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Mr Rickett  
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*From the Secretary of State for Social Services*

Michael Scholar Esq  
 Private Secretary  
 to the Prime Minister  
 10 Downing Street  
 LONDON  
 SW1

10 November 1981

Dear Michael

WHITE PAPER "REFORM OF MENTAL HEALTH LEGISLATION"

I am enclosing an advance copy of the White Paper for the Prime Minister. (Inside Front Cover of file)

The White Paper explains the changes proposed in the Mental Health (Amendment) Bill, and both will be published on 11 November at 10 am. Members of H Committee have seen the White Paper in draft and have approved its publication.

Copies of this letter and the White Paper go to Private Secretaries of Members of the Cabinet, the Paymaster General, Sir Robert Armstrong and the Chief Whip.

Yours ever  
 Brendan O'Gorman

BRENDAN O'GORMAN  
 Private Secretary

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*Nan  
Heath*

The Rt Hon William Whitelaw CH MC MP  
Secretary of State for the Home Department  
Home Office  
50 Queen Anne's Gate  
London SW1

26 October 1981

*Dear Willie.*

MENTAL HEALTH BILL : DRAFT WHITE PAPER

As you are aware we intend to introduce a Bill to amend the 1959 Mental Health Act in the House of Lords at the beginning of next Session.

The 1959 Act has been under review for some six years and a variety of proposals have been canvassed. I propose therefore, to publish a White Paper explaining the provisions which appear in the Bill and the reasons for putting them forward. The White Paper would be published on the same day as the Bill and would serve as a guide to its contents. We are proposing to Legislation Committee when they consider the Bill on 27 October that the Bill should be published on 11 November.

I should be grateful if you would confirm by 2 November that you are content with this approach and with the draft White Paper attached.

I am sending a copy of this letter and the draft White Paper to Number 10, other members of H Committee, and to the Secretary of the Cabinet.

*Your own  
Norman*

NORMAN FOWLER

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## INTRODUCTION

1. Legislation about the rights of the individual and of society in the field of mental health must be both complex and precise if proper protection is to be given to both. The object of this White Paper is to explain the changes proposed in the Mental Health Bill which the Government have presented to Parliament.

The background of the 1959 Mental Health Act and of the Bill

2. The 1959 Mental Health Act was introduced during Mr Harold Macmillan's administration to implement the main proposals of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency about the status and legal position of mentally disordered people in society. In brief, the Act removed statutory control from the great majority of mentally disordered people and set out new conditions for the minority who still need to be subject to special control, whether for the protection of themselves or others. It also ensured that mentally disordered people could benefit from general health and social services facilities by providing that existing legislation (eg the National Health Service Act 1946 and the National Assistance Act 1948) should apply to them.

3. The 1959 Act has worked well. Its first object, to remove statutory control from most mentally disordered people, was achieved and it provided a balanced system for the protection and control of the remaining small minority. But after nearly twenty years, the need for some revision and updating - within the overall framework of the Act - became apparent. A Consultation Paper issued in 1976 was followed in 1978 by the previous Government's White Paper 'The Review of the Mental Health Act 1959' (Cmd 7320). This White Paper was generally welcomed both by the health and social work professions and by other bodies and individuals concerned about the care of the mentally disordered; detailed comments have been offered and further consultations have since taken place. The Government's conclusions are embodied in the Bill they have presented. The Government has made clear the high priority which it wishes health and local authorities to give to developing services for mentally ill and mentally handicapped people. It has done so both in its guidance to authorities "Care in Action" and in its recent discussion paper on resource distribution "Care in the Community".

4. This priority is not affected by the Bill. The Bill is about the status and legal position of those mentally disordered people who need special protection or control. It is not about the services for the much larger number

of mentally ill and mentally handicapped people in hospital and in the community as a whole.

#### The Main Objects of the Bill

5. The Bill improves safeguards for detained patients, clarifies the position of staff looking after them and removes uncertainties in the law.

6. The main improvements are set out below. The references in brackets are to passages explaining them in more detail in the text of this White Paper.

- (i) The period before detention has to be either renewed or ended is halved (para. 19).
- (ii) For certain groups, detention in hospital is allowed only if the person is thought treatable (paras. 13 and 20)
- (iii) Access to Mental Health Review Tribunals is increased (paras. 23-28)
- (iv) The position on consent to treatment is clarified (paras. 35-38)
- (v) The standards of care given to detained patients and the use of powers of detention are safeguarded through the new Mental Health Act Commission (paras. 27-34, 38)
- (vi) Guardianship powers are made to fit current good practice (paras. 41-43)
- (vii) Psychiatric treatment in hospital is to be made easier for those appearing before the courts by introducing, as resources allow, interim hospital orders and remands to hospital (paras. 47-49).

#### DEFINITION OF MENTAL DISORDER

7. The Mental Health Act 1959 sets out the forms of mental disorder which are covered by its provisions. These are mental illness, severe subnormality, psychopathic disorder and subnormality.

#### Mental Handicap

8. The Government shares the concern which is widely felt that mental handicap should not be confused with mental illness and that the needs of different groups of patients should be recognised. They have also considered with the greatest care whether it is still appropriate to provide compulsory powers in respect of any mentally handicapped people and, if so, how this should be done.

9. The weight of professional opinion is that there is a very small minority of mentally handicapped people, without any other mental disorder, who do need to be detained in hospital - usually for their own safety. The Government recognises the importance of stressing that this is only a small minority. While, therefore, the Bill continues to provide for the compulsory detention which is required, subject to all the safeguards provided, in these cases, it does make a change in the words used.

\* 'Severe subnormality' and 'subnormality' are to be replaced by the more up to date terms 'severe mental handicap' and 'mental handicap'

10. The Government has decided it is not practicable to have entirely separate legislation for mentally handicapped patients. It would be helpful, though, to separate out the provisions of mental health legislation which apply to mentally handicapped people. For technical reasons it would be cumbersome to do this during the passage of an amending Bill. References to mental handicap and severe mental handicap appear alongside references to the other disorders, in numerous places in the 1959 Act; to delete these references and bring them together in a separate Part of the Act by means of amending legislation would produce a very long and complex Bill. It would be almost impossible for practitioners in the field who have to implement the amended legislation to find their way through it. The Government therefore intends to present a consolidation of mental health legislation to Parliament soon after the present Bill is passed. The consolidated Mental Health Act <sup>will</sup> set out separately the provisions of the legislation which need to apply to mentally handicapped patients.

#### Mental Illness

11. Mental illness is not further defined and no change is proposed. This condition accounts for the majority of the persons detained in hospital under the Act - some 5,000 of the 7,000 detained patients. As in the case of mental handicap, it is important to understand that the powers required for the small proportion of mentally ill people who need to be detained - 7 per cent of the mentally ill in hospital - do not have any implications for the treatment and care of the remainder of those suffering from mental illness.

## Psychopathic Disorder

12. The Government have considered whether psychopathic disorder should be excluded from the Act, bearing in mind the discussion in the Butler Report. The weight of current medical opinion is that most psychopaths are not likely to benefit from treatment in hospital and are for the penal system to deal with when they do commit offences but that there are some instances of psychopathic disorder which can be helped by detention in hospital. For this reason, this category is not excluded from the Act.

## Age Limits

13. At present, one of the limitations on compulsory admission powers is that they can only be applied to mentally subnormal and psychopathic patients if they are under 21 (although once admitted, the patients can continue to be detained after the age of 25 if they are considered dangerous, under section 44 of the Act). The origin of the age limit lay in medical opinion that mentally handicapped or psychopathic adults were unlikely to benefit from hospital treatment. In the Government's view, this age limit has been shown in the light of recent medical knowledge to be arbitrary. Moreover, it does not apply when courts make hospital orders on mentally disordered offenders and so makes an unnecessarily sharp distinction between those detained under civil powers (Part IV of the Act) and those who have been tried for an offence (Part V). It seems more reasonable to replace the age limit with a provision that would allow mentally handicapped and psychopathic patients of any age to be detained but only if there are grounds for believing that they are likely to benefit from medical treatment (see para. 20). This criterion will replace the reference to "requires or is susceptible to medical treatment" in the definition of these forms of mental disorder. The interpretation of medical treatment in the context of the Act will be amended, in keeping with developments since 1959, to include habilitation and rehabilitation instead of training.

COMPULSORY ADMISSION TO HOSPITAL

14. There are a number of different powers under which a patient may be compulsorily detained in hospital:

section 29 of the 1959 Act authorises admission for up to 3 days in an emergency;

section 25 authorises detention for 28 days for observation;

section 26 is a longer-term power to detain patients for treatment (subject to renewal- see paragraph 19);

section 30 gives doctors the power in an emergency to prevent informal patients from leaving hospital for up to 3 days;

section 136 gives the police the power to bring to hospital or a place of safety a patient found in a public place who seems to be mentally disordered and in need of immediate care or control.

In addition :

under section 60 mentally disordered offenders may be made subject to a hospital order by a court; and

under sections 72 and 73 prisoners may be transferred to hospital by the Home Secretary.

The Bill proposed some changes to most of these powers to ensure that patients are detained for no longer than necessary and to improve the wording of the Act.

Social Workers undertaking Duties under the Act

15. One proposal in the Bill is relevant to most of the admission powers. In the 1959 Act the "mental welfare officer" plays a key role in considering compulsory admission to hospital (though applications for admission may also be made by the patient's nearest relative, or any relative in emergency). Since 1959, local authorities social services Departments have been established and their functions greatly developed. The Bill provides that local authorities should "approve" social workers to carry out the functions of mental welfare officers. The arrangement would be in some ways similar to that for health authorities approving doctors as having special experience in the diagnosis or treatment of mental disorder (section 28). Guidance on approval of social workers is being



prepared in consultation with professional associations, training bodies, employing authorities and other interested organisations. The Bill also makes clear the role and function of the social worker and provides that he must interview the patient before he makes an application for admission to hospital and must satisfy himself that detention in hospital is the most appropriate means of ensuring that the patient receives the care and treatment he needs.

#### Emergency admissions

16. Section 29 provides a power to detain patients in emergencies and therefore involves a less formal procedure than section 25, which was intended as the normal admission power. In particular it requires the recommendation of only one doctor, who need not have any psychiatric expertise, whereas section 25 requires two medical recommendations, one of which must be that of a doctor approved for the purpose under section 28. The Bill therefore proposes amendments to ensure that section 29 is only used in genuine emergencies. The person making the application must have seen the patient within the previous 24 hours, rather than 3 days as at present. The period of 3 days from completing the application, within which the patient must be admitted to hospital, is also to be reduced to 24 hours. The Bill also provides that the right to make an emergency application should be restricted to the patient's nearest relative (as well as a mental welfare officer) rather than any relative.

#### 28 day power

17. The procedure set out in section 25 is referred to in the 1959 Act as admission for observation. Because of developments in psychiatry since the Act was passed it is now used also as a short-term treatment power. It is therefore felt that "assessment" is a more suitable term than "observation" as it implies more active intervention to form a diagnosis and plan treatment. In many cases compulsory detention need not extend beyond (or as long as) the 28 days<sup>which</sup> is the maximum period of detention of a section 25 application; the Bill therefore provides that patients detained under section 25 may be treated for their mental disorder without their consent where necessary in certain circumstances (consent to treatment is considered more fully in paragraph 35 below).

18. Such patients are afforded further protection in the Bill which proposes that it should be possible for the nearest relative of a patient detained under section 25 to discharge the patient, subject to the limitation in section 48 of the Act where the responsible medical officer considers the patient to be dangerous; at present this right applies only to patients detained under section 26. In addition, patients detained under section 25 will

be able to apply to a Mental Health Review Tribunal for their detention to be reviewed. For practical reasons application must be made within the first 14 days of detention and the hearing will take place shortly afterwards. For these short-term cases the Tribunal will of necessity have to evolve new arrangements and will usually have to rely largely on the medical and social workers' reports made at the time of admission, with perhaps an oral report from the patient's responsible medical officer. It will nonetheless provide a new and worthwhile safeguard for patients detained under section 25.

#### Longer-term powers

19. The longer-term power of detention under section 26 will be amended to remove the age limits and include the "treatability" test described in paragraph 20. In addition the duration of authority to detain a patient under section 26 will be reduced from one year to 6 months in the first instance. This would be renewable on the first occasion for a further 6 months (compared with first renewal for a year now) and subsequently for a year at a time (instead of for 2 years at a time as now). In other words the period of detention before renewal has to be considered will in all these cases be halved. Patients will consequently have more opportunities to apply to a Mental Health Review Tribunal (see para. 24 and Table 1). The Bill also proposes that the responsible medical officer should be specifically required to satisfy himself on renewal of detention that the patient is still suffering from mental disorder for which medical treatment in a hospital is appropriate and that the treatment cannot be provided unless detention continues.

#### Treatability

20. The Mental Health Bill provides that the "treatability" test - whether treatment is likely to alleviate or prevent a deterioration in the patient's condition - will in future apply to all patients when their detention is renewed. Detention will not be renewed unless there is an expectation of further benefit from treatment, except in the case of the mentally ill and severely mentally handicapped. Here the Bill recognises that the health services have a responsibility to care for mentally ill and severely mentally handicapped people whose disorder may make them unable to care for themselves by providing that even if the treatability test is not met, detention can still be renewed if the patient is unlikely to be able to care for himself, to obtain the care which he needs or guard himself against serious exploitation.

Patients already in hospital

21. Section 30 is concerned with patients who are already being treated in hospital as informal patients. Such a patient may be detained for up to 3 days if this seems necessary to the doctor in charge of the patient's treatment. This power is used when, for example, an informal patient wishes to leave hospital and the doctor in charge believes that the conditions for compulsory detention are satisfied but has not time to complete the full application procedure (which involves a mental welfare officer or the patient's nearest relative). Nurses have sometimes found it difficult in an emergency to contact the doctor in charge of the patient's treatment immediately so that the detention power can be exercised and have been uncertain about their legal position in trying to prevent a patient from leaving when it is clearly best that he should not.

22. The Bill therefore includes changes which will help to ensure that mentally disordered patients receive the treatment they need and which will ensure that there is no doubt as to the legal position of the staff concerned. Firstly, it will be possible for the power of detention to be exercised by any doctor on the staff of the hospital who is nominated by the doctor in charge of the patient's treatment to act for him in his absence. Secondly, a registered mental nurse or registered nurse for the mentally subnormal will be able to invoke a holding power until the arrival of a doctor with the power to detain the patient; the holding power will in any case lapse after 6 hours. It will apply only where a patient is already under medical treatment for mental disorder. If the nurse decides to exercise the holding power he or she must record, in writing, his or her judgment that the patient is suffering from mental disorder to such a degree that it is necessary in the interests of the patient's health or safety or for the protection of others for him to be immediately restrained from leaving the hospital and that it is not practicable to ensure the immediate attendance of a doctor empowered to detain the patient. As soon as this has been recorded the holding power takes effect. The nurse must give the record to the hospital managers (or whoever is acting for them) as soon as possible.

## SAFEGUARDS FOR PATIENTS AND STAFF

### Mental Health Review Tribunals

23. The Bill gives patients more opportunities to apply to a Mental Health Review Tribunal. It will also introduce automatic Tribunal hearings for patients whose position has not been reviewed by a Tribunal for 3 years. Overall, it is thought that the number of Tribunal hearings will rise from 904 in 1980 to around 4,500 a year. The opportunity to have the need for continued detention reviewed by an independent body is an important safeguard and the Government believes that the proposed increase in the frequency of such reviews is a significant improvement, at no great cost.

24. As explained in paragraph 18 above, patients detained under section 25 (for 28 days) will have a right to apply to an MHRT for an immediate review of their case. Patients detained under section 26, including unrestricted patients under hospital orders and unrestricted transferred prisoners, will have twice as many opportunities to apply to a Tribunal as a consequence of the periods of detention being halved. Restricted patients will be able to ask for a Tribunal hearing once in the second year of their detention and every year thereafter. In addition, the Bill proposes that hospital managers must refer to a Tribunal any patient who has been detained under section 26 but has not had a Tribunal hearing in the first 6 months of detention. A similar provision will apply to unrestricted patients detained under Part V of the Act. Hospital managers will also be required to refer to a Tribunal any patient who has been detained for 3 years without a Tribunal hearing. These proposals will ensure that patients who lack the ability or initiative to make an application to a Tribunal also have the safeguard of an independent review of their case.

25. Table 1 illustrates the changes for a patient who is detained first under section 25 then section 26. If he is detained continuously for 4 years he would have, under the present Act, only 3 opportunities to apply to a Tribunal. The Bill will provide 6 opportunities for the patient to apply to a Tribunal in his first 4 years of detention, with a minimum of 2 Tribunal hearings (after 7 months and 3 years 7 months) if he makes no application himself.

26. Patients under guardianship (see paras 41-43) will also have more opportunities to apply to a Tribunal, in line with the shorter duration of each period of guardianship - 6 months, 6 months, then a year at a time. They will not be covered by the arrangements for automatic reviews, since their liberty is not restricted in the same way as patients detained in hospital.

27. The Bill will also give detained patients under 16 years of age the right to apply to a Tribunal. In the 1959 Act patients under 16 have no such right, though if they are detained under Part V their nearest relative may apply to a Tribunal on their behalf. The Government considers it important that all detained patients should have access to MHRTs. Hospital managers are to be required to refer the very small number of patients under 16 for an automatic review at the end of any 12 month period in which they (or their nearest relative) have not made an application, rather than every 3 years as for adults.

28. Tribunals sometimes wish to ensure that suitable arrangements are made for the care of a patient before he is released. The Bill therefore provides them with a power to order delayed discharge. The Tribunal Rules are also being revised to provide more flexibility in the way cases are handled. The panels from which Tribunal members are chosen may be enlarged since there are to be many more Tribunal hearings, some of which (because of the improvements for patients admitted under section 25) may have to be arranged at very short notice.

Table 1: Rights of Application to the MHRT

	<u>1959 Act</u>	<u>1959 Act as amended by Mental Health Bill</u>
Month One	Admission under Section 25	Admission under Section 25  RIGHT OF APPLICATION TO MHRT IN 1st 14 DAYS
Month Two	Detention for one year under Section 26  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 2 AND 7	Detention for 6 months under Section 26  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 2 AND 7
Month Eight		Detention renewed for 6 months  AUTOMATIC REVIEW IF NO REVIEW SOUGHT IN MONTHS 2 TO 7  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 8 AND 13
Month Thirteen	Detention renewed for one year  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 13 AND 24	Detention renewed for one year  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 13 AND 24
Month Twenty-five	Detention renewed for two years  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 25 AND 48	Detention renewed for one year  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 25 AND 36
Month Thirty-seven		Detention renewed for one year  RIGHT OF APPLICATION TO MHRT BETWEEN MONTHS 37 AND 48
Month Forty-four		AUTOMATIC REVIEW IF NO REVIEW SOUGHT SINCE MONTH 8

## Mental Health Act Commission

29. The most important safeguards to ensure that patients are not detained unnecessarily are the carefully drawn criteria for admission and renewal of detention and access to Mental Health Review Tribunals; but other checks are also needed. The 1978 White Paper discussed the possibility of setting up mental welfare commissions on the lines of the Scottish Mental Welfare Commission, to protect psychiatric patients, but concluded that it was wrong in principle to reintroduce a system for psychiatric patients which is fundamentally different from that for other patients. The present Government takes a different view: patients detained under the compulsory powers of the Mental Health Act are in a unique position because they have no right to discharge themselves, unlike all other patients including other psychiatric patients. Furthermore, they have not entered hospital voluntarily; it is essential that the justification for depriving them of their liberty and the procedures followed in doing so should be subject to scrutiny. The responsibility for undertaking this scrutiny must rest with a body which is independent of those who have been involved in the compulsory admission and continued detention and so the Government proposes to set up a Mental Health Act Commission with a general protective function for detained patients.

30. A new factor since 1978 which has further influenced the Government on this matter is one of the proposals made by the Rampton Hospital Management Review Team, chaired by Sir John Boynton, which reported to the Secretary of State in October 1980 on the management of Rampton Special Hospital. In considering the wider issues surrounding their enquiry the Review Team said:-

"There is a strong case for an appointed body to inspect and monitor closed institutions such as Rampton and the other special hospitals, or indeed wherever patients are subject to detention under the Mental Health Act. The exact powers and functions of such a body would be for further consideration, but we think it might be constituted on the lines of the old Board of Control or the Scottish Mental Welfare Commission. Its functions might include the review of patient care and treatment, the independent investigation of more serious complaints (from whatever source) and a general protective function on behalf of detained patients which need not necessarily cut across the functions of MHRTs. Such a protective function might include some responsibilities in connection with the difficult problem of consent to treatment in respect of detained patients .....

The Bill provides for the Mental Health Act Commission to implement this recommendation.

31. Under this provision the Secretary of State will be required to set up a special health authority to be called the Mental Health Act Commission (MHAC) to exercise a general protective function for detained patients and to carry out certain other functions given to Secretary of State in the Bill.

A 'special health authority' is a body set up under the National Health Service Act 1977 and the Secretary of State makes provision for its membership, may direct it to exercise any of his powers and duties and may give it directions as to how it carries out its functions. The MHAC will thus be responsible to the Secretary of State, but will be an independent body with members who will be eminent in their different fields; it will be a real safeguard to patients wherever they are detained.

32. The Government intends that the members of the proposed MHAC will be lawyers, doctors, nurses, psychologists, social workers and laymen. Their part-time services, as commissioners, will include visiting hospitals where patients are detained. There will probably be one or two visits a year to each of the 300 or so local hospitals and mental nursing homes in England and Wales with detained patients, with around one visit a month to the 4 special hospitals. In their visits the MHAC members will make themselves available to detained patients who wish to see them, will ensure that staff are helping patients to understand their legal position and their rights, and will monitor the use of the compulsory powers of the Mental Health Act. They will look at patients' records of admission and renewal of detention and at records relating to treatment. They will also ensure that detained patients are satisfied with the handling of any complaints they may make.

33. The MHAC will not ~~trespass~~ in any way on the Mental Health Review Tribunal's role of deciding whether an individual patient should continue to be detained; the Commission's concern will be to ensure that hospitals have adopted and are following proper procedures for using the powers of detention. The Commission will look at the use of powers, such as emergency admissions under section 29, which are outside the scope of the MHRT. It will also have an important role in monitoring the use of the explicit power to treat detained patients without their consent subject to certain safeguards (see below): it will ensure that those safeguards are understood by staff and patients and that they are being observed.

34. Equally the proposed functions of the MHAC will be separate from other inspectorial bodies; the MHAC will not inspect and report on services in mental illness and mental handicap hospitals and units in the way that the Health Advisory Service and the Development Team for the Mentally Handicapped do.



The Commission's concern will be the particular problems which arise from detention of specific individuals in hospital rather than the general services which affect all mentally ill and mentally handicapped patients. The name "Mental Health Act Commission" has been chosen deliberately to emphasise its responsibilities for seeing that patients have full advantage of all the available legal safeguards under the Act as amended.

#### Consent to Treatment

35. The Commission will have important duties concerning consent to treatment. This is currently one of the most important and most difficult issues in the mental health field and has been widely discussed. In particular, the question of whether, and to what extent, staff should be authorised to impose treatment on detained patients has been much debated. The Government takes the view that compulsory admission should be closely related to the prospect of benefit from treatment; it therefore proposes to provide specific statutory authority to treat detained patients for their mental disorder without their consent in certain circumstances. But there must be safeguards for the patient and the nature of these too has given rise to considerable debate. A balance must be struck between protecting the rights of the patient and providing for him to receive the treatment he needs. The Bill therefore provides that a detained patient who is capable of giving consent but is unwilling may only be given treatment when a concurring second opinion has been obtained from an independent practitioner. It is intended that, in addition to medical aspects the independent psychiatrist will take into account the wider social and other factors which may be relevant. A second opinion will also have to be obtained if a patient is unable to understand what is involved in consenting to treatment.

36. The Bill provides that these second opinions should be given by doctors appointed for the purpose by the Secretary of State. It is proposed that the doctors so appointed should be medical members of the Mental Health Act Commission. This will ensure that the opinions are independent, and will also enable the Commission to monitor the use of the power to impose treatment and to offer advice on professional and ethical complexities. A psychiatrist on the Commission who gives the second opinion on any case will be able to take account of the views of members of the MHAC from other disciplines and to discuss with them the principles which should apply in giving second opinions. It is also intended that he will discuss the case with members of the treatment team caring for the patient before giving a second opinion.

37. Certain treatments warrant special consideration and the Bill also provides that these should not be given to detained patients even with their consent unless a concurring second opinion has been obtained. The treatments concerned were described in the 1978 White Paper, adopting the terms used in the Butler Report, as "hazardous, irreversible and not fully established" but it is difficult to define such treatments exactly. The Bill therefore provides for Regulations to be made listing specific treatments which must not be given to detained patients without both their informed consent and a concurring opinion from a doctor appointed by the Secretary of State. Secondly it provides for other treatments which may give rise to special concern, depending upon individual circumstances, such as ECT, long-lasting drugs and behaviour therapies, to be set out in a Code of Practice. The MHAC will, on behalf of the Secretary of State, revise the Code of Practice from time to time in the light of new and changing methods of treatment. They will also be able to include in the Code, or in other publications, advice on other issues involved in treating detained patients for mental disorder, drawn from their experience in monitoring the use of the procedures on consent to treatment.

38. In addition to its more general protective function for detained patients, the Mental Health Act Commission will therefore exercise important responsibilities, on behalf of the Secretary of State relating to consent to treatment. It will also be a forum for inter-professional discussion of issues concerning the law and ethics on the treatment of detained patients. The Commission will thus have a central role in the working of the revised Mental Health Act.

#### Other Safeguards

39. The Bill also proposes other changes to the law which affect detained patients in hospital. It will considerably curtail the circumstances in which incoming or outgoing mail may be withheld, and it will ensure that there is no scrutiny at all of the mail of informal patients. The Bill provides that outgoing mail from a detained patient may be withheld only if the proposed recipient has asked that this should be done with correspondence addressed to him by the patient. Incoming mail will not be opened or withheld at all except in the special hospitals, where exceptional arrangements are needed for security reasons. In the special hospitals an officer will be authorised to withhold mail if it is necessary in the interests of the patient's safety or to protect others. This will not apply to letters from a number of persons and bodies including MPs, the Health Service Commissioner, and a Mental Health Review Tribunal. If mail is withheld from a patient in a special hospital on security grounds he will have to be informed within 24 hours and will be able to make representations to the hospital managers.

40. The proposals described above will all help staff as well as patients; one of the greatest problems in using the 1959 Act has been the uncertainty about some of its provisions. The MHAC will be able to discuss and advise on problems concerning the law and good practice in relation to detained patients; as a result staff will benefit from clear recommendations and procedures. The proposals for handling patients' mail will also help staff in special hospitals to carry out their difficult task of caring for patients in conditions of high security. Other proposals in the Bill, notably the introduction of the nurses' holding power, will give staff clear legal protection in carrying out their professional duties.

## CHAPTER 4

### Guardianship

41. A very small number of mentally disordered people who do not require treatment in hospital, either informally or formally, nevertheless need close supervision and some control in the community as a consequence of their mental disorder. These include people who are able to cope provided that they take their medication regularly, but who fail to do so, and those who neglect themselves to the point of seriously endangering their health. For such people, guardianship powers are available under section 33 of the Act. The guardian, who is usually but not always a local social services authority, is given the powers that a father has over a child under 14. These powers are therefore very wide, as well as somewhat ill-defined, and out of keeping, in their paternalistic approach, with modern attitudes to the care of the mentally disordered. The 1978 White Paper in discussing guardianship powers in the Mental Health Act (in Chapter 4) suggested that further consideration was needed and put forward three possible options. One option was to retain guardianship powers in more or less their present form with some minor changes, eg reducing the duration of guardianship powers in line with the proposals for detention in hospital (see paragraph 19). The second option was to introduce a range of community care orders to parallel existing compulsory hospital powers (the proposal of the British Association of Social Workers). The third was to introduce new specific powers to restrict the liberty of the individual only as much as is necessary to ensure that he receives medical treatment and social support and training - the "essential powers" approach.

42. The Government has considered all the issues involved and the many comments received and has decided that the third option, which was widely supported, most closely meets current needs. The Bill therefore provides that guardianship powers should be retained, but that the guardian should have only the "essential powers" rather than all the powers of the father of a child under 14 as at present. The essential powers are:-

- a. power to require the patient to live at a place specified by the guardian;
- b. power to require the patient to attend places specified by the guardian for medical treatment, occupation or training;
- c. power to ensure that a doctor, social worker or other person specified by the guardian can see the patient at his home.

Amendments contained in the Bill have the effect that it will no longer be possible for patients under 16 to be received into guardianship and remove the age limit

of 21 for mentally handicapped and psychopathic patients. The Bill proposes that guardianship will be required to be "in the interest of the welfare of the patient or for the protection of other persons" rather than "in the interests of the patient ...." as at present; this will clarify the purpose of guardianship and ensure that the power is not so wide. Guardianship will last for 6 months initially, renewable for 6 months more, and then for a year at a time- half the present periods. This would give patients under guardianship more opportunities to apply to a Mental Health Review Tribunal (see paragraph 26).

43. One of the effects of the proposed change in guardianship powers is that the guardian will clearly not have implicit power to consent to treatment on behalf of the patient. The proposals in the Bill for treating detained patients without their consent in certain circumstances (see paragraphs 35-40) do not apply to patients under guardianship. Patients under guardianship will therefore be in the same position as informal (voluntary) patients where consent to treatment is concerned.

## OFFENDER PATIENTS

44. Part V of the Mental Health Act provides powers to send to hospital people who come before the courts (section 60) and people who are serving a prison sentence (section 72) and who are found to be suffering from mental disorder such as to warrant their detention in hospital. In either case if it is felt necessary for the protection of the public restrictions may be imposed under sections 65 or 74 respectively which mean that the person can be discharged from hospital only with the consent of the Home Secretary.
45. Many of the changes proposed for patients detained under Part IV of the Act will also apply to patients who are subject to hospital orders or transfer directions under Part V of the Act. The change in the definitions of the different forms of mental disorder will also apply in Part V. The criteria for making a hospital order are to be changed in line with the change in section 26 so that courts will not be able to make a hospital order in respect of a person suffering from psychopathic disorder or mental handicap unless there is medical evidence that medical treatment in hospital is likely to alleviate or prevent a deterioration in the offender's condition. A similar amendment will be made to the criteria on which the Home Secretary may transfer a mentally disordered prisoner to hospital. Once a patient is subject to a hospital order or transfer direction - provided he is not subject to restrictions - he benefits from all the changes proposed for Part IV patients: shorter periods of detention, more access to the MHRT, the 'benefit from treatment' test on renewal of detention, and the overall protection of the MHAC. Restricted patients too will have more opportunities to request a review by the MHRT (see para 24) and the MHAC will afford the same safeguards to restricted patients as to unrestricted patients.
46. Other proposals in the Bill apply to Part V alone. At present where a mentally disordered prisoner is transferred to hospital and made subject to a restriction order, the restrictions last until the end of his sentence, that is, until his latest date of release. Under the Bill, restrictions will be lifted on what would otherwise have been the patient's earliest date of release with remission. In response to a recommendation by the Butler Committee on Mentally Disordered Offenders the Bill also provides that a restriction order may only be made where it appears to the Crown Court to be necessary for the protection of the public from serious harm. At present the 1959 Act says only "necessary for the protection of the public".

47. The Bill will also implement proposals made by the Butler Committee for remands to hospital for a medical report and for treatment and for assessment to determine whether a hospital order would be a suitable method of disposal of the case. The object of these proposals is to give opportunity for a person who has been brought before the courts to be examined and treated in hospital for a limited period before a final decision is taken by the courts on his case.

48. It is proposed that remands to hospital for medical report and for treatment should last for up to 28 days, renewable for up to 12 weeks. Under the proposals remands for medical report could be made on medical evidence that there was reason to suspect that the accused person was suffering from any of the 4 categories of mental disorder; remands for treatment could only be made in cases of mental illness or severe mental handicap. In both cases remand to hospital would be considered only where bail was not possible.

49. An interim hospital order to allow assessment of whether a hospital order would be appropriate could be made for 12 weeks, renewable for up to 6 months, if the court were satisfied by evidence from 2 doctors that the convicted person was suffering from mental illness, psychopathic disorder, mental handicap or severe mental handicap and that a hospital order might be appropriate. An interim hospital order would be an invaluable way for the court and the hospital concerned to find out whether a hospital order is likely to be an appropriate way for the court to deal with the person. In particular, it would enable professional staff to assess whether the patient was likely to benefit from treatment.

50. The Government is awaiting the judgment of the European Court of Human Rights in the case of X v the United Kingdom in which one of the principal issues is the question of whether or not a restricted patient has a periodic right to have the substantive grounds for his detention considered by a 'court' with power to order discharge if it finds that further detention is not justified under domestic law. Under the present law, the Home Secretary must refer the cases of restricted patients to a MHRT periodically if they ask him to do so but the MHRT can then only advise the Home Secretary whether to discharge the patient. It cannot itself order discharge. The Government has decided not to include in the Bill any amendments to the 1959 Act which relate to the issues in this case until the judgement of the Court is available. The judgement is expected to be delivered whilst the Bill is still before Parliament. The Government will then consider in the light of the judgement whether any further amendments should be included in the Bill.

## IMPLEMENTING THE CHANGES IN THE BILL

51. Although the amendments proposed in the Bill do not alter the essential framework of the 1959 Act, they do make considerable changes in existing arrangements for the control, treatment and care of the people concerned, as well as introducing major additions to the structure, such as the Mental Health Act Commission. These changes and additions will mean new regulations, new procedures, new guidance and the provision of extra resources of manpower and money. The introduction of these changes must therefore be carefully timed and those concerned with their practical application must be at all times clear what their legal powers are and how they must be exercised; this is especially important in matters concerning mentally disordered people where decisions may have to be taken quickly and under conditions of stress.

52. The Government hope that, if the Bill is accepted by Parliament, the Royal Assent can be given in the summer of 1982. It is hoped that soon after Royal Assent it will be possible to introduce a consolidation Bill to cover the material in the 1959 Act, as amended by subsequent legislation, including this latest amending legislation. There can, of course, be no certainty as to the timing of a consolidation Bill but consolidation will make it much easier for those who use the legislation to follow it in its amended form and will also provide the opportunity to separate out the provisions which relate to the mentally handicapped.

53. The Government therefore sees considerable practical advantage in synchronising implementation of the greater part of the 1982 Act with the completion of consolidation

54. While work on consolidation is under way, work can proceed simultaneously on the preparation of subordinate legislation, on the revision of guidance and on the establishment of the Mental Health Act Commission. The Government would therefore hope to have a single appointed day for all save three of the provisions of the Bill. On this appointed day several measures with significant resource implications would be put into effect such as the improved access to MHRTs (estimated to cost about £1m a year) and the setting up of the Mental Health Act Commission, with the new arrangements for consent to treatment, etc (which is expected to cost about £ $\frac{1}{2}$ m a year). Indeed, as regards MHRTs, some changes will be made ahead of the appointed

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date to phase in the programme. The Secretary of State's discretionary powers will be used to refer patients to MHRTs who have not had a Tribunal hearing for some years, starting with those who have had the longest wait. This will reduce the backlog of patients who would otherwise have had an automatic hearing in the first year or so of the new scheme.

55. Certain proposals in the Bill will, however, have to be implemented separately at later dates. The obligation on social services authorities to appoint "approved social workers" will require two years preparation and training, during which the existing mental welfare officers will continue to carry out their present function. The DHSS will issue guidance on the new arrangements in 1982 on the standards of training, qualification and experience needed by an approved social worker and local authorities will then be able to start their work on applying guidance to their appointment and arranging for extra training and recruitment as necessary.

56. Finally, as was made clear in the 1978 White Paper, special considerations apply to the introduction of interim hospital orders and remands to hospital. Both these innovations will have significant resource implications, both in manpower and money, for the NHS. It is estimated that interim hospital orders would cost the NHS about £1m a year while remands to hospital could cost £3m a year. The Government therefore proposes to take powers in the Bill to introduce these - if necessary by stages - when sufficient resources can be made available - probably over the 2 or 3 years after the Bill is passed.

57. The Government believe that the changes in the Bill will not only bring up to date the provisions of the 1959 Mental Health Act but will broaden its scope, particularly by the introduction of the Mental Health Act Commission. The changes will help those concerned with the care of mentally disordered people who need to be detained in hospital or made subject to guardianship to build on and improve the structure which twenty years ago revolutionised the status and legal rights of the mentally disordered in our society.

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DRAFT LETTER TO THE HOME SECRETARY  
(AS CHAIRMAN OF H COMMITTEE)

MENTAL HEALTH BILL: DRAFT WHITE PAPER

As you are aware we intend to introduce a Bill to amend the 1959 Mental Health Act in the House of Lords at the beginning of next Session.

The 1959 Act has been under review for some 6 years and a variety of proposals have been canvassed. I propose therefore, to publish a White Paper explaining the provisions which appear in the Bill and the reasons for putting them forward. The White Paper would be published on the same day as the Bill and would serve as a guide to its contents.

I should be grateful if you would confirm by 26 October that you are content with this approach and with the draft White Paper attached.

I am sending a copy of this letter and the draft White Paper to other members of H Committee, to the Secretary of the Cabinet and to No 10.7

TABLE 1.1 ADMISSION BY LEGAL STATUS 1966, 1970, 1974-79<sup>1</sup> MENTAL ILLNESS AND MENTAL HANDICAP HOSPITALS AND UNITS IN ENGLAND AND WALES.<sup>2</sup>

SECTIONS OF THE MENTAL HEALTH ACT 1959

YEAR	25	26	29	30	60(+65)	72	73	135	136	Other compulsory powers <sup>3</sup>	Total
1966	11912	1938	17916	45	1517	159	17	13	1159	447	35123
1970	11143	1214	17260	79	1472	117	14	11	1485	350	33145
1974	7452	800	13559	179	1237	60	10	4	1561	219	25081
1975	7196	780	12835	206	1278	47	13	9	1600	217	24181
1976	6868	791	12057	218	1177	46	11	13	1588	188	22957
1977	6889	836	10257	253	1067	60	13	9	1516	148	21051
1978 *	6356	1003	8938	244	1042	59	11	9	1624	123	19407
1979 *	6042	1172	8398	299	975	89	14	10	1623	99	18721

1. Source: Mental Health Enquiry

2. Figures include Special Hospitals

3. Other sections of the Mental Health Act 1959 or other Acts, for instance, an admission may be recorded under Section 47 of the National Assistance Act, 1948

\* Provisional figures. MHE for 1978-9 not yet published.

TABLE 1.2: ADMISSIONS TO MENTAL ILLNESS HOSPITALS AND UNITS IN ENGLAND AND WALES 1966, 1970, 1974-79  
INFORMAL AND COMPULSORY ADMISSIONS

YEAR	NUMBERS		PROPORTION		
	TOTAL	INFORMAL	COMPULSORY	INFORMAL	COMPULSORY
1966	170281	136466	33815	80.1%	19.9%
1970	183510	151447	32063	82.5%	17.5%
1974	181451	157015	24436	86.5%	13.5%
1975	186215	162714	23501	87.4%	12.6%
1976	190358	168084	22274	88.3%	11.7%
1977	187827	167280	20547	89.1%	10.9%
1978 *	183372	164487	18885	89.7%	10.3%
1979 *	180613	162379	18234	89.9%	10.1%

1. Source: Mental Health Enquiry

2. Figures include Special Hospitals.

\* Provisional figures. MHE for 1978-9 not yet published

TABLE 1.3: ADMISSIONS TO MENTAL HANDICAP HOSPITALS AND UNITS IN ENGLAND AND WALES 1966, 1970, 1974-79  
INFORMAL AND COMPULSORY ADMISSIONS

YEAR	NUMBERS		PROPORTION		
	TOTAL	INFORMAL	COMPULSORY	INFORMAL	COMPULSORY
1966	10887	9579	1308	88%	12%
1970	11593	10511	1082	90.7%	9.3%
1974	12937	12292	645	95%	5%
1975	13914	13234	680	95.1%	4.9%
1976	15262	14579	683	95.5%	4.5%
1977	16170	15645	525	96.8%	3.2%
1978 *	17346	16824	522	97%	3%
1979 *	18307	17820	487	97.3%	2.7%

1. Source: Mental Health Enquiry

2. Numbers include Special Hospitals

\* Provisional figures. MHE for 1978-9 not yet published

TABLE 1.4: ADMISSIONS OF OFFENDERS UNDER PART V. 1966, 1970, 1974-79  
 MENTAL ILLNESS AND MENTAL HANDICAP HOSPITALS AND UNITS IN ENGLAND AND WALES

Year	SECTIONS OF THE MENTAL HEALTH ACT					Total
	Section 60	Section 60 with Section 65	Section 72	Section 72 with Section 74	Section 73 with Section 74	
1966	1259	181	16	133	16	1605
1970	1039	278	18	89	17	1441
1974	808	196	4	40	12	1060
1975	861	156	5	39	15	1076
1976	773	151	6	37	13	980
1977	731	90	11	45	18	895
1978	682	127	12	41	9	871
1979	657	102	14	70	16	859

1. Source: Home Office Criminal Statistics for England and Wales
2. Figures include Special Hospitals

TABLE 2.1: RESIDENTS BY LEGAL STATUS AT 31 DECEMBER 1974-79 <sup>1</sup>  
 MENTAL ILLNESS AND MENTAL HANDICAP HOSPITALS AND UNITS IN ENGLAND AND WALES

SECTIONS OF THE MENTAL HEALTH ACT 1959									
YEAR	25	26	29	30	60(+65)	72 + 73	135 + 136	Other <sup>4</sup> compulsory powers	Total
1974	1107	2834	128	20	2734	251	23	796	7893
1975	1272	2717	102	16	2673	257	4	639	7680
1976	985	2725	101	22	2595	251	9	580	7268
1977	860	2887	94	15	2505	235	23	474	7093
1978	879	2976	103	21	2332	233	24	466	7034
1979	1008	3175	99	24	2294	143	16	361	7115

1. Figures for previous years are not comparable as the method of collection was revised for 1974
2. Source: Form SHB 13C
3. Figures include Special Hospitals
4. Other sections of the Mental Health Act 1959 or other Acts, for instance, an admission may be recorded under section 47 of the National Insurance Act, 1948

TABLE 2.2: RESIDENTS IN MENTAL ILLNESS AND MENTAL HANDICAP HOSPITALS AND UNITS IN ENGLAND AND WALES 1974-79 <sup>1.</sup>  
 INFORMAL AND COMPULSORY RESIDENTS. <sup>2</sup>

YEAR	NUMBERS		PROPORTION		
	TOTAL	INFORMAL	COMPULSORY	INFORMAL	COMPULSORY
1974	150857	142964	7893	94.8%	5.2%
1975	146718	139038	7680	94.8%	5.2%
1976	142272	135004	7268	94.9%	5.1%
1977	138434	131341	7093	94.9%	5.1%
1978	134618	127585	7033	94.8%	5.2%
1979	131095	123942	7182	94.5%	5.5%

1. Figures for previous years are not comparable as the method of collection was revised for 1974.
2. Source: SBH 13C
3. Figures include Special Hospitals



TABLE 3: USE OF GUARDIANSHIP POWERS UNDER SECTIONS 33 AND 60 FOR MENTALLY ILL  
AND MENTALLY HANDICAPPED PEOPLE IN ENGLAND AND WALES, 1966, 1979 1974-78

DATE	MENTALLY ILL	MENTALLY HANDICAPPED	TOTAL
21 DECEMBER 1966	17	302	319 (9)
31 DECEMBER 1970	22	207	229 (5)
31 MARCH 1974	25	134	159 (7)
31 MARCH 1975	27	141	168 (4)
31 MARCH 1976	24	118	142 (4)
31 MARCH 1977	22	109	131 (4)
31 MARCH 1978	37	96	133 (8)

1. Source: SSDA 702 and Home Office Criminal Statistics.
2. Figures in parentheses are the numbers of guardianship orders under Section 60 in each year.
3. Figures for 1979 not available.

TABLE 3.1: RESIDENT PATIENTS BY MENTAL CATEGORY AT 31 DECEMBER 1974-79. MENTAL ILLNESS AND MENTAL HANDICAP HOSPITALS AND UNITS IN ENGLAND AND WALES.<sup>1</sup>

Year	Mental Illness	Psychopathic Disorder	Subnormality	Severe Subnormality	Other	All
1974 Informal	90244	586	12314	39747	932	143823
Compulsory	5213	808	1059	807	46	7933
All	95457	1394	13373	40554	978	151756
1975 Informal	85818	564	12571	38984	1091	139028
Compulsory	4899	787	964	976	54	7680
All	90717	1351	13535	39960	1145	146708
1976 Informal	84660	470	10948	37838	1088	135004
Compulsory	4906	760	827	711	64	7268
All	89566	1230	11774	38549	1152	142272
1977 Informal	80035	513	11265	38337	1191	131341
Compulsory	4954	721	770	608	62	7115
All	84989	1234	12035	38945	1253	138456
1978 Informal	77253	484	10891	37709	1248	127585
Compulsory	5022	696	709	545	61	7033
All	82275	1180	11600	38255	1308	134618
1979 Informal	75249	423	10239	36914	1125	123950
Compulsory	5305	638	685	484	70	7182
All	80554	1061	10924	37398	1195	131132

1. Figures include Special Hospitals

2. Source: Form SWB 13C

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