

Number 36

The White Paper 'Reforming the Mental Health Act'

The long-awaited White Paper was finally published before Christmas¹.

The White Paper provides more details of the Government's proposals for reform following the consultation based on the previous Green Paper. A new Mental Health Act is, however, still not law nor indeed a certainty. A draft Bill will be required and subsequent to that the necessary parliamentary debates. Finding parliamentary time before the next election is virtually impossible and the pressures after the election to deal with other matters are likely to be high. When any Bill is likely to be passed and a new Mental Health Act becomes law is therefore to some extent anybody's guess at the moment.

The White Paper is to be commended as essential reading for anyone involved in this field. This briefing simply seeks to set out a very brief summary of its provisions.

The Intentions

The purpose of the White Paper and the intended legislation can be summarised as follows:

- To provide new powers for the compulsory treatment of those suffering from mental disorder that are consistent with modern care and treatments.
- To improve the quality and consistency of care of those with mental disorder.
- Providing new structures for the minority of patients who are a threat to others (including those suffering from severe personality disorder).
- Filling the "Bournewood gap" by providing safeguards for those who are not subject to the formal powers of the Mental Health Act.
- Providing information on the services available – to include a new duty on NHS Trusts to inform patients as to the availability of services and how to access them.

The White Paper expresses the wish to streamline the processes and therefore proposes a single framework for the application of compulsory powers of detention including common criteria, a common pathway for assessment and no distinctions between different types of mental disorder (including severe personality disorder). The intention is to provide a new patient focus for care and treatment. Patient care and care plans will be approved by the proposed new Mental Health Tribunal (putting onto a statutory basis the current Care Programme Approach).

1. The White Paper is available from the Internet on www.doh.gov.uk/mentalhealth/summary.htm

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The New Process

A new Mental Health Act would have a simplified process:-

1. A preliminary examination by appropriate professionals (probably two doctors and an Approved Social Worker). In addition to medical issues they will take account of social care needs.
2. A formal assessment and period of treatment up to a maximum of 28 days.
3. Further care and treatment will require an order of the proposed new Mental Health Tribunal as indeed will further detention after the 28 days (or after any shorter initial period of detention if a review by the Tribunal is requested earlier by the patient).

Criteria for Use of Compulsory Powers

Again, the wish is to simply this. The criteria are:

1. The patient is diagnosed as suffering from mental disorder.
2. The mental disorder is of a nature and degree warranting specialist care and treatment (i.e. not primary care).
3. A plan of care is available to address the mental disorder, which will include management of patients' behaviour (presumably therefore dealing with the current problems around the "treatability" of severe personality disorder).

The new Mental Health Tribunal will be a "presidential" system. A president will be appointed (presumably by the Secretary of State) and the Tribunal will then sit in various locations around the country. Each Tribunal will be chaired by a senior lawyer supported by two other members with experience of mental health (but not psychiatrists). Expert medical input will be obtained by the Tribunal from a panel of consultant level experts who will provide a second opinion. The panel will be appointed by the Commission for Mental Health (a new body to be established). In addition the Tribunal will be able to accept evidence from others such as the patient, his family or their representative. If care plans and treatment regimes will be submitted to the Tribunal by the patient's medical team. The Tribunal will not have the power to impose its own, different, care plan but if the plan proposed by the patient's treating clinician is not approved, it may be returned to him for reconsideration. Nevertheless, the Tribunal is expected to take ultimate responsibility for the approval of these care plans.

Care and Treatment Orders

There are various elements that these orders are likely to contain:

1. A care plan rather similar to a current full CPA plan.

2. A provision for the duration of the plan. Initially this will be a maximum of six months followed by a further maximum period of six months, extended by up to one year at a time thereafter. These are maxima, however, and shorter periods may be imposed.
3. The location of the patient's treatment, be it in hospital, a hostel or in the community, will be provided for.
4. The care and treatment order will provide whether leave can be granted without seeking the consent of the Tribunal.
5. The plan will provide for whether a transfer between hospitals is permissible.
6. The order will provide for discharge and in particular whether this will be in the discretion of the treating clinician or subject to a further decision of the Tribunal. The power to discharge is only likely to be reserved to the Tribunal in cases of perceived high risk.

Additional Safeguards

The White Paper envisages that a new Act would provide further and additional safeguards for patients. The need to refer all care treatment and detention of patients in excess of 28 days to the new Tribunal will provide a level of independent scrutiny not currently in place.

It is proposed that each patient will have the right to independent advocacy services although the precise nature of these is still subject to consideration.

Safeguards for those suffering long-term mental capacity (those who currently fall into the "Bournemouth gap") are to be provided for, including in particular the provision of a care plan and the ability of the Mental Health Tribunal to review this.

The Mental Health Act Commission will be abolished and replaced by a new Commission for Mental Health. Although they will not undertake routine hospital visits, they will be responsible for reviewing the use and implementation of the Act and will also have a role in reviewing complaints once the NHS Complaints Procedure has been exhausted.

Hospital managers are to be abolished. This is regretted by many as they provide a useful level of independent scrutiny drawn from amongst the ranks of local people.

The role of the nearest relative is to be replaced by a new statutory creature, the Nominated Person. This will be a person whose appointment will have much greater flexibility than the current rules as to the identity of the patient's nearest relative. As patients are likely in many cases not to be in a position properly to nominate the person to act in this role when first admitted to hospital, it will often be the case that this person is appointed by Social Services, taking account however of all the circumstances and any advance agreement made by the patient.

Criminal Cases

This briefing note focuses on the provisions relating to civil detention. The White Paper does, however, at Part 2, deal with high risk patients (namely those suffering from severe personality disorder or offenders). The intention is to achieve enhanced protection for the public and the provision of effective treatment for such patients.

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Many of the existing powers will remain, including restriction orders, conditional discharge and recall, hospital directions and the review of the care of restricted patients (but now by the Mental Health Tribunal).

New proposals include a single power of remand for assessment and treatment based initially on one medical opinion, the ability of the Home Secretary to refer individuals for assessment and the power for the Court to agree leave whilst a patient is on remand.

New duties include the provision for victims of mentally disordered offenders of information regarding their detention and discharge (enabling them to make representations to Mental Health Tribunals regarding that discharge and contact with them or their family), and importantly, a new duty of disclosure requiring Health and Social Services to work with other agencies and provide an exchange of confidential information.

It is early days since the White Paper was published. Further debate and consideration of some of the proposals will no doubt improve the understanding and viability of what is suggested. What is, however, immediately apparent is that the system proposed by the White Paper will require significant resources in the establishment of the new Tribunal and its efficient running. This is likely to be a key factor in the success of the proposals.

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Readers are advised to take specific advice before acting in reliance on the matters set out in this briefing.

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