16 February 2012

Our Ref: IAT/ME/F12/4358

General Medical Council

3 Hardman Street
Manchester M3 3AW

Telephone: 0161 923 6200
Facsimile: 0161 923 6201
Email: gmc@gmc-uk.org
www.gmc-uk.org

Ms Rosemary Cantwell

By E-mail only

Dear Ms Cantwell

Thank you for your e-mail of 1 February 2012 in which you make a further FOI request for consultation responses that the GMC has made in respect of mental health legislation.

I have located the information that I believe you are seeking and I now attach the following:

- GMC briefing on Mental Health Bill, Second Reading debate
- Submission by the GMC, Public Bill Committee on the Mental Health Bill 2006
- GMC briefing on the Mental Health Bill, Second Reading debate
- Consultation on draft revised Mental Health Act 1983, code of Practice
- Joint Committee on the draft Mental Health Bill , GMC – written evidence

I also attach 2 consultation responses that were made in 2009 to the Scottish Government. These may also be of interest to you.

Finally, you also ask about SOADs and Section 12 doctors. These roles are determined by the provisions of the Mental Health legislation. Under our fitness to practise procedures we might consider a complaint where a doctor appears to be practising in these capacities in a manner that is inconsistent with our guidance. I would also refer you to my e-mail of 1 February 2012 in which I explained the circumstances that might warrant GMC action.

I hope that this information is helpful to you.

Yours sincerely

Mark Ellen
Information Access Team
Registration and Resources Directorate
Direct Line: 0161 923 6347
E-mail: mellen@gmc-uk.org

GMC Briefing on the Mental Health Bill
Second Reading Debate

10 April 2007

General Medical Council

Regulating doctors
Ensuring good medical practice

Background

The General Medical Council (GMC) is an associate member of the Mental Health Alliance, a coalition of 79 organisations with an interest in the proposals to reform mental health legislation in the UK.

The GMC licenses doctors to practise medicine in the UK under the provisions of the Medical Act 1983 (as amended). Our objective, as defined in the Medical Act, is to "protect, promote and maintain the health and safety of the public". Our four main functions are:

— to keep up-to-date registers of qualified doctors;
— to foster good medical practice;
— to promote high standards of medical education; and
— to deal firmly and fairly with doctors whose fitness to practise is in doubt.

Our governing body, the Council, is made up of both medical and lay members.

Within the terms of Section 35 of the Medical Act, we have power to advise doctors on standards of professional conduct and medical ethics. We do this primarily through published guidance, which sets out standards that society and the profession expect doctors to follow throughout their working lives.

GMC's interest in the Mental Health Bill

We have an interest in the proposals in the Mental Health Bill as they have implications for doctors' ability to meet the standards of conduct and care expected in their relationships with a particularly vulnerable group of patients.

We believe it is important to ensure that people with mental disorders are able to get the treatment and care which they need, and are not subjected to compulsory assessment and treatment without appropriate safeguards of their rights and interests.

We also acknowledge that there are difficult issues surrounding the management and care of the minority of people with mental disorders who pose (or may pose) a serious risk to public safety. On this point, there is clearly a tension between the public interest in protecting individuals' rights to personal freedom and, on the other hand, protecting the public against risks of serious harm. It is a difficult task to decide how the balance should be struck.

However, it is important that any steps taken to address public safety concerns do not impose responsibilities on doctors which conflict with their professional obligations towards patients and their families and carers.

We are concerned that parts of the Mental Health Bill, as introduced into the House of Lords, did just this. In particular, it raised potential conflicts with the obligations the GMC places on doctors to make the care of their patient their first concern, to prescribe drugs or treatment only when they are satisfied that they serve the patient's needs and to provide treatment and care based on clinical need and the likely effectiveness of treatment.

The amendments passed by the House of Lords in six key areas, including the requirement for detention that a person's decision making is impaired and the reintroduction of a need for treatment to provide a benefit to the person, are important safeguards which help to redress the balance in the legislation.

House of Lords amendments

The House of Lords voted on six amendments to the Mental Health Bill:

- To set out a list of exclusions from the definition of mental disorder, to stop a person being brought under the Act on the basis solely of substance abuse, disorderly conduct, sexual orientation or cultural, religious or political beliefs
- To protect people with full decision-making capacity from being detained
- To require some likelihood that a person's health will benefit from treatment
- To limit the use of SCT to those who would otherwise be in and out of hospital and who cannot otherwise be discharged from hospital safely
- To require a medical opinion before detention can be renewed or a person placed on SCT
- To ensure children detained under the Act are placed in age-appropriate accommodation and cared for by specialists in child and adolescent mental health.

The Government has indicated that it intends to overturn all of the Lord's amendments in the House of Commons. It also made a number of changes of its own, many of which are welcome. These were:

- Reference in the Bill to the (improved) set of principles in the Code of Practice
- Improvements to the system for detaining people for mental health care under the Mental Capacity Act (the "Bournewood" provisions)
- Protecting patients with decision-making capacity from being given ECT without consent

- Allowing 'Gillick competent' 16 and 17 year olds to refuse treatment without their parents being able to override their refusal

- Enabling people to be moved between 'places of safety' to reduce the time people spend in police cells.

We have not commented on all of the Lords amendments or changes proposed by the Government and have confined our comments to those areas which are within the GMC's remit and which potentially impact on doctors' ability to meet their professional and ethical obligations to their patients.

GMC's response to Lords amendments

Exclusions

We support the Government's desire for a broad single definition of mental disorder. However, we do not believe that the additional exclusions passed by the House of Lords detract from this intention. Rather, it should provide greater clarity for those operating under the Act about when the provisions of the Mental Health Act are available and ensure that people are not detained solely on the basis of factors such as substance abuse, disorderly conduct, sexual orientation or cultural, religious or political beliefs. It does not prevent people being detained if they also have a mental disorder and meet the other criteria for detention under the Act.

We would urge the House to retain this amendment from the House of Lords.

Impaired decision-making capacity

In the guidance the GMC publishes for doctors, we make clear that doctors are expected to respect the wishes of patients who have capacity to make their own decision (about treatment or care or disclosures of confidential information), and to act in the best interests of patients who lack such capacity. These are fundamental principles of good medical practice which we would expect to see applied to decisions involving patients with mental disorders in the same way as those suffering from physical conditions.

We therefore welcome the House of Lords amendment which adds an additional condition which must be met before a person can be detained under the provisions of the Act, that a person's ability to make decisions about treatment for their mental disorder is seriously impaired.

The Government is concerned that this may exclude from the provisions of the Act people who need treatment and have stated, "If it cannot be shown that a patient's judgement is impaired, they cannot be detained – regardless of how much the person needs treatment and however much they, and others, are at risk without it".

We believe, as did the House of Lords, that this view is mistaken. The purpose of the test is to ensure that compulsory treatment, against a person's will, can only be provided where the patient's own ability to make decisions about the treatment they

need is impaired. As the Lords made clear, if a person is suicidal or present a risk to others, as a result of their condition, their decision-making is impaired.

The test included by this amendment is deliberately less demanding than the test of capacity under the *Mental Capacity Act 2005*. This approach has been adopted in the Scottish mental health act (the "*Mental Health (Care and Treatment) (Scotland) Act 2003*"). The Scottish Code of Practice provides further guidance on the application of the impaired decision making test, which should alleviate the Government's concerns about people not receiving treatment under compulsion when it is clearly necessary:

> *"One difference between incapacity and significantly impaired decision-making ability arguably is that the latter is primarily a disorder of the mind in which a decision is made, resulting in the decision being made on the basis of reasoning coloured by a mental disorder. Incapacity, by contrast, broadly involves a disorder of brain and cognition which implies actual impairments or deficits which prevent or disrupt the decision-making process."*
>
> *It is important to emphasise that the criterion listed at paragraph 19 above with respect to a significant impairment of decision-making ability means a significant impairment with respect to decisions about the provision of medical treatment for mental disorder."*
>
> **Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 2 - Civil Compulsory Powers (Parts 5, 6, 7 & 20), Scottish Executive, September 21, 2005.**

'Treatability' requirement

The GMC supports the House of Lords amendment to reinstate a treatability requirement into the 1983 Act. It provides that a person should only be detained if treatment is available which is 'likely to alleviate or prevent a deterioration of his or her condition'.

The Mental Health Bill, as introduced in the House of Lords in November 2006, removed the 'treatability' requirement from the Mental Health Act 1983, replacing it with a requirement that 'appropriate' treatment was 'available' for the person. In our view, this fell short of the treatment having to provide any discernable benefit for the patient. This was compounded by the vagueness of the terms used in the Bill including 'appropriate treatment' and taking into account 'all the other circumstances of his case'.

We are concerned that if the House of Lords amendment is overturned, doctors may be required to become involved in the detention of people who: are seen to pose a risk to others; have not been convicted of a serious offence; and for whom no treatment is available which would provide a therapeutic benefit. This would represent a fundamental change in the role of doctors which would be in conflict with their professional obligations, for example the duty to make the care of patients their

first concern and the responsibility to provide treatment and care based on clinical need and the likely effectiveness of the treatment.

The Government's proposals were aimed at a very small group of patients with dangerous personality disorder who it is said are able to flout the law by refusing to cooperate with treatment and hence claim they are untreatable. However, the test as amended by the Lords overcomes this problem while protecting those who can gain no benefit from treatment from being detained. It will allow a person to be detained if treatment is available even if the person is not receiving the treatment at present because they refuse to engage with what is offered.

We support the Mental Health Alliance's view that the Lords amendment is a very balanced amendment that achieves the Government's aims without broadening the powers of compulsion to permit preventative detention.

Use of SCT

We support the amendments made in the House of Lords to insert a new set of narrow criteria for a person's entry onto a community treatment order (CTO) ensure that they are only used for the group of patients that the Government has stated they are intended for; that is, people who can be described as 'revolving door patients'.

The new criteria include the necessity to undertake an assessment of the nature and degree of the person's mental disorder, and the likelihood of compliance with medication, together with the risk of the patient relapsing. It also retains the existing supervised discharge as a less coercive means of keeping a patient who has been discharged under supervision, which is consistent with the principle of minimising restrictions on liberty, which is one of the fundamental principles to be included by the Government in the Code of Practice.

Renewal of detention

The GMC welcomes the House of Lords amendment to require a registered medical practitioner to examine a patient and agree before a renewal of detention can occur or a person can be placed on a Community Treatment Order. This has the effect of ensuring that decisions about renewal of detention (or commencement of CTOs) receive a similar degree of consideration as the original order for detention.

The Government's proposal was for the decision to renew detention to be taken by the person's responsible clinician with a requirement to consult with a registered medical practitioner (if the RC was not one). We were concerned that the duty to consult was too vague and did not include any mechanism to resolve disagreements between the responsible clinician and those who they were required to consult. This could place 'consulted' doctors in a difficult position and they may be placed in the situation of being involved in the continued detention of a person who they do not believe meets the criteria for detention.

The amendment to require agreement between the responsible clinician and a registered medical practitioner also provides an additional safeguard for people detained under the Act.

We believe this provision could be extended to the situation where the Responsible Clinician is also a registered medical practitioner; to require agreement in these circumstances with another registered medical practitioner who is an Approved Clinician. This would ensure that decisions to renew detention or place a person on a CTO are always taken by two qualified professionals.

GMC's response to the Government's proposed changes

Reference in the Bill to the (improved) set of principles in the Code of Practice

We are pleased that the Government has made some concessions on the issue of guiding principles by agreeing to provide a reference in the Bill to an improved set of principles in the Code of Practice which certain people performing functions under the Act (such as doctors, approved clinicians, managers and staff of hospitals) must have regard to. However, we are disappointed that, despite widespread consensus in the House of Lords, the Government has not agreed to include a clear set of overarching principles on the face of the Mental Health Act.

We believe that this would be a valuable way of providing clarity about the scope and purpose of the Bill, so that those working within its framework or affected by its provisions are clear about the basis on which it is considered legitimate to intervene in the lives of people with a mental disorder.

Improvements to the system for detaining people for mental health care under the Mental Capacity Act (the so-called Bournewood provisions)

We welcome the Government's intention to amend the *Mental Capacity Act 2005* to address the implications of the judgment of the European Court of Human Rights in H.L. v. the United Kingdom (the 'Bournewood' judgment).

The further amendments the Government has proposed, such as providing a mechanism for anyone with a concern (such as a family member or carer) to trigger an assessment of whether a person is deprived of their liberty if the hospital or care home has not done so provide greater clarity about the nature of these provisions and their application.

However, we believe that these legislative provisions need to be combined with clear guidance in the Mental Capacity Act Code of Practice, including examples of how the provisions will apply in different situations. This will provide help provide clarity for the professionals required to apply the provisions as well as those who may be subject to them.

Allowing 'Gillick competent' 16 and 17 year olds to refuse treatment without the agreement of their parents

We welcome the Government's decision to bring forward an amendment to allow 16 and 17 year olds to refuse treatment for a mental disorder, without the possibility of

their parents being able to override that decision. We believe this is a welcome first step in rationalising this complex area of law.

As the Mental Health Act provides an alternative to parental consent to detain and treat patients who refuse treatment we believe it is not appropriate to rely on parental consent when faced with the refusal of a competent 16 or 17 year old patient with a mental disorder. These amendments will provide helpful clarity in this area. Using the provisions of the Mental Health Act also provides other safeguards, such as access to the Mental Health Tribunal which are not available if young people are treated in hospital with the consent of their parent(s).

We would also encourage the Government to provide clear guidance in the Code of Practice to the Mental Health Act about the interaction between the Mental Health Act, the Mental Capacity Act and other legislation such as the Children Act in this, and other areas, where there is potential overlap between the Mental Health Act and other legislation.

For more information:
Suzanne Wood
Policy Adviser
Standards and Ethics Team
020 7189 5414
swood@gmc-uk.org

Submission by the General Medical Council
Public Bill Committee on the Mental Health Bill 2006

General Medical Council

20 April 2007

Regulating doctors
Ensuring good medical practice

Background

1. The General Medical Council (GMC) is an associate member of the Mental Health Alliance, a coalition of 80 organisations with an interest in the proposals to reform mental health legislation in the UK.

2. The GMC licenses doctors to practise medicine in the UK under the provisions of the Medical Act 1983 (as amended). Our objective, as defined in the Medical Act, is to "protect, promote and maintain the health and safety of the public". Our four main functions are:

   a. to keep up-to-date registers of qualified doctors;

   b. to foster good medical practice;

   c. to promote high standards of medical education; and

   d. to deal firmly and fairly with doctors whose fitness to practise is in doubt.

3. Our governing body, the Council, is made up of both medical and lay members.

4. Within the terms of Section 35 of the Medical Act, we have the power to advise doctors on standards of professional conduct and medical ethics. We do this primarily through published guidance, which sets out standards that society and the profession expect doctors to follow throughout their working lives.

GMC's interest in the Mental Health Bill

5. We have an interest in the proposals in the Mental Health Bill as they have implications for doctors' ability to meet the standards of conduct and care expected in their relationships with a particularly vulnerable group of patients. We believe it is important to ensure that people with mental disorders are able to get the treatment and care which they need, and are not subjected to compulsory assessment and treatment without appropriate safeguards of their rights and interests.

6. We also acknowledge that there are difficult issues surrounding the management and care of the minority of people with mental disorders who pose (or may pose) a serious risk to public safety. On this point, there is clearly a tension between the public interest in protecting individuals' rights to personal freedom and, on the other hand, protecting the public against risks of serious harm. It is a difficult task to decide how the balance should be struck. However, it is important that any steps taken to address public safety concerns do not impose responsibilities on doctors which conflict with their professional obligations towards patients and their families and carers.

7. The Government has announced that it intends, during the passage of the Bill through the House of Commons, to overturn all of the amendments made to the Bill by the House of Lords. We support the amendments made by the House of Lords as we believe that they help to redress many of the concerns that we have previously expressed about the Government's proposals for changes to the Mental Health Act.

8. In this submission to the Public Bill Committee, we focus on three areas which have potentially significant consequences for doctors and their ability to meet their professional and ethical obligations towards their patients. These are:

a. Impaired decision-making capacity

b. The so-called 'treatability' requirement

c. The power to renew detention

Impaired decision-making ability

9. The House of Lords passed an amendment adding a condition to the requirements for detention under the Mental Health Act, that a person's ability to make decisions about treatment for their mental disorder must be significantly impaired. This amendment means that a person who has capacity to make a decision about treatment for their mental disorder cannot have it forced upon them because a doctor disagrees with their decision.

10. The requirement that a person's decision-making ability must be significantly impaired before they can be detained and treated without their consent is consistent with the guidance the GMC issues to doctors, in which we make clear that doctors are expected to respect the wishes of patients who have capacity to make their own decision (about treatment or care or disclosures of confidential information), and to act in the best interests of patients who lack such capacity. These are fundamental principles of good medical practice which we would expect to see applied to decisions involving patients with mental disorders in the same way as those suffering from physical conditions.

11. A test of significantly impaired decision-making ability is included in the Scottish legislation, the *Mental Health (Care and Treatment) (Scotland) Act 2003*. Volume 2 of the Code of Practice for this Act provides further guidance on the application of the impaired decision making test and the distinction between impaired decision making ability and incapacity:

> One difference between incapacity and significantly impaired decision-making ability arguably is that the latter is primarily a disorder of the mind in which a decision is made, resulting in the decision being made on the basis of reasoning coloured by a mental disorder. Incapacity, by contrast, broadly involves a disorder of brain and cognition, which implies actual impairments or deficits which prevent or disrupt the decision-making process.
>
> It is important to emphasise that the criterion listed at paragraph 19 above with respect to a significant impairment of decision-making ability means a significant impairment with respect to decisions about the provision of medical treatment for mental disorder."
>
> Extract from the Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 2 - Civil Compulsory Powers (Parts 5, 6, 7 & 20), Scottish Executive, September 21, 2005.

12. The Government opposes this amendment. They believe that it will exclude from the provisions of the Act people who need treatment. They have stated, "If it cannot be shown that a patient's judgement is impaired, they cannot be detained – regardless of how much the person needs treatment and however much they, and others, are at risk without it".

13. We do not share the Government's concerns that people who pose a risk to themselves or others could be excluded from the provisions of the Act because of this amendment. In determining whether a person is able to make a decision about medical treatment for their mental disorder, doctors would need to follow a process which assesses whether:

> a. the person is able to understand that they have a mental disorder, what treatment is proposed and why the doctor believes it is necessary
>
> b. they can retain and weigh up this information and make a reasoned decision whether to accept or refuse the treatment
>
> c. their understanding or reasoning is distorted or impaired by their mental disorder.

14. We envisage that following this process would lead, in practice, to the conclusion that although a person who is suicidal or poses a risk to others may still have some capacity to make decisions, their ability to make decisions about medical

treatment for their mental disorder is impaired and they are, therefore, able to be detained under the Mental Health Act, provided the other conditions under the Act are met.

'Treatability' requirement

15. The GMC supports the House of Lords amendment to reinstate a treatability requirement into the 1983 Act. It provides that a person should only be detained if treatment is available which is 'likely to alleviate or prevent a deterioration of his or her condition'.

16. The Mental Health Bill, as introduced in the House of Lords in November 2006, removed the 'treatability' requirement from the Mental Health Act 1983, replacing it with a requirement that 'appropriate' treatment was 'available' for the person. In our view, this fell short of the treatment having to provide any discernable benefit for the patient. This was compounded by the vagueness of the terms used in the Bill and the Draft Illustrative Code of Practice, including 'appropriate treatment' and taking into account 'all the other circumstances of his case'.

17. We are concerned that if the House of Lords amendment is overturned, doctors may be required to become involved in the detention of people who: are seen to pose a risk to others; have not been convicted of a serious offence; and for whom no treatment is available which would provide a therapeutic benefit. This would represent a fundamental change in the role of doctors and would be in conflict with their professional obligations, for example the duty to make the care of patients their first concern and the responsibility to provide treatment and care based on clinical need and the likely effectiveness of the treatment.

18. We support the Mental Health Alliance's view that the reintroduction of a treatability requirement, as proposed by the House of Lords, is a balanced amendment. It achieves the Government's intention - of ensuring that the small group of people with dangerous personality disorder who refuse to comply with treatment are not excluded from the scope of the legislation because they claim to be untreatable - without broadening the powers of compulsion to permit preventative detention.

Renewal of detention

19. The decision to renew a person's detention under the Mental Health Act (or to place them on a Community Treatment Order) requires a decision to made as to whether a person continues to meet all of the conditions for detention, including that their mental disorder is of a nature or degree that requires treatment in hospital and that they are a risk to themselves or others.

20. This is a decision that can have significant consequences for the person detained and it is important that there is a robust system for ensuring that these decisions are carefully considered and involve people who are best placed and with the necessary qualifications and skills to assess whether the necessary conditions are met.

21. The Government's proposal was for the decision to renew detention to be taken by the person's Responsible Clinician with a requirement to consult with a registered medical practitioner (if the Responsible Clinician was not one). We were concerned that the duty to consult included in the Bill was too vague and did not include any mechanism to resolve disagreements between the responsible clinician and those who they were required to consult. This could place 'consulted' doctors in the difficult position of being involved in the continued detention of a person who they do not believe meets the criteria for detention.

22. The GMC welcomes the House of Lords amendment to require a registered medical practitioner to examine a patient and agree before the patient's detention can renewed or they can be placed on a Community Treatment Order. This has the effect of ensuring that decisions about renewal of detention (or commencement of Community Treatment Orders) receive a similar degree of consideration as the original order for detention.

23. This amendment also provides an additional safeguard for people detained under the Act. We believe this provision could be extended to the situation where the Responsible Clinician is also a registered medical practitioner by requiring agreement in these circumstances with another registered medical practitioner who is an Approved Clinician.

General Medical Council
20 April 2007

GMC Briefing on the Mental Health Bill
Second Reading Debate

23 November 2006

General Medical Council

Regulating doctors
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Background

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GMC's interest in the Mental Health Bill

We have an interest in the proposals in the Mental Health Bill as they have implications for doctors' ability to meet the standards of conduct and care expected in their relationships with a particularly vulnerable group of patients.

We believe it is important to ensure that people with mental disorders are able to get the treatment and care which they need, and are not subjected to compulsory assessment and treatment without appropriate safeguards of their rights and interests.

We also acknowledge that there are difficult issues surrounding the management and care of the minority of people with mental disorders who pose (or may pose) a serious risk to public safety. On this point, there is clearly a tension between the public interest in protecting individuals' rights to personal freedom and, on the other hand, protecting the public against risks of serious harm. It is a difficult task to decide how the balance should be struck.

However, it is important that any steps taken to address public safety concerns do not impose responsibilities on doctors which conflict with their professional obligations towards patients and their families and carers. We are concerned that parts of the Mental Health Bill, as currently drafted, do just this. In particular, we believe it raises potential conflicts with the obligations the GMC places on doctors to make the care of their patient their first concern, to prescribe drugs or treatment only when they are satisfied that they serve the patient's needs and to provide treatment and care based on clinical need and the likely effectiveness of treatment.

Summary

- We welcome the exclusion of alcohol/drug dependence and the qualified exclusion of learning disabilities
- We welcome the retention of clinical discretion (the use of 'may' instead of 'shall') in invoking the powers of compulsion under the Mental Health Act ("the Act")
- We believe the opportunity should be taken to include meaningful principles on the face of the Mental Health Act to provide guidance to doctors and other professionals
- We oppose the removal of the so called 'treatability test' as one of the conditions for use of the compulsory powers in section three Part four of the Act (consent to treatment)
- We believe the proposals to address the "Bournewood Gap" fall short of what is necessary to provide adequate safeguards for this group of people

Key concerns

Removal of the 'treatability test'

The Government is proposing to remove the treatability test in the current Mental Health Act for some section 3 patients and replace it with an appropriate treatment test for all section 3 patients.

We believe that the proposed requirement that 'appropriate medical treatment is available' does not provide sufficient safeguards for patients, particularly combined with:

a. the broad definition of 'medical treatment', and

b. the requirement to take into account 'all of the circumstances' of the patient's case, and

c. the removal of the need for the treatment to provide any 'therapeutic benefit' to the patient (i.e., improving, alleviating or preventing deterioration in the patient's condition or symptoms).

We are concerned that, as drafted, the Bill would require doctors to become involved in detention of people who are seen to pose a risk to others; who have not been convicted of a serious offence; and who can't be treated in any meaningful way. This would represent a fundamental change in the role of doctors which would be in conflict with their professional obligations, for example the duty to make the care of patients their first concern and the responsibility to provide treatment and care based on clinical need and the likely effectiveness of the treatment.

Principles on the face of the Act

We are disappointed that principles have not been included on the face of the amended Act (although they are in the Code of Practice) particularly as the government agreed in its response to the report of the Joint Committee on the draft Mental Health Bill 2004, that principles should be set out on the face of the Bill.

While we welcome the principles, including respect for patients, non-discrimination, maximum benefit and minimum restrictions, which are set out in the Code of Practice, we maintain that clear, meaningful principles should be included on the face of the legislation itself.

We believe that this would be a valuable way of providing clarity about the scope and purpose of the Bill, so that those working within its framework or affected by its provisions are clear about the basis on which it is considered legitimate to intervene in the lives of people with a mental disorder.

Provisions to address the "Bournewood gap"

We welcome the government's intention to amend the Mental Capacity Act to address the implications of the judgment of the European Court of Human Rights in H.L. v. the United Kingdom (the 'Bournewood' judgement).

The provisions of the Bill intend to provide additional safeguards for adults with mental disorder or disability who lack the capacity to consent to proposed treatment and care, but who are complying with treatment in circumstances that amount to a deprivation of liberty.We believe that the provisions, as drafted, need further clarification to ensure that they provide adequate safeguards for the group of people they are intended to benefit .

As drafted the provisions are not limited to cases involving treatment and care related to a person's mental health condition. Rather they focus on the circumstances in which any care or treatment is being delivered. In effect what they do is permit deprivation of liberty in cases of people with mental impairments, for the provision of any treatment or care in a hospital or care home, so long as that care is in the person's best interests and would prevent harm to that person. This is wider than the 'Bournewood' case which related to mentally incapacitated adults who were receiving mental health treatment in hospitals or care homes on a so called 'voluntary' basis without access to the protections of the MH Act 1983. If this is a

correct reading of the provisions, it provides less favourable treatment to this group of adults than the rights in relation to deprivation of liberty which the MCA secures for other incapacitated adults without mental impairment. There is no rationale provided for this difference in treatment.

We are concerned that the criteria which must be met for deprivation of liberty to be authorised are not sufficiently clear. For example, it would seem important that the 'best interests' assessment include consideration of questions about the need to protect the individual from risk of harm. It is not clear why protection from harm is seen as a necessary condition for detention, since proposed treatment or care may be intended as a means of improving the person's health or promoting the adult's wellbeing rather than reducing or avoiding risk of harm. In addition, it would seem that the best interests requirement, once assessed, may not be reviewable in some circumstances (schedule 99-108). However it's not clear what the impact of these provisions might be on decisions about ending or renewing an authorisation for detention.

There are other ways in which the proposals, as currently drafted, are not entirely consistent with the principles underpinning the capacity legislation or the safeguards for people detained under current Mental Health legislation.

In particular, it appears that the authority charged with authorising detention under the Mental Capacity Act (and who is responsible for undertaking the assessment of whether the criteria are met) will be the local authority or PCT who was responsible for placing the adult in the hospital or care home. The person charged with making the 'best interests' assessment and recommendation to the supervisory authority to varying degrees will be dependent on information supplied by the supervisory authority (e.g. the needs assessment or care plan). This would appear to be inconsistent with the approach taken in other parts of the MCA, and the Mental Health Act where there is a strong emphasis on ensuring a separation of different functions and responsibilities throughout the process.

In addition, the provisions allow for detention for a period of 12 months (compared with six months under the Mental Health Act after a period of assessment) before review and do not provide the safeguards offered by the Mental Health Review Tribunal.

It may be that some of our concerns are addressed in the proposed new section of the guidance contained in the MCA Code of Practice, but without sight of the draft we are not able to ascertain this.

SE/SW

24 January 2008

General Medical Council

Mental Health Legislation Team
Department of Health
Wellington House
London SE1 8UG

2nd Floor, Regents Place
350 Euston Road, London NW1 3JN

Telephone: 0845 357 8001
Facsimile: 020 7189 5001
Email: gmc@gmc-uk.org
www.gmc-uk.org

Consultation on *Draft revised Mental Health Act 1983 Code of Practice*

Thank you for inviting us to comment on the *Draft revised Mental Health Act 1983 Code of Practice* (the Draft Code), which reflects changes made to the *Mental Health Act 1983* by the Mental *Health Act 2007*.

We welcome the opportunity to comment on the Draft Code, which follow from our ongoing interest in, and contribution to discussions and debates on, amendments to mental health legislation for England and Wales.

As you probably know, the General Medical Council licenses doctors to practise medicine in the UK under the provisions of the Medical Act 1983 (as amended). Our objective, as defined in the Act, is to "protect, promote and maintain the health and safety of the public". Our four main functions are:

a. to keep up-to-date registers of qualified doctors;

b. to foster good medical practice;

c. to promote high standards of medical education;

d. to deal firmly and fairly with doctors whose fitness to practise is in doubt.

Within the terms of Section 35 of the Medical Act, we have power to advise doctors on standards of professional conduct and medical ethics. We do this primarily through published guidance, which sets out standards that society and the profession expect doctors to follow throughout their working lives. In commenting on your draft guidance, we wish to ensure that any obligations it might impose on doctors will not be inconsistent with the standards we set for their professional practice.

The GMC is also an Associate Member of the Mental Health Alliance, a coalition of 75 organisations, a unique alliance of service users, psychiatrists, social workers, lawyers, voluntary associations, charities, religious organisations, research bodies and carers'

groups.[1] The GMC has contributed to, and supports, the Mental Health Alliance's response to this consultation.

I have laid out below responses to the consultation questions on which we feel we can usually contribute. There follows some additional comments, which I hope you will find of some use.

Questions

Q1 – 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?

The primary audience of the draft Code are health professionals and managers and staff of hospitals who have defined responsibilities under the Act. However, it also the stated intention of the Code that it will also be helpful to patients, their representatives, carers, families and friends and other who support them and that it has been drafted as far as possible with this aim in mind.

Drafting a Code in language accessible to a varied audience, particularly in relation to complex legislation such as the Mental Health Act, is a difficult task. We welcome the attempts that have been made to achieve this, including the use of case studies illustrating how the principles in the draft Code might be used to aid decision making in practice. (see further comments on the case studies below 2).

However, we have some suggestions for further improvements:

Language

Use of terms 'should' and 'good practice'

The draft Code needs to be clearer in its use of terms such as 'should' and good practice'. If the Code is setting out a duty imposed by the Act, the term 'must' would appear to be more appropriate with 'should' and 'good practice' used where appropriate to support the duty or to differentiate things which, while not legal duties, are nonetheless considered good practice. As currently drafted, there seems to be some inconsistency about the use of these terms.

This is an issue that the GMC has previously had to consider in drafting guidance for doctors on good practice. Generally, in our guidance we use the terms 'should' and 'must' to describe doctor's professional duties. When we published the most recent edition of *Good Medical Practice*, our core guidance for doctors, we sought to explain more clearly our use of language. This is set out in the section *How Good Medical Practice applies to you* at the beginning of the guidance (http://www.gmc-uk.org/guidance/good_medical_practice/how_gmp_applies_to_you.asp). While such a direct statement may not be necessary, it would be helpful if the draft Code was checked and edited for the consistent use of language and to make clear which parts of the Code

[1] The full membership is published on www.mentalhealthalliance.org.uk.

reflect obligations imposed by the law and which are strongly recommended as good practice.

Plain English

As mentioned above, writing guidance or a Code of Practice intended for a wide audience, with different levels of knowledge and experience of the legislation is very challenging. We welcome the stated intention for the Code to be helpful to a broader range of people than simply those with defined responsibilities under the provisions of the Act, including the police and, importantly, patients, their representatives, carers, families, friends and others who support them.

We believe the draft code does go a lot further than the current Code to be more accessible. However, we believe that there is still room for improvement and we recommend that serious consideration is given to having the draft Code edited for consistency and accessibility in the use of language and presentation. This will help not only the wider audiences you mentioned but should also make it clearer for the target audience. Even those who have duties or powers under the Act will have varied levels of knowledge and understanding of the legislation. For example, doctors and nurses with powers under section 5 of the Act may not regularly have to exercise these and are unlikely to work in the field of mental health services.

The GMC publishes guidance addressed to doctors but we also state our hope that our guidance will help patients and others understand what is expected of doctors. To this end, we have all new pieces of our good practice guidance edited for Plain English. This has proved to be a very positive exercise and we believe has helped us to produce clearer and more accessible guidance. We understand that in finalising the *Mental Capacity Act 2005 Code of Practice*, external advice was sought to make the language as clear and accessible as possible. This is a process that we would recommend for this complex and important document.

Case studies

It would be helpful if consideration was given to more consistent use of well thought through and practical examples/case studies. The current draft feels quite uneven with some sections having no examples at all.

Some further guidance on how the principles might 'play out' in a particular situation would also be helpful. For example, in the Chapters where the case studies are used, they usually consist of a long list of possible questions under the principles that decision makers might need to ask themselves in making a decision but there is no further direction on particular issues, or what a reasonable solution might look like in a particular case. We appreciate that decisions are going to vary, depending on the patient and the individual circumstances, but it might be helpful if decision makers could see what a good decision looks like in a particular case with some further direction about how these principles might apply more generally.

The *Mental Capacity Act 2005 Code of Practice* provides a helpful model in this regard.

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

Please see the comments above about the use of case studies throughout the draft Code. In addition, we believe that the case studies and examples need to be more clearly presented and separated out from the rest of the guidance. This could be easily achieved by changing the layout, possibly using shaded boxes.

While this may not strictly be a structure issue, we feel the draft Code should more clearly signpost to other sources of information, in particular the Mental Capacity Act Code of Practice, other Department or NHS Codes (such as the Confidentiality Code of Practice) and relevant sections of the Mental Health Act. Specific examples of where this might be helpful are also mentioned in the Chapter specific comments, below.

Q6 What do you think of the guiding principles in the draft Code? How could they be improved?

We welcome the way in which the principles are reflected throughout much of the Code but believe that in the current draft, the use and emphasis given to the different principles is uneven. We would refer you to the Mental Health Alliance's detailed comments on the principles and suggestions for amendments.

We believe that the draft Code would be significantly improved by a comprehensive review of the way in which the principles are reflected and incorporated in the various chapters and to ensure that the case studies and examples are clear and relevant and used more consistently throughout the draft Code where they can helpfully expand upon or illustrate how the principles would apply in practice.

Q7 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?

Chapter 3

Paragraph 3.16 – The final sentence appears to be somewhat unbalanced – 'what matters is the needs of the individual patient, the risks posed by their mental disorder (whatever it might be, or however many disorders they may be suffering from) and what can be done to address those risks, both in the short and long time'. Presumably it is not just what can be done to address the risks (if any) posed by their mental disorder but also what can be done to address the patient's needs?

Chapter 4

Paragraph 4.63 – this might seem like a small point but it states that a medical examination must take into account the principles in Chapter 1 and involve 'direct personal examination of the person's mental state'. We suggest that this should be changed to a refer to an examination of the patient (of which assessing their mental state and whether they meet the criteria for detention would form a part); otherwise it might suggest that the

needs of the patient as a whole are irrelevant or lead clinicians to overlook physical conditions which might be affecting the patient's mental state.

Chapter 6 – Appropriate medical treatment

We have previously commented on the substantive issue of what constitutes appropriate medical treatment and we welcome the recognition in the amended Act that medical treatment for mental disorder is only appropriate if the purpose of it is to alleviate, or prevent a worsening of, the mental disorder, or one or more of its symptoms or manifestations.

The draft Code reflects this at a number of points (for example in paragraphs 6.2, 6.6, 6.11 and 6.15). However, on the whole, this Chapter is very unclear and seems at times to be giving conflicting guidance.

Paragraph 6.8 - The Act states that for treatment to be appropriate it must be for the purpose of alleviating, or preventing a worsening of, the mental disorder, or one or more of its symptoms or manifestations. This is restated in paragraph 6.6. At no stage does the Act refer to a mental disorder being 'cured' and this does not seem to be a helpful concept to introduce. Nor does it provide clear guidance to health professionals in making judgements about whether treatment is appropriate (within the meaning set out in the Act). Similarly, the reference to the behaviours arising from a patient's mental disorder is arguably different from symptoms and manifestations and could be interpreted as suggesting a different test than that which the Act imposes.

The definition of medical treatment in section 145(4) of the Act is quite clearly expressed (and repeated in paragraph 6.6). The attempt to further explain this in paragraph 6.8 seems only to confuse matters and may lead to a misinterpretation of the Act's provisions. If the paragraph is not deleted, we recommend that it should be redrafted, to reflect more closely the language of the Act. We would support the redraft suggested in the Mental Health Alliance response:

> "It should never be assumed that any disorders are inherently or inevitably untreatable. Treatment that can alleviate or prevent a worsening of one or more of the symptoms or manifestations of the disorder may be appropriate and necessary even if it cannot be demonstrated that long-term and sustainable changes can be made in the underlying disorder."

We appreciate the desire to make clear the scope of the new test under the Act. It is in the interests of everyone that the new Code is as clear as possible. If there is any uncertainty about how the test of appropriate medical treatment under the Act should be interpreted, this is ultimately a matter for the courts, or for Parliament. It would, therefore, seem sensible for the draft Code to stick as closely as possible to the language in the Act and to allow some time to see how it plays out in practice and if there are any particular difficulties with applying or interpreting the provisions which need to be addressed.

Paragraph 6.12 - We are not clear what point this paragraph is trying to make and the reasoning appears to be somewhat confusing. It does not provide clear guidance for

clinicians making decisions about whether medical treatment is appropriate in a particular case.

The Act refers to the purpose of the proposed treatment rather than the likelihood of the outcome. But, in practice, this distinction is not particularly helpful. While clinicians do not have to be able to demonstrate a *particular* outcome in order for treatment to be appropriate, they surely cannot meet the purpose requirement (or indeed their professional and ethical obligations) unless they reasonably believe there is a likelihood (based on their assessment of the patient's condition, their clinical knowledge and experience and the best available evidence) that the treatment will alleviate, or prevent a worsening of, the mental disorder or one of more of its symptoms or manifestations.

Paragraph 6.14 - We welcome the first part of this paragraph which makes clear that treatment will not generally be appropriate if it only aims to prevent deterioration of a patient's disorder when it should be possible to alleviate the condition.

However, this is somewhat undermined by the second part of the paragraph. We understand that this may be trying to address the specific issue in the Reid case but is currently drafted as having much broader application. This needs to be clarified to make very clear when such care is likely to constitute 'appropriate medical treatment' and that this is will only be in very exceptional circumstances. A clearer explanation of how it meets the 'purpose' requirement in section 145(4) would also be helpful.

Paragraph 6.16 - Guidance is needed on the issue of when it would cease to be clinically appropriate to offer treatments that require patient cooperation, where the treatments are refused or patients refuse to engage with them. Without further clarity, there is a danger that this paragraph could be interpreted as allowing long term preventative detention, which conflicts with the clear statement in other parts of this Chapter and with the Act itself.

Paragraph 6.17 - We agree with the main point of this paragraph – that the reason for detention is a significant factor in deciding on appropriate treatment but the second part of the paragraph needs to be reworded. As it is currently drafted it implies that treatment aimed *solely* at protecting others could be appropriate if this was consistent with the reason for detention. However, under the Act, no medical treatment is appropriate unless it aims to alleviate or prevent a worsening of the person's mental disorder or one or more of its symptoms or manifestations.

Chapter 11 – Holding Powers

Nature and scope of the power

As mentioned in response to Q1, the doctors with holding powers under section 5(2) may not work in mental health (i.e. doctors treating patients for a physical disorder in hospital who may be required to exercise their section 5(2) powers). It is therefore especially important that the language in this Chapter is clear and does not assume a detailed knowledge of the Mental Health Act generally.

Paragraph 11.2 - The use of the terms 'doctor' and 'approved clinician' need to be clarified here and throughout the chapter. An 'approved clinician' may also be a registered medical practitioner and this distinction might not be clear to health professionals not working in mental health.

Nomination of deputies

Paragraph 11.15 - This provides for a doctor or approved clinician with powers under section 5(2) to nominate a deputy who will then 'act on their own responsibility' and 'should be suitably experienced'.

This raises questions about where the responsibility and accountability of doctors, approved clinicians and, ultimately, hospital managers (see discussion on paragraph 11.2, below). More guidance in the draft Code about how the use of holding powers work (or should work in practice) may help to clarify this.

In terms of individual responsibility, is it sufficient that the person appointed to act as a nominated deputy is 'suitably experienced'? Ordinarily (for example where a doctor is delegating some of their responsibility for the care of a patient to another colleague), we would expect that an assessment of suitability would also encompass whether the person has the necessary skills and knowledge (and possibly qualifications although see further comments below about the split between individual and organisational responsibilities). I think the answer to this question might turn on what exactly it means to nominate a deputy (is it analogous to delegation or is it more akin to the obligations on doctors and other health professionals to make sure that there are suitable arrangements in place for patient care when they are off duty? For an example of how we, as the medical regulator address these two issues, see paragraphs 48 and 55 of *Good Medical Practice*)

Paragraphs 11.17-11.18 - It would be helpful to have some explicit guidance about the level of experience that a 'Junior Doctor' should have before being nominated as a deputy (e.g. F1, F2) and indeed, what is meant by the term 'junior doctor' as this is insufficiently clear. This section is also silent on who else could be nominated deputies.

Also, does the reference to 'senior psychiatrist' in this section mean a Consultant Psychiatrist or could other psychiatrists be considered 'senior' enough for a junior doctor to consult (for example, provided they are more senior than the doctor who is consulting them)?

Paragraph 11.21 - Further to our comments in paragraph 11.5, this paragraph also raises a question about responsibility and accountability.

If this, as it appears, is attempting to address a particular issue in relation to 'junior' doctors routinely acting as the 'nominated deputy' without sufficient training or competence, it needs to be clearer.

In addition, it imposes the obligation on the nominating doctor to ensure that all doctors liable to be on duty are competent and adequately trained. While it may be reasonable to expect a doctor nominating an individual colleague (i.e. as if they were delegating care) to satisfy themselves the person was competent to take on the task, it would surely be the

responsibility of hospital management to ensure that *all* doctors liable to be on duty are competent to fulfil the role as nominated deputy and are suitably trained?

Ending section 5(2)

Paragraph 11.24 - This states that patients must be informed once they are no longer detained under the holding power although there is no corresponding guidance on informing patients at the outset of the assessment about the purpose and effects of detention under this power. This would, at the least, be good practice, and consistent with the guidance in paragraph 2.2 on communication with patients (and the Participation principle in the Code of Practice).

Chapter 14 – Safe and therapeutic responses to disturbed behaviour

In the case study, the first bullet point under 'Least restrictive alternative principle' appears to start with what appears to the most, rather than the least, restrictive option (ie longer seclusion). As suggested, in response to Q1, we recommend that all of the case studies and examples are reviewed for consistency and also to make sure they offer clear and helpful guidance on how the principles are likely to apply in practice.

Chapter 15 – Physical security

Paragraph 15.8 – it would be very helpful to include clearer links to the relevant parts of Mental Capacity Act Code, when it is published.

Chapter 17 – Confidentiality and information sharing

Confidentiality and decisions about sharing and disclosing confidential information about patients are often particularly difficult in relation to mental health.

Patients being treated for mental disorder, including under the provisions of the Mental Health Act, have the same right to confidentiality as other patients. However, the circumstances in which health professionals may be asked/need to disclosure information, for example in the public interest, often arise more frequently in mental health than in other areas. In our experience of giving advice to doctors, patients and the public on good practice, it is also an area where tensions and conflicts between the different parties often arise.

One common example is family members of a detained patient who complain that a doctor will not meet them to listen to their concerns because it would be a breach of confidentiality or, where a doctor listens to family members but then tells the patient what was discussed, which in turn may affect the patient's relationship with their carers or family. These are difficult areas for clinicians and it would be helpful if the draft Code was clearer on difference between the duty of confidentiality owed to patients and obligations to others (such as carers and family members) and how these could be balanced.

We suggest that the first part of the Chapter continue to focus on the duty of confidentiality to patients, emphasising the fact that patients detained under the Mental Health Act are owed the same legal and professional duty of confidentiality as other patients.

The second part of the Chapter, which deals with information sharing more generally could be helpfully expanded to include advice on the issue of sharing information with family members/carers. While difficult, these issues need to be recognised in the Code, and hopefully some guidance or direction given on how doctors might balance their duty of confidentiality to patients with the need to be sensitive to the needs/wishes of those close to the patient. If health professionals are not able to respect the confidence of a patient's carer or family member, the Code should make clear that this should be explained to the person, which may help to prevent later misunderstanding.

Paragraph 17.5

This paragraph should be checked for consistency with the Mental Capacity Act. The second sentence states that a decision to share information 'needs to take into account the patient's best wishes and any wishes previously expressed by the patient....'. Our understanding is that the decision is whether the disclosure is in the patient's best interests (an assessment of which would include taking into account the patient's previously expressed wishes and the views of carers etc about the patient's likely wishes) or whether there is any other lawful authority (e.g. because it is in the public interest or an Attorney has been appointed who has the right to receive the information). We also suggest that there is a reference included to Chapter 16 of the Mental Capacity Act Code of Practice about access to information about a person who lacks capacity.

Paragraph 17.6 – 17.9

The description of 'public interest' needs to accurately reflect that disclosures in the public interest are not simple about protecting others but that it may also be justified to protect the patient themselves from a risk of death or serious harm. This needs to be added to paragraphs 17.7-17.9, wherever there is a reference to protecting others. Further clarification of 'serious crime' and a reference to the NHS Confidentiality Code of Practice would be very helpful.

Chapter 25 – Treatment regulated by the Act

We understand why extensive guidance on consent and capacity is not included in the Draft Code. However, a clear understanding of the law and professional obligations in relation to consent and capacity is critically important in relation to treatment decisions under the Mental Health Act. We believe that there is the need for more guidance in this section of the Code (or at the very least, clearer signposting to the Mental Capacity Act Code of Practice). It might be helpful to include relevant sections from the Mental Capacity Act Code of Practice in shaded boxes to make clear that it is separate from the main Code.

Paragraph 25.3 – we suggest that the last sentence should be amended to read:

> 'Nor does a patient's co-operation with the treatment amount to consent if the patient, ***has not been given sufficient information about what is proposed and why,*** lacks capacity (or, in the case of a child who is less than 16 years old, competence) to give such consent.

Paragraph 25.11 – it might be helpful to include a reference to what those professional/ethical obligations are (e.g. guidance from the relevant regulators of healthcare professionals)

Paragraph 25.13 – We think this paragraph needs to expanded to cover the important issue of accountability and responsibility – e.g. what a Responsible Clinician's obligations are when they are not in charge of a treatment (for example, overall management of the patient's care but are there additional responsibilities or safeguards when they are not in charge of a treatment, such as satisfying themselves that the patient has given valid consent etc?)

Paragraph 25.14 – This section should include a reference to the relevant parts of Mental Capacity Act Code of Practice and, it might also be helpful to also reference the Department of Health Reference Guide on Consent.

Chapter 32 – Renewal, extension and discharge from detention and SCT by Responsible Clinicians

The process for the Responsible Clinician to seek written agreement of a second professional seems to go beyond that envisaged by the Act and leaves a great deal of uncertainty about determining the most appropriate person to fulfil this role.

We support the Mental Health Alliance's recommendation that the Code should include a similar process to that relating to role of the AMHP in considering whether a Community Treatment Order should be made (see paragraph 28.10-12). It should also be made explicit that the period of detention may not be extended if the second professional does not agree that the conditions for detention are met.

Paragraph 32.8 – As currently drafted this is confusing and needs to state clearly what the position is – either the patient must be discharged from SCT immediately or their SCT cannot be extended beyond its expiry date.

Chapter 39 – Children and young people

The law in relation to capacity and consent for children and young people is extremely complex and, at times unclear. Particular difficulties arise in relation to questions about overriding a competent young person's refusal of treatment.

In light of this complexity and uncertainty, it is essential that the Code gives clear guidance, which accurately sets out the legal position (as far as this is reasonably possible), highlights any areas of uncertainty that practitioners need to be aware of, and provides helpful guidance on how decisions about treatment of children and young people for mental disorder should be approached.

We support the attempt to include guiding principles about decisions in relation to children and young people. However we are concerned that, overall, this chapter does not provide sufficient clarity for practitioners. Given the complexity of the issues raised, it is difficult to give detailed paragraph by paragraph comments on how the draft Code should be amended. However, we would be happy to discuss this issue further with you, if it would be helpful. We have recently published new guidance. *0-18 years: guidance for all doctors*, (http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance/index.asp) which sets out doctors responsibilities for children and young people which addresses issues in relation to consent and capacity and may be able to share some of our experience in grappling with these issues in an attempt to provide clear guidance.

Additional observations

Status of the Code

The draft Code states that any departures from the Code could give rise to legal challenge and a court, in reviewing any departure from the Code will scrutinise the reasons for the departure to ensure there is sufficiently convincing justification in the circumstances (paragraph ii). We share the Mental Health Alliance concern that this fails to clearly and accurately state the correct legal status of the Code. We believe that this needs to be made clear at the outset of the draft Code, in keeping with the commitment given by Lord Hunt during the parliamentary debates.

I hope this is of some assistance. Please do not hesitate to contact me if you wish to discuss these matters further.

Yours sincerely

Suzanne Wood
Policy Adviser
Standards & Ethics
Direct Tel 020 7189 5414
Email swood@gmc-uk.org

Joint Committee on the Draft Mental Health Bill
General Medical Council (GMC) - Written Evidence

1. The General Medical Council licenses doctors to practise medicine in the UK under the provisions of the Medical Act 1983 (as amended). Our objective, as defined in the Medical Act, is to 'protect, promote and maintain the health and safety of the public'. Our four main functions are:

- To keep up-to-date registers of qualified doctors
- To foster good medical practice
- To promote high standards of medical education
- To deal firmly and fairly with doctors whose fitness to practise is in doubt.

Our governing body, the Council, is made up of both medical and lay members.

2. Within the terms of Section 35 of the Medical Act, we have power to advise doctors on standards of professional conduct and medical ethics. We do this primarily through published guidance, which sets out standards that society and the profession expect doctors to follow throughout their working lives. Copies of our principal guidance booklets are enclosed for information:

- Good Medical Practice, 2001 edition.
- Seeking Patients' Consent: the ethical considerations, 1998.
- Confidentiality: Protecting and Providing Information, 2004 edition.

3. We have an interest in the proposals in the draft Bill as they have implications for doctors' ability to meet the standards of conduct and care expected in their relationships with a particularly vulnerable group of patients.

General

4. We believe it is important to ensure that people with mental disorders are able to get the treatment and care which they need, and are not subjected to compulsory assessment and treatment without appropriate safeguards of their rights and interests. We would welcome reformed legislation which achieves these aims, taking account of the way that modern mental health services are provided in hospital and the community, and reflecting modern human rights law.

5. We also acknowledge that there are difficult issues surrounding the management and care of the minority of people with mental disorders who pose (or may pose) a serious risk to public safety. On this point, there is clearly a tension between the public interest in protecting individuals' rights to personal freedom and, on the other hand, protecting the public against risks of serious harm. It is a difficult task to decide how the balance should be struck. However, it is important that any steps taken to address public safety concerns do not impose responsibilities on doctors which conflict with their professional obligations towards patients and their families and carers.

6. It is with these considerations in mind that we offer comments on the draft Bill. Our response is focussed on those aspects of the Bill which appear to raise substantial points of principle.

Q1. Is the draft Mental Health Bill rooted in a set of unambiguous basic principles? Are these principles appropriate and desirable?

7. The draft Bill proposes (Clause 1) that the principles which should guide application of its provisions will be set out in a Code of Practice. We have not seen a draft of the Code and there is little in the explanatory memorandum exploring what the principles should encompass. Even so the Bill allows that, whatever principles are established could be disapplied wherever they are considered 'inappropriate' or 'impractical' (Clause 1.4). We have reservations about this approach as it creates uncertainty about the scope of the Bill and the statutory protections which would be available to patients.

8. It is important to provide clarity about the scope and purpose of the Bill, so that those working within its framework or affected by its provisions are clear about the basis on which it is considered legitimate to intervene in the lives of people with a mental disorder. A statement of principles, imposing a statutory obligation on decision makers to give effect to them, would be a valuable means of achieving this. We note that such an approach is being adopted in the Mental Capacity Bill, which will interact with this Bill, and the principles outlined there seem an appropriate starting point.

9. We also note that the expert committee (Richardson Committee) set up to review the 1983 Act proposed a number of principles which should underlie new legislation, and that many organisations representing patient or professional views have expressed strong support for those proposals.

10. The principles in the Mental Capacity Bill and the Richardson principles are consistent with the obligations we place on practising doctors (see the enclosed booklets). In particular we make clear that doctors are expected to respect the wishes of patients who have capacity to make their own decision (about treatment or care or disclosures of confidential information), and to act in the best interests of patients who lack such capacity. These are fundamental principles of good medical practice which we would expect to see applied to decisions involving patients with mental disorders in the same way as those suffering from physical conditions. Therefore, we would expect any statement of principles to include appropriate references to issues of decision-making capacity, consent and best interests, as part of the framework for ensuring that patients' rights are restricted as little as is compatible with ensuring they receive necessary care and public safety is not endangered.

11. Incorporating these principles would mean taking a different approach, in a number of crucial areas. Principally, it would require more account to be taken of the rights of people who have capacity to consent to or refuse treatment for mental disorder. For example there is inconsistency between the right given to patients to consent to or refuse ECT, whereas consent is not required and refusal is not

possible for long term administration of psychiatric medication (Part 5, Clauses 177-201). We note that the Joint Committee on Human Rights, in their review of the draft Bill, have stated that they "..have doubts about whether it should be possible to override the wishes of the patient, expressed when capable of making a decision, about treatment."

Q2. Is the definition of Mental Disorder appropriate and unambiguous? Are the conditions for treatment and care under compulsion sufficiently stringent?

Mental disorder

12. The definition of mental disorder (Clause 2) is very broad. Consequently there is a concern that many people for whom compulsory assessment and treatment would be inappropriate could be caught by the Bill's provisions. This might include, for example, people with learning disability or people who fall within the definition solely by reason of drug/alcohol dependence or anti-social behaviour. We note that a number of organisations with experience of the operation of the 1983 Act argue that the Bill should make explicit exclusions from its scope of such categories of patients, to ensure that mental health laws are not used as a means to contain people who display challenging behaviour. This seems a sensible proposal.

13. Alongside the definition of mental disorder, it is important to establish clear limitations on the scope of the powers which can be exercised under the legislation. However, considered together with other key provisions - the definition of 'medical treatment' and the conditions which must be met before compulsion can be used - we believe that the overall scope of the Bill is drawn too widely.

Conditions for the use of compulsion

14. The conditions (Clause 9) do not provide a sufficiently clear or stringent basis for decisions which interfere with a patient's rights.

15. The first, second and fifth conditions (that medical treatment is necessary and appropriate treatment is available) are crucially dependent on the definition of medical treatment. We are concerned about the broadness of the definition (Clause 2) in that it includes interventions, such as social care and employment training, which are not generally regarded as medical treatment or as requiring the supervision of an 'approved clinician' (if this means a doctor).

16. The third condition includes provision for compulsory treatment "..for the protection of others", but it does not specify from what they might need to be protected such as to justify coercive treatment. Further uncertainty is created by the provision which extinguishes the need for compulsion to be used as a 'last resort' in cases where there is "..substantial risk of causing serious harm to other persons." No rationale is provided for creating these two levels of risk with differential powers to use compulsion.

17. There is no specific requirement for 'treatment' to offer therapeutic benefit in terms of improving, alleviating or preventing deterioration in a person's condition or symptoms.

18. Overall, the definitions and conditions set out in the Bill do not establish a clear minimum threshold which would justify intervention in the lives of those with mental disorder. Lack of clarity on such a key point is unhelpful to those expected to work within the framework, or likely to be affected by the provisions, of the Bill. (See also our comments on Question 3.) We understand that uncertainties about the basis on which powers of compulsion can be used, for people in need of mental health services, can be a powerful deterrent to seeking help voluntarily.

Q3. Does the draft Bill achieve the right balance between protecting the personal and human rights of the mentally ill on the one hand and concerns for public safety on the other?

19. We believe that the draft Bill does not achieve the right balance. This is based on our concerns about the effect of the widely drawn definitions of mental disorder and medical treatment, and the focus on risks rather than therapeutic benefit in the conditions for compulsion (see paragraphs 15-16 above).

20. We acknowledge that there may be circumstances in which the rights and interests of a patient may have to be balanced against those of a third party. On other issues of public safety (for example child protection, communicable diseases) we advise that the threshold which might justify overriding an individual's freedom is where there is a risk of death or serious harm. For example, we advise that a careful weighing of the competing public interests in protecting a patient's right to confidentiality and protecting the patient or a third party from death or serious harm may justify breaching confidentiality in a particular case. We are concerned that, as currently drafted, the Bill would enable treatment to be imposed on people with capacity to make their own decision, when they are not at serious risk of harming themselves or others.

21. We draw particular attention to the conditions for using compulsion which propose two levels of risk to third parties, with differential rights for patients in each category. Our major concerns are that:

a. The provisions appear to exclude from the protection of the Bill those people who need treatment and lack capacity to decide but do not present serious risk to themselves or others.

b. The provisions appear to allow the use of compulsion for those who meet the risk criteria, but whose condition or symptoms could not be 'treated' in terms of providing any therapeutic benefit.

Q4. Are there important omissions?

Risk assessment

22. Use of compulsion will be dependent, to a greater or lesser degree, on the level of risk that a person with mental disorder poses to him/herself or others. To ensure transparency and fairness, it would be helpful if the Bill made clear the process and/or criteria which should be applied to risk assessments. A clear

procedure, with provision for patients to challenge decisions and arrangements for external scrutiny, should be part of the safeguards provided within the legislative framework. (The Scottish Mental Health Act offers a useful model for this approach.) This would seem to be particularly important where the level of risk is seen as justifying increased powers to impose detention.

Use of restraint

23. No specific provision is made for the use of coercive control and restraint procedures for the management of patients. The question arises whether inclusion of such procedures in a patient's care plan provides sufficient legal authority for their use, or sufficient protection against abuse.

Q6. Are the safeguards against abuse adequate?

24. The Bill contains many welcome provisions such as the role of the Expert Panel in advising the Tribunals on decisions about granting assessment and treatment orders and on proposed care plans, and patients' right to an independent advocate to represent their interests.

25. We are not in a position to comment generally on whether the safeguards are adequate. However, we note with some concern that the Tribunals will be able to authorise continued compulsory 'treatment' of a patient who is subject to civil compulsion, irrespective of a decision by the clinical supervisor that the patient should be discharged. This would present doctors with a real dilemma since they have a professional obligation not to provide treatment and care which they consider to be clinically inappropriate or not in the interests of the patient.

Q8. Is the draft Mental Health Bill adequately integrated with the Mental Capacity Bill (as introduced on 17 July 2004)?

26. There are a number of areas of overlap or tension between the two Bills which would need clarification or further work . The analysis provided by the Royal College of Psychiatrists in their response on this question is very helpful in setting out the key points.

27. The point we would stress in particular is the importance of clarifying the protection for patients who lack capacity and who are compliant with the treatment being offered. The Government has indicated that provisions for these patients will be included in the Mental Capacity Bill. We are concerned that patients treated under the Mental Capacity Bill have fewer safeguards and protections. For example, whereas the Mental Health Bill provides for formal reviews and inspection of services which are provided without consent to a patient; there is no parallel in the Mental Capacity Bill. We note that the need to ensure proper mechanisms are in place for taking and reviewing decisions and auditing services for these patients was highlighted in the recent ECHR ruling (HL v United Kingdom, judgment of 5 October 2004).

Q10. What will be the effect on the role of professionals?

28. We would refer the Committee to our answers at Questions 3 and the point made about the powers of Tribunals in paragraph 25.

29. We are concerned that, as drafted, the Bill would require doctors to become involved in preventive civil detention for people who are seen to pose a risk to others; who have not been convicted of a serious offence; and who can't be treated in any meaningful way. This would represent a fundamental change in the role of doctors which would be in conflict with their professional obligations, for example the duty to make the care of patients their first concern and the responsibility to provide treatment and care based on clinical need and the likely effectiveness of the treatment.

30. If preventive civil detention is to remain a part of the Bill, we would prefer to see a clear separation between the role of doctors providing therapeutic care and treatment and others who might be responsible for providing social care and/or custody for people who are considered to be a danger to society.

November 2004

Joint Committee on the Draft Mental Health Bill

General Medical Council (GMC) - Written Evidence

Summary of key points

- Mental health legislation should ensure that people with mental disorders are able to get the treatment and care which they need, and are not subject to compulsion without appropriate safeguards of their rights and interests.
- To provide clarity about the purpose and scope of the Bill, a statement of principles should be included which imposes a statutory obligation on decision makers.
- The principles included in the Bill should be consistent with doctors' obligations to respect the wishes of patients who have capacity to make their own decisions and to act in the best interests of those who lack such capacity.
- We note that the Richardson principles are consistent with our guidance on professional standards and have a wide degree of support.
- The definitions of mental disorder and medical treatment should be drawn more narrowly, through specific exclusions and a requirement for therapeutic benefit to the patient.
- The conditions for the use of compulsion do not establish a clear minimum threshold which would justify intervention in the lives of those with mental disorders.
- The Bill does not achieve the right balance between protecting individuals rights and the concern for public safety.
- We consider that the threshold to justify overriding individual rights should be risk of death or serious harm, either to the patient or a third party.
- We believe that the legislation should set out the process and/or criteria to be applied to risk assessments to ensure transparency and fairness.
- We are concerned about the proposed power of Tribunals to authorise continued compulsory treatment where a doctor has recommended that a patient be discharged.
- We would not wish to see doctors become involved in preventive civil detention of people who are considered to be a danger to others, but who can't be treated in any meaningful way.
- We believe it's important to ensure consistency and clarity between the powers available under the Bill and the Mental Capacity Bill.

General
Medical
Council

6 November 2009

GMC Scotland
5th Floor, The Tun,
4 Jackson's Entry,
Edinburgh, EH8 8PJ

Telephone: 0845 357 6999
Facsimile: 0131 525 8701
Email: gmcscotland@gmc-uk.org
www.gmc-uk.org

[redacted]
Mental Health Division
Head of Policy & Legislation Team (Branch 3)
3-ER St Andrews House
Regent Road
Edinburgh EH1 3DG

Dear [redacted]

Amendments to the Mental Health Legislation in the Event of a Civil Emergency or Influenza Pandemic

The General Medical Council is pleased to be able to respond to the Scottish Government's consultation on Amendments to the Mental Health Legislation in the Event of a Civil Emergency or Influenza Pandemic. We are unable to comment on the proposals themselves as these are operational matters outwith our remit. However we thought that you might find the following information useful.

From 16 November 2009 any doctor wishing to practise in the UK will, by law, need to hold both registration and a licence to practise. It will be the licence (rather than the registration) that will give the doctor the legal authority to practise. Doctors who are registered with the GMC but do not hold a licence will not be able to exercise the legal privileges which will be restricted to those who hold a licence (for example, writing prescriptions, signing death and cremation certificates and working as a doctor in the NHS).

We are aware of a recent 2009 Statutory Instrument 1592 which has changed the criteria for doctors sitting on tribunals to say "registered medical practitioner with or without a licence".

When licensing is introduced it will be important that doctors do not allow there to be any ambiguity or confusion about their GMC status. It will remain a criminal offence for a doctor to pretend to be registered when not and it will also become a criminal offence to be pretend to be registered with a licence when not.

There is also provision under the Medical Act 1983 (as amended) for the GMC to grant registration - under prescribed circumstances - in times of national emergency. The responsibility for declaring a national emergency rests with the UK Secretary of State.

Yours sincerely

Jane Todd
Head of Scottish Affairs

General
Medical
Council

09 November 2009

GMC Scotland
5th Floor, The Tun,
4 Jackson's Entry,
Edinburgh, EH8 8PJ

Telephone: 0845 357 6999
Facsimile: 0131 525 8701
Email: gmcscotland@gmc-uk.org
www.gmc-uk.org

[redacted]
Scottish Government Health Directorates
Mental Health Division
Head of Policy & Legislation Team (Branch 3)
3–ER St Andrews House
Regent Road
Edinburgh EH1 3DG

Dear [redacted]

Consultation on the Review of the Mental Health (Care and Treatment) (Scotland) Act 2003

Thank you for providing us with the opportunity to respond to your consultation. The General Medical Council licenses doctors to practise medicine in the UK under the provisions of the Medical Act 1983 (as amended). Our objective, as defined in the Medical Act, is to "protect, promote and maintain the health and safety of the public". Our four main functions are:

a. to keep up-to-date registers of qualified doctors;

b. to foster good medical practice;

c. to promote high standards of medical education; and

d. to deal firmly and fairly with doctors whose fitness to practise is in doubt.

Question 1: Advance Statements

We would support the recommendations in this section of the report. Our guidance to doctors on consent emphasises the importance of early discussions with patients to ascertain their wishes in relation to treatment and care, particularly where the patient may be facing the situation in which loss or impairment of capacity is a foreseeable possibility. Our guidance does not place any obligations on doctors to help formalise a patient's wishes, such as in an advance statement, but we encourage doctors to signpost patients to other organisations which might be able to assist with this.

In relation to widening the range of people who can witness advance statements to include *independent advocates and 'all staff'* (2.4), we agree that it should be clear what their role is. However certifying that someone is competent to make an advance statement may not always be as simple as the report implies – particularly in cases where a patient may have fluctuating capacity. Staff would need to be competent to do this, and be encouraged to seek advice from a more experienced colleague if they are in doubt.

A requirement for regular review of treatment which is in conflict with a patient's advance statement seems like a sensible way of ensuring that proper consideration is given to patient's stated wishes and is in line with our guidance on consent which requires regular review of decisions.

Question 3: Named Persons

We believe that a named person should have access to the same information as the Tribunal and other parties, in order to be able to fulfil their obligations properly. If there is a good reason for information to be withheld this should only be done in accordance with the Tribunal rules. We agree that it is important that the mental health officer submits only relevant information to the Tribunal in the first instance. In our confidentiality guidance, we advise doctors that when writing reports they must include only information that is relevant to the request and that this usually means that the full record should not be disclosed.

However, it can sometimes be difficult to judge in advance what information will be relevant to a Tribunal's decision and it is possible that this might include wider information about the service user's medical or social history. The proposed changes to the named person system to ensure that a named person is directly appointed by the service user and that the nominated person must consent to the appointment should hopefully reduce the concerns about the information given to named persons that have been raised by both carers and service users. As the report notes, a service user appointing a named person should understand that this will involve the named person receiving confidential medical information about themselves. Information about the role of a named person and what will happen when they are appointed should be given to both service users and named persons at the time of appointment to ensure that this is understood.

We note the proposal to allow young people under 16 to appoint a named person. We agree that this should be the case where the young person has the capacity to make this decision. However, it does not necessarily follow that because a young person has capacity to make a decision about whether to consent to particular medical treatment that they therefore also have capacity to decide who they want to be their named person in the event that they are subject to compulsion under mental health legislation.

In *0-18 years: guidance for all doctors*, we give advice on assessing capacity in which we note:

> *26 It is important that you assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision to be made. You should remember that a young person who has the capacity to consent to straightforward, relatively risk-treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences.*

We also advise that, even where young people do have capacity to consent, doctors should encourage them to involve their parents in making important decisions, but that doctors should usually abide by any decision they have the capacity to make themselves.

Question 4 – Medical matters

Medical reports

It is not for the GMC to comment on who should write the medical reports which accompany an application to the Tribunal for a compulsory treatment order. We would, however, have some concerns about moving to a single report system. Making a decision to detain someone under the provisions of mental health legislation is a very significant one with serious consequences for the person. Basing a decision on a medical report from a single practitioner may be seen as insufficient to ensure that the person's best interests are properly considered. In all areas of medical practice it is common to seek second opinions in cases where decisions are complex or consequences for the patients are potentially serious. Arguably, the same principle could apply to decisions under mental health legislation.

We note the concerns about the reluctance of some GPs to complete reports. In all aspects of their practice, we require doctors to recognise and work within the limits of their competence. This applies equally to writing reports as to examining or treating patients. In writing a report for the purposes of an application for a CTO we would expect doctors to only include information that is relevant to the request and that is factual and verifiable. We would also expect them to make clear the basis on which they are writing their report (for example whether it is based on examination of the patient or from a review of medical records or other written information provided to them). It might be helpful, as proposed, to clarify the difference in purpose of the first report (written by a psychiatrist) and the GP report so that doctors can have some assurances that they are not being asked to provide a report on matters which fall outside their competence.

Consent

We agree that the requirement in Section 238 for written consent should remain. However, in addition to circumstances where a service user refuses to sign but indicates verbal consent, you may also wish to include (either here or in the Code of Practice) some advice on obtaining valid consent when a person cannot physically give written consent.

Other Comments

We note the Review Group's support for a review of the inclusion of learning disability in the Act as recommended by the Millan Committee. The Millan Report presented detailed arguments both for and against the inclusion of learning disabilities. A review would provide the opportunity to explore these issues in more detail and would also be able to take advantage of any evidence in relation to the interaction between the mental health and incapacity legislation in relation to the treatment and care of people with learning disabilities.

I hope you find our comments of some assistance. Please do not hesitate to contact me if you wish to discuss any of our comments further.

Yours sincerely

Jane Todd
Head of Scottish Affairs
0131 525 8700
JTodd@gmc-uk.org