## COLLEGE QUARTERLY AND ANNUAL MEETINGS

Members are requested to submit papers which they would like to be considered for presentation at the College's Annual and Quarterly Meetings during 1979.

These meetings will be held as follows:

6, 7 February (London); 1, 2 May (Sheffield); 10–13 July (Exeter, Annual Meeting); and 15, 16 November (London).

If a member has a preference to be considered for any particular meeting, this should be specified as early as possible. The Committee are trying to arrange programmes several months in advance, therefore papers should be sumitted accordingly.

E. G. Lucas
*Secretary*
*Programmes & Meetings Committee*

## COLLEGE RESEARCH ON ECT

The Research Committee is pleased to announce that they have received the good news that the Department of Health and Social Security have granted £55,800 for their proposed survey of ECT. An advertisement for a full-time research fellow of senior rank will shortly appear in the medical and national press.

Sheila A. Mann
*Secretary, Research Committee*

## PSYCHOTHERAPY SECTION

An Open Meeting will be held on Wednesday, 13 December, at the Tavistock Centre, Belsize Lane, London NW3, at 8.15 p.m. Speaker: Dr. J. Pedder—title to be announced.

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# REVIEW OF THE MENTAL HEALTH ACT, 1959: A SUMMARY OF THE WHITE PAPER

By Dr. Robert Bluglass

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The White Paper (HMSO Cmnd 7320) was published on 13 September, and its proposals are stated to be based on the need to strengthen the rights and safeguard the liberties of the mentally disordered, whilst retaining a proper regard for the rights and safety of the general public and staff.

Most of the proposals were discussed in the preceding Consultative Document but a few were not, or were not fully dealt with. The most important topic here is the question of what compulsory powers, if any, are needed outside hospital.

The Wales Act 1978, if it becomes law, may alter the legislation for Wales. Part VIII (property) and Sections 127 and 128 (sex offenders) are being considered elsewhere.

**Chapter 1**

This chapter considers what changes are needed in the definition of mental disorder and also considers the legal status and rights of informal patients.

It is intended to amend Sections 90 (deportation), 134 (withholding mail) and 141 (legal action against staff) so that they cease to apply to informal patients and so that no distinction exists between informal mentally ill patients and informal physically ill patients. (1.4)

The White Paper suggests that informal patients are not always clear about their rights, and staff may have difficulties about detaining informal patients. In order that the rights of informal patients may be more firmly safeguarded it is proposed (1.14), (i) that an informal patient on admission should receive a statement of his rights (to leave hospital; to refuse



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treatment) of his obligations if he wishes to leave, and of the implications of admission, (ii) he should be informed in writing of any changes in his status—with associated rights, (iii) a requirement that the doctor should explain the nature of irreversible treatments and should first seek a second opinion.

*Definition of mental disorder* (1.15)

Various suggestions had been made for revising the definitions of mental disorder to which the Act applies, but it is considered that the present definition of mental disorder should continue (references to sub-categories), but that the definitions of subnormality, severe subnormality and psychopathic disorder should be revised. Mental illness will remain undefined. Mental handicap should be retained as a ground for compulsory admission—but now with a proviso to the effect that mental handicap (or any other form of mental disorder) is not by itself sufficient to justify compulsory powers—other criteria must also be met.

To avoid the terms 'subnormality' and 'severe subnormality' (which can be offensive and distressful) they should be replaced by 'mental handicap' and 'severe mental handicap'.

*Mental handicap* will be defined as *a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning.*

*Severe mental handicap* should be acknowledged as a more severe impairment of the above. (1.21)

'Treatment' is redefined, with the mentally handicapped in mind, to make clear that it includes 'care, training, the use of habilitative techniques and medical, nursing and other professional help'—more in line with the needs of the mentally handicapped, but covering the treatment needs of other mentally disordered. (1.23)

*Psychopathic disorder* Powers should be retained for compulsory admission of psychopaths irrespective of whether they have committed an offence (1.24), but only where there is a good prospect of benefit from treatment (1.26). The wording at present 'and requires or is susceptible to medical treatment' should be replaced by 'a prospect of benefit from treatment'.

*Drug and alcohol abuse and sexual deviancy* The Act should contain a specific provision excluding alcohol and drug dependency *in themselves* from its terms. (But would not exclude the possibility of related mental disorder being a ground for compulsory detention.) Sexual deviancy will similarly be positively excluded as a ground *in itself* for compulsory detention.

**Chapter 2** (Compulsory admission to, and detention in hospital)

*Section 29* (emergency admission) should be strengthened to be used *only* in emergencies. It is proposed:

(i) the maximum period within which the applicant must personally have seen the patient should be reduced from 3 days to 24 hours.

(ii) admission should occur within 24 hours of the examination or application (instead of 3 days) (2.6)

Admission should be to any 'appropriate place of assessment' and application should be restricted to the nearest relative (not 'any relative') or the Mental Welfare Officer.

*Section 25* (admission for observation and assessment) There has been doubt in the past about the extent to which this section authorized treatment compulsorily.

It is proposed that Section 25 should explicitly provide for short term assessment and *treatment*, but the Act should make clear:

(i) the mental disorders in respect of which a patient can be subject to a Section 25 order

(ii) stronger safeguards for patients detained under the Section. (2.12)

The scope of the Section will remain unchanged, but the statement of reasons for detention should indicate from which category of mental disorder the patient is suffering (or is suspected to be suffering)—or what form of disorder—if 'any disorder or disability of mind' is the basis of the detention. (2.14) The nearest relative should have the same right to discharge a Section 25 patient as for a Section 26 patient. Where a Section 25 (26 or 60) patient requests a review by the managers this must be arranged within three days and a decision given within seven days. The possibility of an appeals procedure is being considered (2.17)

*Section 135* (Power to enter premises and remove to a place of safety)

This should be retained to include the case of *two* mentally disordered people living together and unable to care for themselves (at present only a person living alone and unable to care for himself is included). (2.19)

*Section 136* (Constable's power to remove a person from a public place)

To remain unchanged, but guidance will be issued advising the use of a police station as a 'place of safety' only in an exceptional emergency. (2.25 and 2.26)

*Section 30* (short-term detention of a patient already in hospital)

The difficulties and legal problems facing staff detaining patients while a doctor is found are discussed. (2.30)



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It is proposed that a Registered Mental Nurse should have a 'holding power' for a period of not more than 6 hours to enable a Section 30 properly to be invoked. A formal document could be completed.

The maximum period of detention under Section 30 should be 72 hours (like Sec 29, 135 and 136) (2.33)

*Age limits and treatability under Sections 26 and 60* For Section 26—psychopathic and mentally handicapped patients—the age limit of 21 will be removed and patients of any age will be admissible. This removes anomalies. Instead it will be necessary to certify (for these two categories of mental disorder only) that the patient is 'likely to benefit from treatment'. This will also apply to Sections 60 and 72. (2.40)

*Other criteria for admission and detention* (Section 26) This will be clarified so that detention in hospital has to be necessary:

(a) in the interests of the health or safety of the patient or (b) to protect others from harm for all four categories of mental disorder, and would be additional to the need (in cases of mental handicap and psychopathic disorder) to certify the likelihood of benefit to the patient of the proposed treatment. (2.42)

*Criteria for renewal of detention* For mentally ill or severely mentally handicapped, renewal of detention should occur only if:

(a) he is unable to maintain himself (even with family or community help) or to protect himself from serious exploitation ('grave incapacity') or
(b) there is a likelihood that he will cause serious harm to others (2.44)

For renewal of detention for psychopathic and mentally handicapped patients there should again be a need to certify that the patient would benefit from treatment. (2.45)

*Number of medical recommendations* There should continue to be one recommendation, by the Responsible Medical Officer—with the safeguards of the new criteria and improved monitoring (2.46)

*Periods of detention under Sections 26 and 60* These should be reduced to 6 months, followed by a possibility of a further 6 months (at present one year and a further year). (2.47)

**Chapter 3** (Admission procedures)

*Doctors 'approved' under Section 28* An alteration to allow both recommendations (for Section 26 and 60) to be from doctors on the staff of the receiving hospital (as long as one works mostly elsewhere) is recommended. (3.4)

Further, for Court Orders, the two doctors should not be two who work for most of their time in the same institution. (3.5)

The approved doctor should *wherever possible* be experienced in the particular form of disorder from which the patient is suffering. (3.6) (e.g. mental handicap).

*Mental Welfare Officers* It is proposed that MWO's should be approved in a similar way to 'approved' doctors, and criteria are suggested. A new title 'Approved Social Worker' is proposed, with:

(a) a statutory duty to interview the person concerned before making an application for compulsory admission; and
(b) a responsibility to satisfy himself that the care and treatment offered is in the least restrictive conditions practicable in the circumstances.

A code of practice should be drawn up (3.12)

*Relatives* Their powers should remain unaltered, but only the nearest relative should have a power of application under Section 29 and a power of discharge under Section 25. The meaning of 'relative' is clarified. (3.17)

*Health Authorities and Social Service Authorities,* Guidance will be issued recommending authorities to set up committees to act for the managers on decisions relating to discharge (and admission) procedures. This will include operating the formal procedure to consider discharging a patient on request. (3.22)

**Chapter 4** (Guardianship and Compulsory Powers in the Community)

Several organizations suggested the need for some form of continued compulsory supervision in the community (or greater use of guardianship).

The Government (4.13) believes that powers of compulsion (in the community) are needed for a small minority of people, but has reached no firm conclusions on what these powers should be.

*Option* (i) Guardianship in a revised form—that is to say, with some minor changes.

*Option* (ii) Community Care Orders—similar to Hospital Orders.

*Option* (iii) 'Essential powers' approach—limited powers regarding residence, attendance for treatment, occupation or training and to allow access for a particular professional in the patient's home or elsewhere.

**Chapter 5** (Offender patients)

The Paper acknowledges the increasing difficulty in obtaining beds for these patients, but 'it would be wrong to regard regional secure units as offering anything like a complete solution to the problem'.

*Section 60*

(i) for patients suffering from psychopathic disorder or mental handicap there should be



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a requirement, both on admission to hospital and at renewal of detention, of likelihood of benefit from treatment. (5.7)

(ii) present periods of detention under Section 60 (both at admission and on renewal) should be halved. (5.7)

(iii) medical recommendations made for the purposes of Section 60 should not be made by two doctors from the same prison, hospital or other institution. (5.7)

(iv) the provisions of Section 28(4) of the Act should apply to medical recommendations under Part V. (5.7)

*Section 65* The Butler Committee recommended a tighter wording relating to the seriousness of the offence. The Government accepts this, and the wording should indicate more clearly the essential purpose of the Restriction Order and that its purpose is to protect the public from serious harm. (5.15)

The powers and duration of Section 65 should remain (determinate and indeterminate restrictions on discharge), but there should be a provision for annual reports on restricted patients to the Home Secretary. (5.29). However, new *arrangements* are proposed to make receiving hospitals aware in cases where the court might consider a Restriction Order that this is in mind, to give hospitals an opportunity to express a view on any difficulties such an order would create. This would involve a combination of amending legislation and guidance. (5.34)

Guidance would also be issued regarding closer contact being maintained between hospital staff and supervising officers of restricted patients. (5.35)

*Transfer of prisoners to hospital* Restrictions under Section 74 should cease to apply on what would have been the Earliest Date of Release of a prisoner transferred to hospital under Section 72. (5.49)

After the EDR if Section 72 patients still need detention they should be treated as if under Section 26, but without formalities. (5.51)

*Section 73* Changes in the law relating to disability in relation to trial generally are under review. This Section relates to them.

*Remands to Hospital and Interim Hospital Orders* These matters are under separate discussion and consultation.

**Chapter 6** (Safeguards for patients)

*Mental Health Review Tribunals*

(i) Opportunities for detained patients to refer their cases to a Tribunal and for detained patients under a Restriction Order to ask for their cases to be referred to a Tribunal should be increased in line with the proposed reductions in the periods of detention (except that patients under a Restriction Order should not have the right to request reference to a Tribunal within the first 12 months). (6.2)

(ii) Automatic reviews by Tribunals should be introduced for unrestricted patients. These should take place after 6 months, then within three years of admission and at three-yearly intervals thereafter. (6.3)

(iii) The Home Secretary should be required to refer the case of a restricted patient automatically to a Tribunal at the end of any 3 year period in which the case has not been otherwise referred. (6.3)

(iv) Powers should be taken in the Act further to reduce these periods by regulation if this proves practicable and desirable in the light of experience. (6.3)

(v) Tribunals should be able to order delayed discharge (for up to 3 months). (6.5)

(vi) Tribunals should be able to recommend trial leave, transfer to another hospital or to guardianship, and should receive reports on these, and be able to make an alternative finding if their recommendation cannot be implemented. (6.5)

(vii) An application should not be withdrawn without permission and withdrawal should not prevent a further application.

(viii) Greater use should be made of members with Social Services experience, and a fourth member of the Tribunal should be appointed where appropriate. Forensic psychiatrists should be included on the medical panel where possible. (6.7 and 6.8)

*Consent to Treatment*

Nothing in the Act authorises or implies that informal patients can have treatment imposed without consent. (6.15)

(i) With regard to detained patients, the power to impose treatment in certain circumstances is implied, but needs to be made more specific. The Act should make it clear that staff may in certain circumstances (as well as in an emergency) treat a *detained* patient for his mental disorder without his consent. But this only applies to Section 25, 26 and 60 patients. (Not to Section 29, 30, 135 or 136). (6.16–6.21 and 6.27)

(ii) Treatment not relating to mental disorder should not be imposed on a detained patient without his consent, other than such treatment as is immediately necessary to preserve



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his life or health. (6.24)

(iii) Treatment which is irreversible, hazardous or not fully established should not be imposed without the consent of the patient (except to save life), and even if the patient (informal or detained) does give consent treatment should not be administered without a concurring second opinion. (6.23 and 6.25)

(iv) A second opinion should be sought wherever there is doubt as to whether a particular form of treatment is irreversible etc. (6.25)

(v) A detained patient should be asked for his consent if he can give it. If he refuses an alternative treatment should be sought to which he will agree. With a second opinion, treatment could be given against his will to save the patient's life, or to prevent violence or deterioration.

(vi) If a detained patient cannot give valid consent, necessary treatment (not irreversible etc) should be given by the consultant. (6.23)

(vii) Second opinion should be obtained if there is any doubt about his ability to give consent or if consideration must be given to over-riding his objection.

(viii) Second opinions should be obtained from a multidisciplinary panel established by each Area Health Authority for this purpose.

(ix) The hospital managers must inform patients of their rights to give and refuse consent to treatment and to ask for a second opinion.

(x) A limited number of experimental schemes of 'patients' advisers' should be introduced.

**Chapter 7** (Safeguards for staff)

At present (Section 141) civil or criminal proceedings against a member of staff acting under the Mental Health Act can only be brought with the leave of the High Court.

The Government believes the new measures to give a nurse authority to hold a patient for up to six hours (Section 30) and to clarify powers and limitations to impose treatment improves the legal position of staff, but the legal position in non-emergency situations is less clear.

*Removal of criminal action from Section 141* The Director of Public Prosecutions (rather than the High Court) would, in future, have to give leave before criminal proceedings against a member of staff can be initiated. High Court leave would apply only to civil actions. (7.5)

*Civil Actions* There would need to be 'reasonable' grounds for the case (at present 'substantial') for leave for an action to be given. (Some fear that this might increase actions by patients against staff). (7.6)

Civil actions against staff under Section 141 of the Act would only be relevant to detained patients and complaints about their treatment. (7.10)

Guidance will be issued to staff about their position. (7.11)

*The right to search patients and their belongings and to withhold items in the interests of security* Reasonable powers of search exist under common law and Section 3(1) of the Criminal Law Act 1967. No new powers are to be introduced, but new guidance will be issued. (7.15)

The importance of adequate staffing levels is stressed, as is the potential role of regional secure units.

**Chapter 8** (Other matters)

*Patients' mail* The power to withhold mail to and from informal patients will be withdrawn (8.8) and this will also apply to detained patients except for some defined outgoing mail. For patients in Special Hospitals and regional secure units there will be some new powers of control and appeal against these measures. (8.11–8.14)

*Compulsory return of absconding patients* Powers compulsorily to return absconding patients under short-term detention (Section 29, 25 and 30(2)) will be withdrawn as unnecessary. (8.21)

Patients detained under Section 26 and 60 must in future be returned within 28 days whatever category of mental disorder they are suffering from. (At present psychopathic and subnormal patients can be returned up to 6 months).

*Compulsory removal of non-patrial psychiatric patients* The Home Secretary's powers to send home these patients will be limited to those under Section 26 and Section 60, with an automatic review by a Mental Health Tribunal of any recommendation in a procedure to be decided. (8.28–29).

There will also be a new power to recall a restricted patient who returns to this country after being removed. (8.30)

**Chapter 9** (Resource implications)

The resource and financial implications of the proposed amendments to the Mental Health Act 1959 are discussed.

### References

*A Review of the Mental Health Act 1959*. HMSO 1976—('the Consultative Document').

*Report of the Committee on Mentally Abnormal Offenders*. Cmnd 6244 HMSO 1975 (The Butler Committee's Report).



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