and had a more positive feel. But it needed to be cross-referenced to and reflect other legislation and guidance and to clarify clashes and overlap with the MCA. Many respondents noted the absence of information on the use of mechanical restraints and recommended that the Code acknowledge their occasional use. There was a strong view from some respondents that the Code should spell out minimum training requirements for staff and that the use of alternative terminology should be explained, but kept to a minimum so as not to deprive patients of safeguards. Timescales engaged many respondents, whether the time period to elapse before the multi-disciplinary team meet to discuss an episode or review periods. There

was a call from some respondents for flexibility in timings of reviews at night. While there was strong support for longer term segregation to be reviewed clinically, many respondents flagged up the impracticality of expecting this of adjacent trusts and suggested the use of the second opinion appointed doctor (SOAD) service. Some respondents could not understand why restraint was seen to differ between cultures and genders. It was the same for all, although any sensitivities had to be respected.

Government response

We have revised the chapter in the light of comments. We have provided further guidance on the review of seclusion. The revised guidance allows for greater flexibility of reviews of seclusion, particularly at night. It emphasises the need for an early multi-disciplinary meeting to consider reviews and provides guidance on the use of seclusion where there is a risk of self-harm. We have also included guidance on the use of mechanical restraint. We thought some of the detail requested in the response was not appropriate for the Code, in particular requests for greater detail to be provided on training and the use of mechanical restraint. We believe the detail is more appropriately addressed in national guidance and local policy

Chapter 15: physical security

Fewer than 15 written responses commented on this chapter, in addition to a small number of comments made at the consultation workshops. The chapter was criticised as muddled and outdated, lacking references to modern security procedures and safeguards such as electronic locks and needing a redraft to give clearer guidance. It should variously consider the practice of locking wards for frail elderly patients to ensure their physical safety and that of their possessions, the use of locking in as an economic decision and locking doors to prevent the ingress of undesirables. One respondent suggested a statement on health and safety was necessary to ensure safe evacuation and clarity on what constituted a safer environment. Others suggested that the Code had to emphasise that information should be given in locally-used languages and links to the relevant parts of the MCA were requested. In addition, there were a variety of comments and suggestions on points of detail.

Government response

We have revised and merged this chapter with chapter 21 in the light of comments and in the interest of greater clarity. We have amended the guidance on physical security to reflect the use of modern security procedures such as electronic swipe cards and key fobs. The revised guidance emphasises that arrangements for physical security should not be disproportionate and should be based on a written policy that is freely available to patients and others and in languages other than English where necessary. We continue to believe that arrangements for the use of mobile phones, e-mail and the internet are a matter for local policy. We have, however, expanded considerably the guidance to provide greater clarity about the sorts of issues that local policies need to address. The revised guidance on personal searches emphasises the need to respect a person's gender, culture and faith. And the revised chapter

begins with a reference to the need to respect a person's private life in accordance with Article 8 of the European Convention on Human Rights (ECHR).

Chapter 16: preferences and decisions made in advance

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. A number of people commented that it was helpful to have a chapter on this issue, but there were mixed views on how easy the chapter was to read – some respondents said they found it clear, some found it confusing. The majority of comments were about the detail of the drafting and included several suggested changes to make the meaning clearer in places. A number of people commented that the Code needed to contain more, and clearer, guidance on the interface between the 1983 Act and the MCA.

Government response

We have revised the chapter in the light of comments, largely to make it easier to follow and use. In particular, we made a number of changes to emphasise that the chapter is dealing with specifically with the issues as they impact on decisions made under the 1983 Act, rather than with the issues in general which are more fully addressed in the MCA code of practice.

Chapter 17: confidentiality and information sharing

Around 30 written responses commented on this chapter, in addition to a small number of comments made at the consultation workshops. Views were mixed on whether it was helpful for this chapter to try to give guidance on general issues relating to confidentiality and information sharing, rather than just those specific to the 1983 Act. Some respondents thought it was not helpful, other respondents wanted more detail on these general issues. Several respondents suggested that the chapter should refer to the MCA and to other sources of guidance. Some suggested there were inconsistencies with the MCA. Several people asked for more guidance on how professionals should balance the issues of patient confidentiality with the benefits of involving carers and other people with an interest in patients' care. Some respondents thought that more should be said about carers' access to information. There were a variety of other detailed comments and suggestions.

Government response

We have extensively revised the chapter in the light of comments, particularly to focus more clearly on issues which are specific to decisions which are made under the 1983 Act itself.

Chapter 18: information for patients and nearest relatives

Around 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents made a variety of detailed comments and suggestions. Information had to be provided in a form that would be easily understood by the patient or carer and this should be provided proactively. Professionals should be directed to listen to

concerns; poor communication was seen as a common crisis trigger. There were calls for cross-reference to the MCA and to the Code chapter on communication. There were suggestions for additions to what should be communicated to patients, including the availability of advocacy, treatment options, the effects and side-effects of medication, the role of the Mental Health Act Commission (MHAC) and the right to seek discharge from supervised community treatment.

Government response

We have revised this chapter in the light of comments and combined it with chapter 2.

Chapter 19: advocacy

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. Some respondents criticised this chapter as very general, short, unclear and containing little useful information. Others found it useful as an introduction to the advocacy role. There were calls from some respondents to define and clarify independent advocacy and the independent Mental Health Act advocate (IMHA) role and specific functions. Some people thought the current description was too narrowly defined and there was a suggestion that the name of the service should describe more specifically what it did. Several respondents wanted more guidance on advocacy services for patients who lack capacity and how advocates were to visit patients on supervised community treatment.

Government response

We have revised the chapter in the light of comments, in particular to make clearer that the chapter is not guidance on how IMHA services should be organised and operated, nor guidance for IMHAs themselves. Rather it is guidance for the people to whom the Code is addressed on the implications of IMHA services and the rights that IMHAs have in connection with the support they provide to patients. Separate guidance on implementing IMHA services will be issued in due course.

Chapter 20: visiting patients detained in hospital

Fewer than 10 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents made a variety of comments and suggestions on the detail of this chapter. A number of points were raised by several respondents. In particular respondents suggested there was no need to mention age when referring to children. But the Code should recommend providing information about visiting in age-appropriate ways and service users should be involved in drawing up visiting plans. The Code should also underline the importance of disrupting family relationships and friendships as little as possible. The status of legal representatives was important. It should be clearly set out and guidance clarify that they should expect privacy. Some respondents drew attention to national guidance on access in secure hospitals. Others sought recommendations on helping financially with

accessibility, using other means to keep in touch and befriending schemes for patients without family or friends.

Government response

We have redrafted the chapter to provide greater clarity where respondents felt the guidance was not clear, in particular for children and young people visiting and being visited. We have included further detail to clarify the guidance relating to those who have a right to visit the patient in private.

Chapter 21: privacy and security

Around 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents made a variety of comments and suggestions on the detail of this chapter. A number of points were raised by several respondents. In particular respondents noted the absence of a reference to Article 8 of the ECHR. Some thought that the code should be explicit in recommending police participation in searches where weapons or drugs might be involved. Women-only facilities were welcomed as improving safety, but also criticised as discriminatory. There were calls for extension of segregated facilities for people with learning disabilities and older people. Some respondents called for clear guidance on the use of mobile phones, camera phones and personal computers. It was not acceptable to leave this to local protocols; there had to be common standards across services. Security of belongings was important; theft upset all patients. And it was important to respect patients' personal and religious belongings during any searches.

Government response

We have revised and merged this chapter with chapter 21 in the light of comments and in the interest of greater clarity.

Chapter 22: leave of absence

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents made a variety of detailed comments and suggestions on the content and wording of the chapter, but without any particular common themes emerging. A number of respondents suggested that the chapter needed to make clearer that only certain patients were eligible for SCT and more than one questioned the statement that the Ministry of Justice (MoJ) would regard an application for more than a few consecutive nights' leave for a restricted patient as an application for conditional discharge. Other suggestions included more guidance on: whether leave is needed to allow a patient to be transferred to another hospital for medical treatment in an emergency; whether leave is required to visit other parts of a site on which more than one hospital is based; the responsibilities of approved clinicians (ACs) and RCs when patients are given leave on the basis that they reside in another hospital; renewing detention while patients are on leave; and guidance encouraging hospitals to record the outcome of leave. A carers' organisation

suggested that more need to be said about carers and about support for patients while on leave.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes and additions. In particular: the guidance now makes clearer that section 2 and restricted patients cannot be discharged onto supervised community treatment; there is more on responsibilities of responsible and approved clinicians when patients are on leave to another hospital; and new guidance on the importance of recording the outcome of leave.

Chapter 23: absence without leave

Fewer than 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents made a variety of detailed comments and suggestions. A few issues were raised by more than one respondent. A number noted that the list of situations in which patients were absent without leave was not complete. Some thought the chapter should be more prescriptive about what the police should, or should not, be expected to do. Two respondents queried why the possibility of faxing authorisations was mentioned, but not other methods such as e-mail.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes and additions.

Chapter 24: treatment plans

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. A number of respondents commented that the guidance in the chapter was not very detailed. Of those, one suggested the whole chapter should be deleted while others suggested that it should be greatly expanded. There were a variety of detailed suggestions, particularly for additions to the chapter. Several of those related to the importance of involving patients and carers fully in the process, the interface with the MCA and the potential role of advocates.

Government response

There is no longer a separate chapter on treatment plans. We have revised the material in the light of comments and made it part of a new combined chapter on medical treatment under the 1983 Act generally.

Chapter 25: treatment regulated by the Act

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. Many respondents criticised the chapter for being confusing and hard

to follow. There were calls for guidance boxes, examples, flowcharts and bulleted lists. Several people argued that the chapter should, like the current Code, contain more general guidance on issues of consent and capacity. On capacity, there were conflicting views: some respondents wanted full guidance rather than reference to the MCA Code of Practice. Others were against repetition of MCA guidance, but wanted clear signposting to that source. There were a variety of detailed suggestions for changes to the chapter. Subjects suggested for additional guidance included: what kind of treatment can be considered to be treatment for mental disorder; the legal basis for administering electro-convulsive therapy (ECT) to children and to people who lack capacity; the difference between responsible clinicians and approved clinicians.

Government response

In the light of comments, we have completely revised and restructured this chapter and chapters 24 and 26 to make the guidance on what is unavoidably complex subject matter easier to follow. The material is now divided into two. The first chapter (chapter 23) deals with treatment under the Act in general, the second chapter (chapter 24) deals with the special rules and procedures, including the role of SOADs, which apply to specific forms of treatment. We have made a variety of specific changes and additions. In addition, some general guidance on consent and capacity has been restored to the first chapter, with the guidance on capacity consisting largely of material taken from the MCA.

Chapter 26: second opinion appointed doctors

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. Comments were largely on matters of detail. They included suggestions on: who SOADs should consult before giving certificates; the factors that SOADs should consider; the procedure that SOADs should follow. A number of respondent pointed out that the chapter did not recognise the practical difficulty of SOADs consulting other professionals in person.

Government response

We have revised the material in this chapter and combined it with material from the previous chapter in a new chapter 24 dealing with treatments subject to special rules and procedures. We have made a variety of specific changes and additions. In particular, the chapter no longer says that only in exceptional circumstance may discussions between SOADs and treating clinicians not be face-to-face.

Chapter 27: psychological treatments

Around 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. There were mixed views about the value of this chapter. Some of those who commented were pleased to see this chapter included. They thought that psychological treatments were a key aspect of care and use should be encouraged, but some

also said that it was important to avoid any implication of one-sided and unfair criticism of psychiatry. Others took a counter view. They thought the chapter could be condensed or removed as it gave little practical guidance. There was disappointment that it promised content but did not deliver; for example on competencies, children, consent to treatment. A further view was that there was no need to provide guidance as the treatment was now mainstream. Staff competence and experience caused concern. There were numerous qualifications in existence which were not accredited. The Code should have an explicit requirement of professional membership/registration/accreditation and staff should demonstrate supervised practice in training and an understanding of the evidence. Respondents underlined the importance of giving information to patients and using a variety of communication methods. Culturally sensitivity and awareness was vital, as was the need to address inequalities and mental health teams should be pro-active and anti-discriminatory by considering culturally diverse patients and providers. Mental Health Teams should also be encouraged to work with social care workers to deliver holistic and effective health care.

Government response

There is no longer a chapter on psychological treatments. We have included the guidance in the chapter on medical treatment under the Act where we emphasise the need for psychological therapies to be considered as part of the treatment plan.

Chapter 28: supervised community treatment

Around 45 written responses commented on this chapter, which was also extensively discussed at the consultation workshops. Some responses revealed misunderstanding or lack of knowledge of the new provisions for SCT, or revisited concerns expressed during the passage of the Act. Many respondents wanted more guidance on the practicalities of SCT, such as how the transition between hospital and community and vice versa, would be managed. There were calls from several respondents for more guidance on when SCT would not be appropriate, how to “come off” SCT, on the conditions and how they should be framed and on the various roles and responsibilities of the care team. A number of questions were raised about the process for recall and about the status of a recalled patient. Some respondents argued that the balance of the chapter was focused more on risk assessment than on patient care and benefit.

Government response

We have revised the chapter to provide greater clarity where it was evident that respondents found the wording confusing or inadequate; in particular the paragraphs about the decision whether SCT is appropriate, setting the conditions and the recall process. We have included more on when patients should be discharged, the need for consultation, how arrangements should work on the ground, care planning, and respective roles and responsibilities. Some of the concerns raised are not for the Code, but will be addressed over the coming months through the training programme and dissemination of information which will take place before implementation.

Chapter 29: guardianship

Around 25 written responses commented on this chapter, in addition to a small number of comments made at the consultation workshops. Many respondents wanted more guidance on the relationship between guardianship and the MCA and in particular the new DOL safeguards. Several respondents also wanted guidance on the new power to convey guardianship patients to the place where they are required to live. There were a variety of other comments and suggestions on matters of detail.

Government response

We have revised the chapter in the light of comments, and made various specific changes. Guidance on the new power of conveyance has been added, as has further guidance on the relationship with the MCA.

Chapter 30: after-care

Around 25 written responses commented on this chapter, in addition to comments made at the consultation workshops. A variety of comments and suggestions on points of detail were received. Several respondents asked for greater reference to the involvement of the patient and for cross-referencing to other guidance and case law, greater clarity on ending aftercare services and a requirement on local authorities to ensure fair allocation of resources.

Government response

We have revised the chapter in the light of comments, in particular to emphasise the importance of ensuring that patients reach informed decisions on section 117 after-care. The revised chapter also further emphasises the need for communication with primary care trusts (PCTs) and LSSAs over preparations for after-care in the event of a Tribunal discharging a patient. Whilst we do not believe the Code can be prescriptive over circumstances in which section 117 after-care should end, we have responded to requests to say a little more about this.

Chapter 31: guardianship, leave of absence or supervised community treatment?

Around 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. A number of respondents made a variety of comments and suggestions on points of detail. The tables of factors to consider were thought to be helpful by those who commented on them, although there were calls for more detail. Some respondents wanted guidance on use of the MCA, in particular the deprivation of liberty safeguards, to be included. More illustrative examples were requested.

Government response

We have revised the chapter in the light of comments to include brief material on the deprivation of liberty safeguards in the MCA. We have also accepted a number of points of detail which are covered in the final chapter. We have not expanded the chapter to the extent that some respondents wished, either because the material is available in other chapters or is not appropriate for the Code; for example where a full explanation of legal provisions was requested.

Chapter 32: renewal, extension and discharge from detention and supervised community treatment by responsible clinicians

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. A number of national bodies argued that the guidance on the procedure for obtaining the agreement of a second professional to renewal of a patient's detention was unsatisfactory. They thought it should be more prescriptive and restrictive. In particular, they opposed the idea that a decision could, in effect, be appealed to a more senior professional. There were a variety of other comments and suggestions on points of detail.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes. We agreed, to a degree, with those respondents who suggested that the guidance should allow less flexibility in relation to the role of the second professional in renewing detention and we have revised the material accordingly. We have also expanded the chapter to include material on NR's powers to discharge patients from detention and SCT, including an illustrative standard letter which hospital managers might make available to nearest relatives on request. The optional statutory form for this purpose is to be abolished.

Chapter 33: functions of the hospital managers

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. There were variety of comments and suggestions, mostly on matters of detail. A number of people misunderstood the explanation of the way in which NHS foundation trusts could delegate their functions, suggesting that the drafting was not clear. Several comments revealed confusion about the meaning of "hospital managers" and a number of people suggested that the chapter should distinguish more clearly between the formal hospital managers and the different people who exercise functions on their behalf.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes and additions. In particular, we have attempted to signal clearly the difference between the formal hospital managers (ie the organisation or individual in charge of the hospital), "managers' panels" which taken discharge decisions on their behalf and the other people who exercise functions on behalf of the hospital managers.

Chapter 34: the hospital managers' discharge

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. There were a variety of comments and suggestions on points of detail. Several respondents wanted the chapter to be more prescriptive about the approach managers should take, about the timescales within which documents should be provided, and similar issues. A number of people either questioned or asked for more explanation of the statement that managers should “usually” discharge patients whose discharge had been barred under section 25 if they disagreed with the responsible clinician's barring order. A number of people suggested that the distinction between contested and uncontested renewals of detention should be removed and that hearings should be held in all cases. A number of respondents asked for further guidance on the role of NHS bodies in respect of NHS patients who are in, or are the responsibility of, independent hospitals.

Government response

We have revised the chapter in the light of comments and made a variety of specific changes and additions. In particular, the chapter no longer states that procedures should differentiate between contested and uncontested renewals. That is now left to local decision. Hospital managers' residual discretion to discharge, or not to discharge, is now covered in more detail. We have also substantially revised the guidance on NHS bodies' role in relation to NHS patients for whom independent hospitals are responsible.

Chapter 35: mental health review tribunals

Around 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. The detail was considered helpful but there were a variety of comments and suggestions. In particular one respondent suggested the checklist for completion of the social circumstances report was out of date and should refer to Mental Health Review Tribunal (MHRT) guidance issued in 2002. Another said that the Code should advocate local policies setting out requirements on staff in relation to MHRTs. Additional guidance was suggested to cover: what to do if members of a clinical team have different views; who should complete the social circumstances report; how to deal with contested material; and the rights of legal representatives. Some respondents went further, suggesting that RCs needed legal training and that trusts should consider additional experienced representation by trained and legally qualified staff. Some respondents noted that the Code was not the place to try to influence the composition of MHRTs, but members should be trained in cultural competency, if not ethically and culturally diverse themselves. Some thought the Code should draw MHRT members' attention to the respect principle with particular reference to race and culture.

Government response

We have extensively revised the chapter in the light of comments, in particular to make clearer that it is not intended to give guidance to MHRTs themselves. We have included additional

guidance to clarify the right of independent doctors to visit the patient in private and to inspect the records.

Chapter 36: part 3 of the Act

Around 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. Respondents made a variety of comments and suggestions on the detail of this chapter. A number of points were raised by several respondents. In particular some respondents thought it was important to stress the importance of court-based diversion schemes and that local policies should be drawn up to make best use of them and with a commitment to liaison. Some others said there also needed to be Information gathering and sharing protocols which would ensure that relevant and accurate documentation followed a patient through the system and PCTs should have a responsibility to provide information and advice to the police and the Crown Prosecution Service (CPS) and work with courts to develop service level agreements (SLAs) for the provision of psychiatric reports. Some respondents said that guidance should cover how the principles applied to Part III patients, how a staff member could pursue a prosecution and what had to be done for a patient leaving prison at the end of a sentence, returning to hospital and thence to SCT. Amongst other comments were that information about benefits and rights was important, as was the need to involve carers and families.

Government response

We have increased the detail of this chapter to respond to the concerns expressed.

Chapter 37: people with learning disabilities

Around 20 written responses commented on this chapter, in addition to comments made at the consultation workshops. This chapter was criticised by some respondents as being descriptive not prescriptive and good practice guidance rather than operational guidance. It was therefore not appropriate for inclusion in a legal code of practice and its contents should be put in a supplementary handbook, or used for training. The case study was variously described as helpful/disappointing/useful/needing amendment. Some respondents called for carers' contributions to the assessment process to be required and given equal weight with those from practitioners. The particular needs of this group of patients were highlighted, with requests for guidance on communication - particularly non-verbal communication and the appropriate means of communicating - and the importance of the least restrictive principle, given possible reactions to hospital settings. Some respondents suggested a legal difficulty with assessing abnormally aggressive and seriously irresponsible behaviour and that the Code should recommend assessing patients against people with learning disabilities, not against the population. Some people commented that the connection between the 1983 Act and the MCA should be made; it was a complex legal area and AMHPs needed guidance on the legal basis for decision-making.

Government response

We are grateful to a number of expert commentators for suggestions on a range of professional and technical issues in this chapter which we have revised in the light of their comments.

Chapter 38: people with personality disorder

Around 15 written responses commented on this chapter, in addition to comments made at the consultation workshops. Some respondents thought the chapter was inappropriate because it contained little practical advice and it was unclear what practitioners were being required to do. They thought it could be condensed and restricted to the compulsion of people with personality disorder, expanding guidance elsewhere in the Code - for example, how to apply the appropriate medical treatment test – but avoiding guidance on diagnosis. Some respondents criticised the tone of the chapter as being too negative, with repeated links to offending behaviour and continuing the perception of dangerousness. A variety of other detailed comments and suggestions were made.

Government response

We have extensively revised the chapter in the light of comments and have focused it more clearly on particular issues of relevance to the 1983 Act.

Chapter 39: children and young people under 18

The provisions for children in the MHA were seen as a positive development and this chapter was welcomed. However, while some respondents thought it helpful and easy to read, others criticised it as not giving enough clarity for practitioners and failing to explain the law in key areas. They wanted more on the Gillick competent child. They wanted it to explain very clearly the links between MCA and the 1983 Act and replicate guidance in MCA code because they thought the guidance did not match and it was confusing. There were calls to list other legislation and to reference the Children Act and the United Nation Convention on the Rights of the Child (UNCRC). The flowcharts drew conflicting responses. Some welcomed their clarity but wanted them aligned with paragraphs. Others criticised them as overly simplistic and suggested they were undermined by the inconsistency of the text. Some respondents criticised what they saw as an all-or-nothing approach to capacity and felt there was over-emphasis on court intervention. They feared this would make professionals defensive, and could lead to delay of delivery of care and treatment. There were reservations expressed by some people about the concept of the zone of parental responsibility. They felt clear guidance was needed and this was not currently met by the examples given. The term should also be included in the glossary. There was a call for guidance on when treatment in an adult environment took precedence over age-appropriate environment and specific questions for hospital managers to assess an age-appropriate environment. Respondents stressed the need to provide information in a format children and young people could understand, to give their views equal weight to an adult's and to advocacy. Also requested were examples of staff skills, training

and knowledge and of specific practice and case studies. A criticism was that without a chapter on age-appropriate services for older people there was a risk of discrimination.

Government response

We have reordered and partly rewritten the chapter to take account of the responses received, particularly to provide greater clarity for practitioners. We have re-ordered the text so that practitioners are taken through decisions on admission and treatment of under-18s separately, setting out first whether the individual is capable of consenting (16/17 year olds) or Gillick competent (under 16s), then considering informal admission and informal treatment for each scenario. We have added at the start of the chapter references to other relevant legislation. We have reduced the number of flow charts and these now more closely reflect the main text. The text now makes it clearer, through the introduction of a specific section on applications to the High Court, when it might be appropriate to go to Court for a decision. The text on the concept of the zone of parental responsibility, now renamed the zone of parental control to avoid any confusion, has been revised to provide clearer guidance. The section on age appropriate services includes examples on when treatment in an adult environment might take precedence over an age appropriate environment. The need to provide information in a format that children and young people can understand and to consider their view is contained in the general considerations section of the chapter. The chapter now includes six examples for use with the flow charts. The reference to age appropriate services only relates to children and young people, not older people, because there is specific provision only for them in the legislation.

Secondary legislation

Mental Health (Hospital, Guardianship and Treatment) Regulations 2008

These updated existing regulations covering a variety of procedural issues as a consequence of the changes made by the 2007 Act.

Fewer than 15 written responses commented on these regulations. They were not greatly discussed at the consultation workshops.

General

Q1.1 Do you think that we have covered the right areas in the regulations (given what the Act allows)?

Of the few people who commented specifically on this question, all agreed that the regulations covered the right areas.

Q1.2 Do you think we have missed anything that should be covered (given what the Act allows)?

Of the few people who commented specifically on this question, none suggested any other areas that should be covered.

Q1.3 Is there anything you think we could leave out of the regulations?

Of the few people who commented specifically on this question, none suggested anything that should be left out of the regulations.

Q1.4 Do you think we have made the right changes compared to the current regulations?

Of the few people who commented specifically on this question, none answered “no”

Q1.5 Are there other changes you think we should have made?

There were a few suggestions for other changes, mostly related to questions about specific aspects of the regulations which are described below.

Government response

Although only a relatively few comments were received, we are reassured that the draft regulations covered the appropriate areas.

Supervised community treatment

Q1.6 Do you agree with the draft regulations about supervised community treatment?

Of the few people who commented specifically on this question, none disagreed except one respondent who disagreed with SCT in general.

Government response

Again, although only a relatively few comments were received, we are reassured that the draft regulations in relation to SCT were appropriate.

Nearest relatives

Q1.7 Have we identified the correct people who should be notified that the functions of the nearest relative have been delegated to another person under draft regulation 21?

Of the few people who commented specifically on this question, none suggested anyone else who should be notified. One respondent thought that patients should not only be notified, but given reasons for the delegation. Another respondent thought that the people to whom NRs delegate their functions should be required to confirm their agreement before the delegation took effect.

Q1.8 Draft regulation 21 also says that the notification must be in writing and that notice can be transmitted electronically in order to provide for a speedy delegation where this is needed. Is this right?

There were mixed views on this question. Some respondents favoured the use of e-mail in particular, although some of those who favoured it also felt that there needed to be specific safeguards to protect patients' confidentiality. Others felt that allowing electronic communication was either unnecessary or insufficiently certain and secure.

Government response

We do not agree that the delegates should be required to agree to the delegation before it took effect. In practice, if the delegate is not prepared to exercise the functions, the delegation is of no practical effect. We noted the mixed views about allowing NRs to use electronic communication methods when delegating their functions, but on balance decided that the regulations should allow it, provided the recipient is happy to accept notification in that form. NRs and the people to whom they delegate their functions are, for the most part, private individuals and we do not think it necessary or appropriate to impose on them any particular security measures relating to electronic communication.

Treatment safeguards

Q1.9 Do you agree with draft regulation 24 that surgical implementation of hormones for reducing male sex drive should remain subject to section 57 of the Act?

Respondents who commented on this all agreed with the proposal. One respondent suggested that deep brain stimulation should also be covered by section 57.

Q1.10 Do you agree with draft regulations 24 and 25 that the use of medications administered as part of ECT should be covered by section 58A of the Act and that they should only be immediately necessary in the Act in the same cases that ECT itself is?

Respondents who commented on this all agreed with the proposal. One respondent suggested that force feeding of patients with eating disorders should also be covered by section 58A.

Government response

We consider it is worth exploring further whether other forms of treatment should be covered by the special safeguards in sections 57, 58 and 58A, but think that separate, specific consultation will be required before any decisions were taken.

Other changes in the regulations

Q1.11 Do you agree with the new draft regulation 23 about information for patients and nearest relatives?

Those respondents who commented on this question welcomed the new requirements.

Electronic communication and record keeping

Q1.12 Do you have a view on what, if any

- official written notices, information etc required by the Act or regulations people should be able to write and send electronically?
- official records required by the Act or regulations people should be able to keep in electronic form without having to have a hard copy as well?
- conditions or limitations there should be on this?

Most respondents who commented had no objection to the use of electronic communication provided confidentiality safeguards, backup systems and access controls were properly addressed. Some, however, thought it unnecessary or that it should only be used in cases of urgency. And it was pointed out by one respondent that service users, NRs and carers did not always have access to e-mail.

Government response

We believe there is a case for an order under the Electronic Communications Act 2005 (“the 2005 Act”) for allowing greater use of electronic communication of statutory documents under the 1983 Act. However, we think that further, more focused, consultation would be required before any decisions were taken. In the interim, the regulations will allow electronic communication to be used in a limited number of circumstances where no order under the 2005 Act is required, but only with the recipient’s agreement. The requirement for the recipient to agree will allow local decisions to be taken on what, if any, particular arrangements are required to ensure the security and confidentiality of information transmitted electronically

Statutory forms

The consultation included an invitation to comment on a revised set of statutory forms to be included in regulations under the Act.

Q2.1 Do you agree that the concept of statutory forms as a major part of the way the 1983 Act operates should be retained?

Those who commented all thought that statutory forms should be retained.

Q2.2 Do you agree with the Department’s broad criteria for when statutory forms are likely to be appropriate?

There were mixed views on this question, with a number of respondents suggesting that the criteria were too narrow

Q2.3 Do you think that the proposed numbering system for forms is useful and appropriate?

The people who commented on this question agreed that the numbering system was helpful.

Q2.4 Do you think that responsible clinicians should be required to use specific forms when discharging patients from detention or supervised community treatment?

The people who commented on this question all favoured such a form.

Q2.5 Do you agree with the Department's suggestions for forms which can be abolished?

There were mixed views on this, but in general people who commented were more likely to suggest retention of forms than agree with their abolition.

Q2.6 Are there other forms which you think should be added or deleted?

There were several suggestions for additional forms, including forms for suspension of conditions in SCT, hospital managers' discharge decisions, urgent treatment under section 62 and after-care under section 117 of the 1983 Act. Two respondents suggested the abolition of forms for joint medical recommendations - although, in fact, the legislation would not allow that.

Q2.7 Do you agree with the Department's suggestion for how doctors should be required to give their reasons for thinking that detention under section 3 of the Act is necessary? Do you think it would be useful for approved mental health practitioners to have to give their reasons on any particular forms?

No-one who commented disagreed with the proposed approach to doctors' reasons in recommendations for detention under section 3. Those who commented on AMHPs' reasons all agreed that they need to be recorded, but there were different views on whether they should be recorded on the statutory application form or, as now, in a separate outline report for the relevant hospital.

Q2.8 Do you agree with the Department's approach to remove checklist material from the forms?

Most people who commented on this question disagreed with the Department's approach, arguing that the material helped hospital managers in particular comply with their statutory duties.

Q2.9 Do you have any other comments on the proposed forms?

Respondents made a variety of specific comments and suggestions on the detail of the forms, some suggesting that extra information be recorded: eg the patient's date of birth, the name of the relevant NHS body as well as the name of the hospital in question.

Government response

Although most people who commented were in favour of taking a more expansive approach to statutory forms, we are not persuaded of the case for more statutory forms or for retaining the "checklist" material on them. Our view remains that statutory forms are not and should not try to be a substitute for effective local record-keeping and monitoring. For similar reasons, although it was welcomed by those who commented on it, we have decided not to proceed with the proposal for a statutory form by which RCs may discharge patients. The only substantive argument advanced by respondents in favour of such a form was that RCs were more likely to complete a statutory form than to comply with local management requirements. We do not think that is a compelling argument for requiring those organisations which do have effective local arrangements to abandon them in favour of a statutory form. We have made a variety of detailed changes to the forms in the light of consultation.

Mental Health Act 1983 (Independent Mental Health Advocates) Regulations 2007 []

The 2007 Act introduces IMHA services for all detained patients as well as those subject to SCT or guardianship. It was a move universally welcomed. The draft regulations covered how advocacy services should be commissioned and advocates appointed, what training, experience and characteristics they should demonstrate and when they can act as an advocate.

Commissioning independent mental health advocate services

Q3.1 Currently the regulations do not specify which organisation should be responsible for commissioning the independent mental health advocate service at a local level. There are advantages and disadvantages in making primary care trusts or local authorities responsible for commissioning this service. Your views, along with rationale, would be appreciated on which organisation you consider most appropriate to undertake this.

Some respondents favoured Trust commissioning and argued that placing it with PCTs or LSSAs would lead to inconsistency, citing their experience of the operation of the independent mental capacity advocate (IMCA) services. Others believed that LSSA commissioning would demonstrate advocates' independence from direct provision of mental health services and would build on the IMCA experience – this time cited as a good one. A third view was that commissioning should go to whoever had experience. Many suggested that IMCA and IMHA services should be combined.

Appointment of independent mental health advocates

Q3.2 Do the regulations sufficiently cover the criteria that must be taken into account when appointing someone to be an independent mental health advocate and that should be taken into account when commissioning an independent mental health advocate service?

Most respondents welcomed the idea of a qualification and there was support for a single national standard.

Local circumstances

Q3.3 Do the regulations strike the right balance between ensuring that commissioners should have regard to particular local circumstances and special needs when commissioning independent mental health advocate services, whilst allowing sufficient flexibility to ensure efficiencies and economies of scale?

This was supported, but it was noted that the need for advocacy should always have priority over meeting special needs.

Person not professionally concerned with a patient's medical treatment

Q3.4 Do the regulations provide the right balance in ensuring that the independent mental health advocate works solely for the patient and should not be part of the clinical team?

Those who commented on this felt that working as part of the clinical team was seen as compromising the advocate's independence, but they should be involved in all areas where the patient is seen.

Patients' records

Q3.5 Should the regulations provide for dealing with requests from independent mental health advocates to see patients' records where patients lack the capacity to give consent?

Alternatively, is this issue better dealt with in the code of practice?

Respondents thought this should be in Regulations.

Government response

These helpful and detailed comments will inform the IMHA regulations and guidance which will be drawn up later this year.

The Mental Health (Approval of Persons to be Approved Mental Health Professionals) (England) Regulations 2008

As a result of the 2007 Act, the ASW role is to be replaced by the AMHP which will be open to professions other than social worker. The draft regulations covered how AMHPs should be approved and for how long, which professions they should be drawn from and what competencies they should demonstrate.

General

Q4.1 Are any amendments to these regulations required to strengthen them for the benefit of patients?

Three respondents commented on this question and suggested that AMHPs be required to provide annual evidence of competence.

Government response

The regulations require AMHPs to undertake annual training and it will be for the approving LSSA to agree what training will be undertaken and how the learning is evaluated.

Granting approval

Q4.2 Do the regulations strike the right balance between ensuring that approved mental health professionals can move between England and Wales without too much bureaucracy and local social services authorities have a sound basis for approving them?

Q4.3 Do the regulations sufficiently address the possibility of approved mental health professionals shopping around different local social services authorities for approval?

Comments were received that: a national body, such as the MHAC (or its successor) should oversee training quality and set appropriate standards; national standards should be in place on approval criteria and process; a national AMHP database should be established and maintained, to include suspensions etc. Clarification was sought by some respondents in respect of return to practice in the case of an AMHP who completes their training and then does not directly enter practice as an AMHP, e.g. because of maternity leave

Government response

The General Social Care Council (GSSC) will quality assure standards of AMHP training. The requirements for granting approval, setting conditions and suspension of approval have been set out in regulations. It is for LSSAs to determine local systems and processes for approval and the maintenance of records. The regulations allow for an individual who has completed training approved by the GSSC or the Care Council for Wales in the last 5 years to be approved as an AMHP.

Suspension of conditions attached to registration

Q4.4 Do the regulations need to include some provision for the possibility of the suspension eg of a professional's registration?

The provision of suspension was supported by those who commented on this question, as was the need for re-approval.

Government response

We have included provision for suspension in the final regulations

Conditions of approval

Q4.5 Do the regulations strike the right balance between ensuring that approved mental health professionals continue to have the relevant competencies to act as an approved mental health professional and discretion for local social services authorities to decide how best to achieve this?

There were varying views on whether the requirement for 18 hours annual training should be set, but most agreed. Queries were received about who will approve/accredit the 18 hours training per year and what it will consist of. Suggestions were made that at re-approval there should be an update course to take account of changes to the law and case law.

Government response

We have retained the requirement for 18 hours annual training. It is for LSSAs to determine and agree this annual training for AMHPs they approve. LSSAs will wish to update this training as necessary to take account of changes.

Records

Q4.6 Do the regulations provide the right balance between minimising bureaucracy and ensuring that suitable administrative arrangements are in place?

Respondents were generally content with draft regulations in this respect. Some suggestions were made that records should include details of suspension or conditions and competencies evidenced. Also calls were made to specify how long records should be kept for.

Government response

We have redrafted the regulations to say that records should include suspension and for how long records should be kept. The need for other records is for LSSAs to determine.

Competences

Q4.7 Are there any key competences that are missing and should be covered?

Q4.8 Have we identified the keys pieces of legislation that approved mental health professionals need to be aware of and have particular reference to in their practice?

Q4.9 Can you suggest alternatives where competencies appear to be duplicative, overlapping or inappropriate?

Q4.10 If you find any of the competencies unhelpful as currently drafted, please suggest alternatives.

Mental Health Act 2007 Consultations Report

Among those who commented there was general support for competencies as drafted with some suggestions for aligning the AMHP competencies with those set out for the AC.

Government response

We have redrafted the regulations to be consistent in the way the competencies on the AC and AMHP are presented, but there will ultimately be differences as they are different roles.

Mental Health Approved Clinicians Directions 2008

Another role opened out by the 2007 Act is that of the responsible medical officer. (RMO). This is replaced by the RC, an approved clinician who is in charge of a patient's treatment. The AC role will not only be open to registered medical practitioners but to other professions. The draft regulations covered how ACs should be approved by and for how long, which professions they should be drawn from and what competencies they should demonstrate.

Q5.1 Are any amendments to the directions required to strengthen them for the benefit of patients?

Approval to act as an approved clinician

Q5.2 Do the directions strike the right balance between ensuring that approved clinicians can move between England and Wales without too much bureaucracy and the approving authority has a sound basis for approving them?

Q5.3 Currently, these directions for England do not make any provision for an approved clinician approved in Wales to act in England. The Mental Health (Mutual Recognition) (England and Wales) Regulations 2008, which also form a part of this consultation exercise, make provision for section 12 doctors to continue to act for their patients across borders in specific circumstances.

Q5.4 How long should the time limit for required approved clinician training be?

Among the comments made by the 4 respondents were calls for national standards for competencies; approved clinician courses to be authorised by the Secretary of State; a national body to oversee training quality and set appropriate standards. Concerns were raised about Strategic Health Authorities' (SHA) ability to delegate responsibilities for approving ACs to PCTs. The need for clear lines of accountability between ACs, the PCT and the SHA was emphasised.

Government response

We will not be setting requirements for standards on competencies and training in regulations. However, CSIP is supporting a cross-disciplinary working group to look at these issues and to develop guidance for SHA and PCTs.

Period of approval

Q5.5 Is the approval period for an approved clinician of 5 years reasonable and appropriate?

Among those who commented on this specifically there was general agreement that the 5 year period is appropriate. There were some calls for local discretion in the period. A few suggested that annual training should be required as with AMHPs.

Government response

We have retained the 5 year period retained and included provision for SHAs/PCTs to set other conditions.

Suspension

Q5.6 Do the directions need to include some provision for the possibility of suspension e.g. of a professional's registration?

There was general agreement among those who commented on this specifically that the directions need to include provision for the possibility of suspension.

Government response

We have redrafted the directions to include provision for suspension.

Conditions of approval

Q5.7 Do the regulations strike the right balance between ensuring that approved clinicians continue to have the relevant competencies to act as an approved clinician and discretion for strategic health authorities to decide how best to achieve this?

There were some calls for ACs to be required to evidence annually mandatory training as a continued condition of approval and retraining for re-approval. Some respondents also suggested that guidance should be provided so that SHAs are consistent in the evidence they require on AC competencies.

Government response

We have included provision for SHAs/PCTs to set other conditions. It will be for SHAs/PCTs to determine whether they wish to use this to set refresher training requirements, but there is no national requirement to do so

Records

Q5.8 Do the regulations provide the right balance between minimising bureaucracy and ensuring that suitable administrative arrangements are in place?

There was general agreement among those who commented on this question that records should include all those suggested by the Welsh legislation and that an archived record be kept.

Government response

We have included in the regulations the provision for a wider range of records to be kept and specify the period they should be retained

Competencies

Q5.9 Are the requirements set out in Schedule 2 (Relevant Competencies) appropriate? Are there any key competences that are missing and should be covered? Have we identified the key bits of legislation that approved clinicians need to be aware of and have particular reference to in their practice? Are there any key competencies that are missing and should be covered? If competencies appear to be duplicative, overlapping or inappropriate, please suggest alternatives. If you find any of the competencies unhelpful as currently drafted, please suggest alternatives.

Respondents generally supported the competencies as set out, but a call for more consistency with the AMHP competencies. A number of very detailed suggestions for changes to the competencies were made which were considered and adopted where appropriate: eg to improve consistency and aid clarity.

Government response

We have aimed to be more consistent in the way the competencies on the AMHP and AC are presented, but there will ultimately be differences as they are different roles

Transitional arrangements

Q5.10 Is the three year approval period for a responsible medical officer becoming an approved clinician under transitional arrangements proposed below reasonable and appropriate?

Some calls were made for existing RMOs to be approved for five years as opposed to three years under transitional arrangements, but others supported three years.

Government response

The transitional arrangements for ACs are not set out in these directions and we will be making the arrangements clear in appropriate legislation in due course.

The Mental Health (Conflicts of Interest) (England) Regulations 2008

These regulations provide a patient safeguard by covering the circumstances in which an AMHP or medical practitioner applying to admit a patient for assessment or treatment might have a conflict of interest due to financial, business or personal reasons which may impinge on their professional judgement. Fewer than 10 written responses were received on these regulations.

General

Q6.1 Are the circumstances where there may be potential conflicts of interest, as set out in the regulations, appropriate and reasonable?

Q6.2 Are the requirements set out in the regulations reasonable and practicable?

Q6.3 Are any amendments to the regulations required to strengthen them for the benefit of patients?

There was a view that a patient or their nearest relative should not be known personally to the AMHP or medical practitioner.

Government response

We have simplified the regulations in this respect.

Potential conflict of interest for business reasons

Q6.4 The regulations for Wales separate the potential conflicts of interest for business and professional reasons, whereas the regulations for England put them together under the one heading. Would it be helpful to make same distinction in the regulations for England or are they clear as they are?

Q6.5 Do the regulations strike the right balance between the assessor, where there might be a conflict of interest for business reasons and safeguarding the patient's interests?

Q6.6 Currently, the regulations cover a conflict of interest where the assessor works for another assessor or the patient's nearest relative. Are there any other relationships that should be covered? Eg should the business/professional relationship between the patient and the assessor be covered? Is this an issue in practice or is it covered by professional codes of conduct?

Mainly respondents said that it would be helpful if business and professional conflicts of interest could be separated. A minority view was that it is better to combine business and professional reasons. There was support for detailing the potential conflicts of interest in regulation.

Government response

We have separated business and professional reasons in the regulations.

Potential conflict of interest for personal relationships

Q6.7 Do the regulations strike the right balance for when a spouse might have a potential conflict of interest and safeguarding the patient's interests?

The only comment received was that the list of relationships should be aligned with those set out in the DOL safeguards regulations

Government response

We will align DOL safeguards regulations and these regulations

Emergency provision

Q6.8 As currently drafted, regulation 6 is wider than the current provisions in section 12 of the Act, which allows for both doctors who make medical recommendations in an emergency to be on the staff of the same hospital, provided that one of them works less than half time. Do the regulations establish the right balance?

There were some calls for clarification on when conflicts of interest can be overridden because of urgency.

Government response

We have made this clearer in these regulations and in the Code.

The Mental Health (Mutual Recognition) (England and Wales) Regulations 2008

These regulations set out the circumstances in which a section 12 practitioner and an AC who are approved in England are treated as approved in Wales and vice versa.

Q7.1 Are the circumstances where an approved clinician approved in England may act in Wales and vice versa, as set out in the regulations, appropriate and reasonable?

Q7.2 Are the requirements set out in the regulations reasonable and practicable?

Q7.3 Are any amendments to the regulations required to strengthen them for the benefit of patients?

No specific comments were received on these questions.

Government response

We have made minor technical drafting changes.

Mental Health Act 2007 (Commencement [No] and After-care Under Supervision: Savings, Modifications and Transitional Provisions) Order 2008

The order makes transitional arrangements for patients currently on after-care under supervision (ACUS) (also known as supervised discharge). The 2007 Act abolishes ACUS and introduces a new way of managing patient care in the community - SCT. The order gives time for affected patients to be re-assessed and their future treatment planned.

Q8.1 Is three months the right period for the examination to be carried out?

Q8.2 If not, should it be longer or shorter and by how much?

Although some respondents agreed that three months was the right period, other felt that longer was needed and six months was suggested.

Government response

We accept that a longer period in which to carry out the examination and to make the determination required by the order would be helpful to professionals in managing the transition. We have therefore revised the order to allow a maximum of six months for this to take place.

Mental Health (Nurses) (England) Order 2008

This updates the definition in current legislation

Q9.1 Do you agree with what is proposed in this draft order ?

The small number of people who commented on this all agreed with the proposal

Government response

We propose to take an early opportunity to make the Order which will come into effect on 3 November 2008..

Equality Impact Assessment

Q10.1 Has the equality impact assessment identified the equality implications of this draft secondary legislation?

Q10.2 Are the proposed provisions a suitable response to the issues?

Three of the five respondents were satisfied with the EIA. A fourth respondent welcomed the improvements as regards the NR and the introduction of advocacy – although they were disappointed with the implementation date for the latter. The fifth respondent wanted gender identity issues to be added to the regulations to give them greater credence and provide further clarity for mental health workers.

Government response

We understand concerns about the implementation date for advocacy, but want to ensure that a viable, high-quality service is established. Existing advocacy provision will continue. We do not believe that the regulations are the place for detail around gender identity.

Conclusion

Following the consultation exercises the Code of Practice and secondary legislation were revised and were laid in Parliament on 7 May 2008.

We intend to monitor the changes that the 2007 Act makes to the 1983 Act. We have agreed the revised data collections which will be needed. We are also considering research. A study commissioned through the National Institute for Health Research aims to test the effectiveness of SCT and there has been a recent tender invitation to look at the impact on clinical practice of the revised definition of mental disorder and the appropriate medical treatment test.

Appendices

Appendix 1

list of respondents¹

11 Million
15 Approved Social Workers, Leeds City Council
Action for Advocacy
Advocacy Experience
Advocacy Partners
Afiya Trust's National BME Mental Health Network
A:gender
Anchor Trust
Approved Social Worker Interest Group (ASWIG)
Approved Social Worker Leads Network
Approved Social Workers of Gateshead Council
Approved Social Workers in Lancashire County Council
Ashworth Hospital Seclusion Monitoring Group
Russell Ashmore
Baroness Barker
Barnado's
Beachcroft LLP
Bolton, Salford and Trafford Mental Health NHS Trust - Adult Forensic Directorate
Bradford Approved Social Workers Forum
Bradford Healthy Minds (CAMHS Strategy) Group
Bradford Mental Health Modernisation Partnership
Brain Injury Social Work Group (BISWIG)
British Association of Brain Injury Case Managers (BABICM)
British Association for Counselling and Psychotherapy
British Association of Social Workers (BASW)
British Medical Association
British Geriatrics Society
British Psychological Society
British Psychological Society (Lesbian and Gay Psychology Section)
Anthony Burton
Cambridge House
Cambridgeshire and Peterborough Mental Health Partnership NHS Trust
Care Programme Approach Association
Care Services Improvement Partnership Child and Families Programme CAMHS Regional
Development Field Force
Care UK
Lois Chaber
Central and West London NHS Foundation Trust
Cheshire County Council
Cheshire Social Services – Older Peoples' Services
Cheshire and Wirral Partnership NHS Foundation Trust
Dr David Chilvers
City of York Council

¹ Note – some respondents commented jointly.

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College of Occupational Therapists, Specialist Section – Mental Health
Coventry and Warwickshire NHS Mental Health Partnership Trust
Coventry City Council
Coventry Primary Care Trust
Commission for Social Care Inspection
Steve Deckett
Derbyshire Mental Health Services NHS Trust
Dorset Healthcare NHS Foundation Trust
East Midlands Advocacy Service
East Midlands Mental Health Act Carers Reference Group
Emergency Social Services Association
Keith Fenby
General Medical Council
Gloucester Partnership NHS Foundation Trust
Gloucestershire Lifestyles
Sooty Goraya
Dr Carolyn Hall
Halton Borough Council
Hampshire County Council
Michael Harden
Tom Hore
Earl Howe
Dr Marcus Hughes
Independent Police Complaints Commission
Information Commissioner’s Office
Institute of Psychiatry
International Society for the Psychological Treatments of the Schizophrenias and Other
Psychoses (ISPS UK)
Lynn Johnson
Dr Alan Johnston
Richard Jones
Dr Joseph Joyce
Justice for Victims
King’s Fund
The Law Society
Colin Le Guillou
Lincolnshire Emergency Duty Team
Pip Littler
Loud and Clear Mental Health Advocacy
Dr Harriet Lupton
Dr Duncan Mackenzie
Robert McLean
Kevin McNeill
“magwal”
Medical Protection Society
Mental Health Act Commission
Mental Health Alliance
Mental Health Coalition
Mental Health Foundation
Mersey Care NHS Trust

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Metropolitan Police
Middlesbrough Borough Council
Mind
David Morris
Geoff Morris
Lady Murphy
National Autistic Society
NHS Confederation
NHS Security Management Service
Newcastle upon Tyne Mental Health Social Worker Team
Collins Ngome
North East London Mental Health NHS Trust
Northamptonshire Healthcare NHS Trust
Northamptonshire Mental Health Carers Reference Group
Northumberland Tyne and Wear NHS Trust
Nottinghamshire County Council
Nottinghamshire Healthcare NHS Trust, High Security Service, Rampton Hospital
Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust
Oxleas NHS Foundation Trust
John Parkinson
Patient and Public Involvement Forum for Humber Mental Health Teaching NHS Trust
The Princess Royal Trust for Carers
Susan Puttman
Julian Radford
Riviera Ambulance Service
Mike J Roberts
Robert Robinson
Royal College of General Practitioners
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Psychiatrists (Faculty of psychiatry of old age)
Royal College of Psychiatrists (multi-agency group to develop standards in relation to the use of section 136)
Sainsbury Centre for Mental Health
St Andrew's Healthcare
Jacqui Saradjian
Section 12 Panels National Reference Group
Dave Sheppard
SIGN Health
Andrew Smith
Social Care Institute for Excellence
South Essex Partnership NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
Penny Stafford
Stonham
Jo Sutherland
Tees, Esk and Wear Valleys NHS Trust
Together (London and East of England Service Users Regional Steering Group)
Turning Point
UK Psychiatric Pharmacy Group and College of Mental Health Pharmacists

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Unison
United Response
Victims Voice
Voice
Dr Gary Wannan
Warwickshire County Council
Warwickshire Primary Care Trust
West London Mental Health NHS Trust
West Yorkshire Police Authority
Alison Wheelton
Lord Williamson
Wirral Department of Adult Social Services
Women in Secure Hospitals (WISH)
Dr Paul Wolfson
John Woodcock
Young Minds

Appendix 2 respondents by category

Professional bodies and organisations

Approved Social Worker Interest Group (ASWIG)
Brain Injury Social Work Group (BISWG)
British Association of Brain Injury Case Managers (BABICM)
British Association for Counselling and Psychotherapy
British Association of Social Workers (BASW)
British Geriatrics Society
British Medical Association
British Psychological Society
British Psychological Society (Lesbian and Gay Psychology Section)
College of Occupational Therapists, Specialist Section – Mental Health
The Law Society
Royal College of General Practitioners
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Psychiatrists (Faculty of psychiatry of old age)
Royal College of Psychiatrists (multi-agency group to develop standards in relation to the use of section 136)
UK Psychiatric Pharmacy Group and College of Mental Health Pharmacists

NHS and healthcare

Bolton, Salford and Trafford Mental Health NHS Trust – Adult Forensic Directorate
Ashworth Hospital Seclusion Monitoring Group
Cambridgeshire and Peterborough Mental Health Partnership NHS Trust
Central and West London NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Coventry and Warwickshire NHS Mental Health Partnership Trust
Coventry Primary Care Trust
Derbyshire Mental Health Services NHS Trust
Dorset Healthcare NHS Foundation Trust
Gloucester Partnership NHS Foundation Trust
Mersey Care NHS Trust
NHS Security Management Service
North East London Mental Health NHS Trust
Northamptonshire Healthcare NHS Trust
Northumberland Tyne and Wear NHS Trust
Nottinghamshire Healthcare NHS Trust, High Security Service, Rampton Hospital
Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust
Oxleas NHS Foundation Trust
Patient and Public Involvement Forum for Humber Mental Health Teaching NHS Trust
Riviera Ambulance Service
St Andrew's Healthcare
Section 12 Panels National Reference Group
South Essex Partnership NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Trust

Warwickshire Primary Care Trust
West London Mental Health NHS Trust

Local government and social services

15 Approved Social Workers, Leeds City Council
Approved Social Worker Leads Network
Approved Social Workers of Gateshead Council
Approved Social Workers in Lancashire County Council
Bradford Approved Social Workers Forum
Bradford Healthy Minds (CAMHS Strategy) Group
Bradford Mental Health Modernisation Partnership
Care Programme Approach Association
Cheshire County Council
Cheshire Social Services – Older People’s Services
City of York Council
Coventry City Council
Emergency Social Services Association
Halton Borough Council
Hampshire County Council
Lincolnshire Emergency Duty Team
Middlesbrough Borough Council
Newcastle upon Tyne Mental Health Social Worker Team
Nottinghamshire County Council
Warwickshire County Council
Wirral Department of Adult Social Services

Other public sector

Care Services Improvement Partnership Child and Families Programme CAMHS Regional
Development Field Force
Commission for Social Care Inspection
General Medical Council
Independent Police Complaints Commission
Information Commissioner’s Office
Mental Health Act Commission
Metropolitan Police
Social Care Institute for Excellence
West Yorkshire Police Authority

Voluntary bodies and umbrella groups

11 Million
Action for Advocacy
Advocacy Experience
Advocacy Partners
Afiya Trust’s National BME Mental Health Network
A:gender
Anchor Trust
Barnado’s
Cambridge House
Care Programme Approach Association

Care UK
East Midlands Advocacy Service
East Midlands Mental Health Act Carers Reference Group
Gloucestershire Lifestyles
International Society for the Psychological Treatments of Schizophrenias and Other Psychoses
(ISPS UK)
Justice for Victims
King's Fund
Loud and Clear Mental Health Advocacy
Mental Health Alliance
Mental Health Coaliton
Mental Health Foundation
Mind
National Autistic Society
NHS Confederation
Northamptonshire Mental Health Carers Reference Group
The Princess Royal Trust for Carers
Sainsbury Centre for Mental Health
SIGN Health
Stonham
Together (London and East of England Service Users Regional Steering Group)
Turning Point
United Response
Victims Voice
Voice
Women in Secure Hospitals (WISH)
Young Minds

Others

Beachcroft LLP
Institute of Psychiatry
Medical Protection Society
Unison

Individuals

Russell Ashmore
Baroness Barker
Anthony Burton
Lois Chaber
Dr David Chilvers
Steve Deckett
Keith Fenby
Sooty Goraya
Dr Carolyn Hall
Michael Harden
Tom Hore
Earl Howe
Dr Marcus Hughes
Lynn Johnson

**Mental Health Act 2007
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Dr Alan Johnston
Richard Jones
Dr Joseph Joyce
Colin Le Guillou
Pip Littler
Dr Harriet Lupton
Dr Duncan Mackenzie
Robert McLean
Kevin McNeill
“magwal”
David Morris
Geoff Morris
Lady Murphy
Collins Ngome
John Parkinson
Susan Puttman
Julian Radford
Mike J Roberts
Robert Robinson
Jacqui Saradjian
Dave Sheppard
Andrew Smith
Penny Stafford
Jo Sutherland
Dr Gary Wannan
Alison Wheelton
Lord Williamson
Dr Paul Wolfson
John Woodcock

Appendix 3 Final Equality Impact Assessment

Summary of the purpose and aim of the proposed Code of Practice

The Code of Practice (the Code) exists primarily to give guidance on the exercise of functions under the Mental Health Act 1983 (the 1983 Act). Producing the Code and revising it from time to time is a statutory requirement under section 118 (1) of the 1983 Act.

The current Code was produced in 1999. The changes made to the 1983 Act by the Mental Health Act 2007 (the 2007 Act), plus advances in best practice, have been the catalyst for the Code's revision. The objective has been to issue a Code which will make a practical difference in promoting both the effective, lawful and appropriate use of the powers in the Mental Health Act 1983 and the effective, lawful and appropriate treatment of people who have mental disorders, but which will not restrict local flexibility to respond to the needs of patients and the public in the most appropriate way, nor hold back the development or adoption of innovative good practice.

For the first time the 2007 Act introduced a requirement that the Code include a statement of principles which should inform decisions under the Act. This is an important innovation, and in preparing the statement of principles it required us to address matters including "*respect for diversity generally, including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006)*" and "*avoidance of unlawful discrimination*" (section 8 of the 2007 Act).

This requirement was included not only to reinforce adherence to equality legislation already applicable in mental health services and to the people who work in them, but to address particular stakeholder concerns.

In drawing up the revised Code, we reflected the Department's duties under relevant legislation, including the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005 and the Equality Act 2006. We also had regard to the Department's Single Equality Scheme.

We paid particular attention to the:

- concern about the impact of mental health legislation on BME patients;
- fact that many people affected by the 1983 Act could be considered disabled as defined by the Disability Discrimination Act 2005;
- differences in rates of mental disorder by age;
- different needs people of different gender, age, culture and religion will have in hospital.

Race Equality Impact Assessment (REIA) on Mental Health Bill (2006)

It is important to note that a comprehensive REIA was carried out on the Mental Health Bill (which became the Mental Health Act 2007) between April and November 2006. This focused on the six items amending the Mental Health Act 1983 and the one item to amend the Mental Capacity Act 2005. This was in line with the requirement under the Race Relations (Amendment) Act 2000 to undertake a REIA on new policies and functions. The Department of Health undertook extensive consultation which included seven regional events, interviews with over 120 detained patients, a series of meetings with stakeholders, four consultation events with the BME Mental Health Network and a web-based questionnaire. The assessment was published on the Department of Health website, and a summary of the REIA is attached at annex A.

Consultation

During the passage of the Mental Health Bill through Parliament we made an illustrative version of the draft Code available on the Department of Health website, to assist people to understand the effects of the Bill and to inform the debate. Whilst this was not a consultation draft, we invited people to make comments.

In developing the draft Code, we consulted people working on improvements in mental health services in relation to older people, disabled people, gender, sexual orientation, race, religion or belief and children and young people. Their views were considered in the drafting.

The draft Code issued for formal consultation reflected the comments made during this part of the process. We provided examples of how issues of equality were being addressed in the Code, and whilst our view - based on the initial consultation - was that there was nothing in the Code that was likely to impact adversely in a disproportionate way on groups of people because of their race, religion, gender or age, we welcomed comments on the material, both as part of the general comments on the Code and through a specific consultation question on equality. The question we asked was:

'Do you think that the Code has identified all the areas in which equality is a major issue? If not, what changes would you make?'

The formal consultation invited comments on the Code from anyone with an interest and attracted a wide range of responses from different groups with over 160 written responses from individuals and organisations.

The majority of those who specifically responded to this question thought the issue of equality had been addressed well and in a more meaningful way than in the current Code, although there were some calls for a separate equalities chapter. There was support from some respondents for more references to disability in some areas. Some said the needs of

transgender people had to be better acknowledged, and sexual orientation should be more prominent. Other respondents thought that there should be a requirement to take social factors into account. Cross-references to discrimination legislation and the Human Rights Act 1998 were felt by some respondents to be vital.

We have reflected these comments in preparing the final Code.

As well as seeking written consultation responses, we ran a series of workshops across the country. These workshops were run with colleagues in the Care Service Improvement Partnership (CSIP). They were open to a range of people and were attended by professionals working in mental health including ambulance and police services, and service users and carers. Across the workshops, there was representation from older people's services, learning disability services, children and young people's services, people from BME communities and advocacy services. The workshops invited comment on all aspects of the Code and were structured to address equality issues with a focus on the consultation questions. The comments and feedback from the workshops were considered as part of the overall consultation process to inform the development of the Code.

Guiding Principles for the Code of Practice

As laid down in the Mental Health Act 2007, for the first time the Code includes a set of guiding principles which should be considered when making decisions about a course of action under the Act. One of those is the "respect principle" which says:

'People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.'

In consultation editions of the Code the principles were placed at the front of the Code and have been referred to only infrequently in the body of the Code. In this version case scenarios which apply the principles have been woven into the Code at intervals, and whilst they do not form part of the Code itself they illustrate how the principles might be considered in number of different scenarios.

Impact Assessment

Race

Mental health legislation is known to be applied more frequently to people from some BME communities. The reasons are complex and are being addressed as part of the wider *Delivering Race Equality in Mental Health Care* programme – a comprehensive five-year action plan designed to secure improvements in BME communities' access to, and experience of, services, including care provided under the Mental Health Act. As already mentioned, the Mental Health Bill was subject to a detailed race equality impact assessment (see Annex A).

With the principles stressing respect for diversity and avoidance of discrimination and the emphasis on best practice, the Code has been designed to have a positive and favourable impact on the treatment of Black and minority ethnic patients. The guidance in the Code has been written to be applicable to people whatever their race, promoting equality of opportunity and treatment, while recognising that race and culture are among the factors to be considered when making decisions under the 1983 Act.

In the text of the Code, there are a variety of references to race and culture, intended to highlight and particularise, in specific contexts, the implications of equality legislation and the statement of guiding principles.

For example, the chapter on mental disorder (chapter 3) makes clear the need to avoid allowing stereotypes of cultural difference to influence diagnosis. It states clearly that people cannot be diagnosed as having a mental disorder solely on the basis of their cultural beliefs, values or options.

The chapter on information for patients, nearest relatives and others (chapter 2) stresses that where an interpreter is needed that every effort should be made to identify one who is appropriate to the patient and that everything possible is done to ensure that information is provided to patients in a way that is accessible to them.

The chapter on assessment (chapter 4) outlines the importance of the need to be sensitive to the patient's cultural and racial background in setting up and an assessment under the Act. The chapter on appropriate medical treatment (chapter 6) specifies the need to take into account the patient's culture and ethnicity.

The chapter on the safe and therapeutic responses to disturbed behaviour (chapter 14) stresses the need for policies, educational material, training and practice initiatives relating the safe and therapeutic management of patient to be based on the need to demonstrate and encourage respect for racial and cultural diversity and recognise the need for privacy and dignity.

Guidance is provided to Approved Mental Health Professionals (AMHPs) in the chapter on supervised community treatment (SCT) (chapter 25) on not making assumptions about the suitability of SCT simply on the basis of the patient's ethnicity or social or cultural background.

Disability

Disability is expressly referred to in the "respect principle. By definition, many people who have mental disorders are likely to be, as a result of those mental disorders, disabled as defined by the Disability Discrimination Act. As a result the Code will inevitably have a differential impact on the grounds of the disability of mental illness, whereas it will be of no relevance at all to the large majority of people who are not disabled, or who are disabled, but not because of mental disorder.

That aside, the Code has been designed to have a modest positive differential impact on people with disabilities because of the deliberate steps we have taken to provide additional guidance (in comparison with the current Code) on particular issues which arise in respect of people who are deaf, or who have learning disabilities or autistic spectrum disorders.

Learning disability and autistic spectrum disorder are the forms of disability most relevant to mental health care, in part because they can make other forms of mental disorder more difficult to diagnose. This is why the Code pays special attention to these issues, with a specific chapter providing guidance on patients with learning disabilities, autistic spectrum disorders or both. (chapter 34).

The chapter was written following close consultation with key stakeholders and service users, including a workshop with people with learning disabilities. The workshop focused on particular aspects of the Code, including the underpinning principles. Views were also sought from professionals working with people with learning disabilities and, as with other consultation responses, these were fed in to the process to inform the final version of the Code.

As well as the specific chapter, the particular needs of people with learning disability are addressed throughout the Code. The chapter on mental disorder (chapter 3) gives guidance on the learning disability qualification and the chapter on applications for detention highlights the importance of having someone with particular experience of learning disabilities available wherever possible during the assessment process. Chapter 4 of the Code cross-refers to the Mental Capacity Act Code of Practice and there will be further guidance on mental capacity in the supplementary Code on the deprivation of liberty safeguards which will be published in due course.

Specific guidance on the particular needs of deaf people is provided in the chapters on applications for detention (chapter 4) and safe and therapeutic responses to disturbed

behaviour (chapter 14). The importance of having regard to the physical health – and physical health needs - of people with mental disorders is also addressed at various points in the Code, in particular considerations for conveying patients (chapter 11) and factors for consideration in aftercare (chapter 27).

Given its subject matter, the Code does not provide an opportunity directly to encourage the participation of disabled people in public life.

Gender

Men are more likely to be subject to compulsory measures under the 1983 Act than women - for example, of the 15,300 patients detained in hospitals in England at 31 March 2007, 66% were men. (*Count Me In census, Healthcare Commission*). It follows that the guidance in the Code will therefore be more often of relevance to men than to women.

The guidance in the Code has been written to be applicable to both men and women, promoting equality of opportunity and treatment, while recognising that gender is one of the factors to be considered when making decisions under the 1983 Act.

The need for decision makers to consider, and be sensitive to, issues of gender is made explicit in the statement of guiding principles and at many points throughout the Code. For example, the chapter on applications for detention in hospital (chapter 4) stresses the importance of considering the patient's gender in setting up the assessment. The chapter on privacy and safety (chapter 16) points to the importance of providing single sex areas. The chapter also stresses the importance of searches being carried out by a member of the same sex, wherever possible, to maintain the patient's privacy and dignity.

Transgender people

The text of the Code has been amended to reflect consultation responses with the intention of better addressing the needs of transgender people, although we have no evidence suggesting that transgender people are more or less likely to be subject to compulsory measures under the 1983 Act.

The guidance in the Code has been written to be applicable to people regardless of their gender identity, promoting equality of opportunity and treatment, while recognising that gender identity is one of the factors to be considered when making decisions under the 1983 Act.

The “respect principle” does not mention gender identity specifically, but the principle calls for recognition of, and respect for, all the diverse needs, values and circumstances of patients and

would therefore include issues of gender identity and could have a positive effect for transgender people.

The Code specifically references transgender issues in three places: in chapter 4 (in the context of the need to ensure, as far as possible, that assessments for possible detention under the 1983 Act, are carried out by the most appropriate people in the circumstances); in chapter 6 (as one of the factors to be considered in determining whether available medical treatment is appropriate for an individual patient); and in chapter 16 (in the context of sex segregated accommodation).

Religion or belief

We have no reliable evidence on the extent, if any, to which religion or belief is correlated with the likelihood of being subject to compulsory measures under the 1983 Act. However, we are not aware of evidence suggesting, and consultation responses did not suggest, that the Code is likely to impact differently on people on the grounds of their religion or belief. The guidance in the Code has been written to be applicable to people regardless of their religion or belief (or lack of it), promoting equality of opportunity and treatment, while recognising that religion or belief are among the factors to be considered when making decisions under the 1983 Act.

The need for decision makers to consider, and be sensitive to, issues of religion or belief is made explicit in the statement of guiding principles and at many points throughout the Code. In addition, chapter 3 (mental disorder) expressly states that religion or belief (of any type) – even if they appear unusual or cause other people alarm, distress or danger – are no basis for compulsory measures under the 1983 Act unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind.

Sexual orientation

We have no information on the extent (if any) to which people of different sexual orientation are more or less likely to be subject to compulsory measures under the 1983 Act. The Healthcare Commission's *Count Me In* census of mental health inpatients asks for information about patients' sexual orientation but the results do not provide evidence of differences in care.

However, the guidance in the Code has been written to be applicable to people regardless of their sexual orientation, promoting equality of opportunity and treatment, while recognising that sexual orientation is among the factors to be considered when making decisions under the 1983 Act.

The need for decision makers to consider, and be sensitive to, issues of sexual orientation is made explicit in the statement of guiding principles and at various points throughout the Code.

The Code states unequivocally (in chapter 3) that homosexuality and bi-sexuality are not mental disorders for any purpose.

Age

With the exception - explained below – of children, we are aware of no evidence to suggest that the Code is likely to impact differently on people of different ages. The guidance in the Code has been written to be applicable to people regardless of their age, promoting equality of opportunity and treatment, while recognising that age is one of the factors to be considered when making decisions under the 1983 Act.

The Mental Health Act 2007 requires the provision of age-appropriate environments for children and young people aged under 18. This is a response to deeply-held concerns that children and young people should not be treated in adult wards.

The Code reflects this requirement and emphasises the importance of the involvement of people with specialist expertise in child and adolescent mental health services in decisions about children and young people. It also emphasises, in several places, the importance of services and accommodation being suitable to the needs of children and young people. The deployment of specialist expertise and the provision of age appropriate services in a greater proportion of cases would represent a positive differential impact for children and young people, justified by their vulnerability and specific developmental needs.

In addition, the Code has been drafted to reflect a range of specific legal requirements relating to children. A separate chapter on children and young people under the age of 18 (chapter 36) has been included in the Code which offers guidance on particular issues arising in relation to children and young people. In addition to the individual chapter, the needs of children and young people are addressed in other parts of the Code, in particular in relation to assessment under the Act (chapter 4), the chapter on police powers and places of safety (chapter 10) and the needs of children and young people when visiting and being visited on wards (chapter 19)

Elimination of harassment and promotion of good relations between different groups of people.

It cannot be claimed that the Code will, of itself, make a significant impact in helping to eliminate harassment or promoting good relations between people of different groups, but we judge its overall impact to be consistent with those aims.

Monitoring

We have agreed changes to the Mental Health Minimum Data Set to monitor the changes made to the 1983 Act. We have commissioned research on three new provisions introduced by the 2007 Act and are considering others. We will continue engagement with stakeholders and specialist organisations, both on the changes to the 1983 Act and as part of the overall mental health programme. There is also a statutory requirement on the Mental Health Act Commission (and its proposed successor body) to monitor the operation of the 1983 Act and report biannually to the Secretary of State.

Any variation between ethnic groups in the way that the Act, and by extension the Code of Practice, are applied will also be assessed and examined by the Department's Delivering Race Equality in Mental Health Care action plan.

ANNEX A

MENTAL HEALTH BILL 2006: RACE EQUALITY IMPACT ASSESSMENT

EXECUTIVE SUMMARY

The purpose of mental health legislation is primarily to protect patients and others from harm that can arise from mental disorder. It sets out the procedures that must be followed when it becomes necessary to treat someone for their mental disorder without their consent and the safeguards and support there should be for the patient. It is important that these processes are seen to apply consistently to all people. But the Government recognises that the effects of mental health legislation apply disproportionately to some BME groups. Research evidence and data shows that disproportionate numbers of BME patients are subject to certain parts of mental health legislation, but there is no agreed explanation of why this is.

Some concerns identified through the REIA have already been addressed in the move from the draft 2004 Bill to the amending proposals and others addressed in the actions generated by the REIA. But we need to go further. We will build on the REIA with a new governance structure for ensuring that we deliver race equality across the health & social care sector and develop a comprehensive programme and action plan to:

- implement the actions stemming from this REIA;
- continue monitoring race equality in mental health services;
- continue addressing areas of adverse impact.

We are already addressing known disparities in the impact of the 1983 Act through Delivering Race Equality and we are committed to moving to a position where the operation of the Mental Health Act is further aligned with the positive general duties arising from the Race Relations Amendment Act 2000 to ensure that people from BME backgrounds are not adversely affected when using mental health services.

The Department of Health is particularly grateful to the Advisory Group on the REIA, chaired by Lord Patel of Bradford OBE. The Advisory Group devised an analysis tree to look at the impact of the amendments to the definition, SCT and professional role on other parts of the Act. The Advisory Group's membership is at Annex B.

The following list summarises the changes made to the legislative proposals and the draft Code of Practice as a result of this and the work done for the 2004 Bill, and further actions to take forward. We will work with BME stakeholders to implement the actions arising from the REIA, as part of the new governance structure for delivering race equality.

ACTION TAKEN

The REIA work for the draft 2004 Bill contributed to the Department's decision to adapt or not pursue the following policies:

- adapted Supervised Community Treatment (SCT) and introduced clauses in the amending Bill that mean all patients must first be detained and assessed in detention in hospital before they are placed on SCT and no one can be detained in a community setting. BME groups had suggested that there would be a lower threshold for using compulsory community treatment orders in the draft 2004 Bill and this could affect BME patients;
- decided against a separate condition for patients at substantial risk of causing harm to another person (BME groups felt their communities would suffer from stereotyping) and instead has largely retained the current structure for criteria for detention;
- decided against the policy that anyone should have the statutory right to request the relevant authority to consider an examination against the first four criteria for detention (initial examinations). BME groups felt that patients could be more likely to be subject to vexatious requests;
- decided against the policy that Mental Health Tribunals could sit with fewer than three members. Instead the current MHRT with three panel members will be maintained;
- decided against the policy that police could enter premises without a warrant. There was concern from BME groups that patients would be subject to 'urgent' entry of their premises;
- decided against the policy to stop free aftercare services for compulsory patients after 6 weeks. Instead we will maintain the status quo so that all aftercare services are free for people treated under compulsion.

As a result of the REIA work this year on the amendments to the 1983 Act, the Department has introduced into the amending Bill and the draft Code of Practice:

- a regulation making power on Bournemouth safeguards to allow for collection of data on patients for whom an application for a deprivation of liberty is made, including data on ethnicity, recognising BME groups' concerns that Bournemouth provisions should be monitored by ethnicity;
- a clause that states that AMHPs must always act on behalf of a Local Authority, to emphasise their independence from assessing doctors. Training for AMHPs will address the skills required for independent practice and the approval criteria will reflect this too.

Code of Practice

The draft Code of Practice's first chapter is a set of guiding principles, including non discrimination on the grounds of race, ethnic, social and other criteria. The principles work together to provide for balanced decision making, and any decision maker

should have regard to these principles in respect of any patient under mental health legislation.

The draft Code of Practice makes clear that in the absence of a mental disorder no-one may be considered to be mentally disordered because of their political or cultural beliefs, values or opinions; and that appropriate treatment takes account of all a patient's circumstances, including cultural, ethnic and religious considerations

The Code on SCT

- The draft Code sets out the importance of culturally appropriate treatment with respect to SCT. Services should involve family members in SCT to ensure treatment is appropriate and supportive to the individual.
- The draft Code addresses the use of the recall power in SCT.
- The draft Code makes clear that if the conditions of a SCT are broken the carer should, where possible, be informed.

The Code on professional roles

- The Code refers to the need for cultural awareness to be part of the training for both the Approved Mental Health Professional and the Responsible Clinician. This will also be reflected in the competencies for AMHPs/RCs.

FURTHER ACTION

Monitoring/Research

Monitoring

- The Department of Health (DH) and Welsh Ministers will work with the Mental Health Act Commission and the Health Care Commission to ensure there is proper local and national monitoring of the impact of the 1983 Act as amended.
- DH will ensure there is monitoring of SCT; the reasons for its use; its impact by ethnicity; and of those other parts of the Act that feed into SCT.
- DH will discuss with the NHS and Department of Constitutional Affairs (DCA) how best to gather details of the ethnicity of patients attending/applying to the MHRT to allow appropriate analysis.
- We will look at how DRE Census data is brought to the attention of more practitioners and used as a way of influencing behaviour and the way services are provided.

Research/analysis

DH will consider whether further research (possibly to look at the impact of the new definition and the changes to professional role) and/or analysis is required of the current differences in the experiences of BME groups under Mental Health Legislation and the possible solutions.

Delivery

Training

- DRE contains existing proposals for training in cultural capability for the whole workforce. We will look at the need to review training for responsible clinicians and section 12 doctors in England in light of the DRE training, to ensure that diagnosis is not inappropriately influenced by factors relating to patients' ethnicity.
- DH and the NAW will ensure that training on the operation of the Act as amended includes issues of culture, ethnicity, race and religion, building on recently established programmes on cultural competence and values based practice.
- DH will consider extending the current series of research seminars on values based and holistic approaches to psychiatric assessment and diagnosis, to explore their relevance to the over-representation of certain BME groups among those subject to compulsion.
- We will take forward work with the GSCC to strengthen AMHP training with respect to cultural diversity. Welsh Ministers will work with the responsible regulatory bodies including the Care Council for Wales to build on the current training to emphasise the importance of the social model of illness within a holistic assessment.
- DH and the Welsh Ministers will work together with the MHRT judiciary to develop a strategy for establishing the popular voluntary courses on Equal Treatment and Diversity, and Transcultural Aspects of Mental Health, as central components of the future training programme.

Code of Practice

- The draft Code chapters will be developed with the involvement of BME representatives.
- Both DH and Welsh Ministers will work to ensure that the final Codes of Practice promotes race equality by highlighting the importance of diversity and the need to treat a patient in a holistic manner when considering detention and treatment

Nearest relative

- We will discuss with DCA the production of an explanatory leaflet that explains the nearest relative process, and how people can apply to the County Court to displace their nearest relative.

Bournemouth

- The draft Code chapters in the Mental Capacity Act Code will be developed with the involvement of BME representatives.

