Second Reading Briefing on the Mental Health Bill 2006
House of Commons: 16th April 2007

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organisation for doctors specialising in psychiatry. The College is a member of the Mental Health Alliance and is in agreement with their briefing. This supplementary briefing selects particular issues of importance for the College.

"We start from the proposition that mental health patients are a particularly vulnerable group. Their dignity and autonomy, and their related human rights including their liberty and physical integrity, are specifically threatened by a regime of compulsory assessment, treatment and detention. Compared with most other people, they are less likely to be able to take action to protect their own rights. Because of this, they therefore depend heavily on other people to provide proper safeguards, and on legislation to ensure that those safeguards will be in place." Joint Committee on Human Rights, 25th Report, Draft Mental Health Bill 2004

For further information please contact Agnes Wheatcroft, Public Affairs Officer, The Royal College of Psychiatrists.

Telephone: 020 7235 2351

E-mail: awheatcroft@rcpsych.ac.uk

Summary

To maintain relationships between doctor and patient and improve patient outcomes the powers under the Mental Health Act should be tightly confined and unambiguous, it should command the support of the professional groups and patients, there must be a proper balance between clinical discretion and patient safeguards, and between paternalism and respect for autonomy. While public protection is an important dimension of the psychiatrist's role it should not overshadow the main purpose which is the care, safety and wellbeing of the patient.

Introduction

1.1 Mental health legislation directly affects a minority of our patients1but indirectly sets the climate for the provision of care to all others. By absorbing the time of clinicians and social workers it affects resources. As well as their responsibilities for the care of their patients psychiatrists have central legal powers and responsibilities under the Act. They make the formal recommendations that a patient be detained for compulsory treatment and they recommend any renewals of that detention. They must discharge from compulsion the patient who no longer meets the conditions for detention. Psychiatrists as responsible medical officers (and second opinion approved doctors) have responsibility for the patient's treatment, including when treatment is to be given without the patient's consent. Forensic psychiatrists have particular responsibilities for giving reports on mentally disturbed offenders to the courts and on conducting risk assessments of patients in secure hospitals. For all these reasons the reform of mental health legislation is of vital concern to psychiatrists[2].

1.2 The Mental Health Act 1959 was a beacon of enlightened practice in its time and was improved by its amendments in 1983. It needs updating to take account of changes in the practice of psychiatry and the expectations and aspirations of patients, their families and staff. For this reason the Royal College of Psychiatrists has welcomed its reform and has participated fully at all stages. In the divisions and faculties of which the College is composed – including those specialising in psychiatry for children and young people, forensic patients and older people the issues in this Bill, and its predecessors in 2002 and 2004, have been fully canvassed.

1.3 The College was of the firm view that the Mental Health Bill as presented to Parliament and the 1983 Act needed to be subject to significant revision. We warmly welcome the amendments made by the House of Lords and hope that further improvements in the House of Commons will ensure that it is more fit for purpose.

1.4 Our approach to new legislation

The College approach to new legislation has been informed by principles which include the following.

1). **The law should support modern principles and practice of care and treatment for mental health patients**

New programmes such as assertive outreach, early intervention and crisis intervention, programmes for those with personality disorder and initiatives for minority ethnic communities are all part of a forward looking government agenda which promises real improvements in

---

[1] There were 46,000 detentions in 2004-5 which is estimated to be two fifths of the total of those who were informal or voluntary inpatients. Numbers of patients under detention have however risen significantly in the last two decades.

[2] The role of psychiatrists is broadened to other groups of professionals under the new Bill (this is a change supported by the College)

mental health. NHS principles emphasise patient choice, human rights and equality. The Mental Capacity Act promotes empowerment and dignity of people who may at times lack capacity through mental ill health. The Act should be in harmony with these developments. The amendments in the House of Lords (e.g. on principles, impaired decision making and CTOs and the Bournewood provisions) have improved the Bill in this regard but there remain other key issues that need to be addressed in relation to patient choice and human rights. (see below)

(2) **The law should seek to reduce stigma and discrimination against people with mental illness. Wherever possible the principles governing mental health care should be the same as those which govern physical health**.
Stigma and discrimination remain the regular experience of people with mental health problems and, despite anti stigma campaigns by the College and by government, have worsened over the last decade[3]. These are serious issues that have a measurable destructive impact on the lives of our patients. Mental health legislation can contribute to that stigma. We applaud the House of Lords for recognising this issue and voting overwhelmingly in favour of a principle of impaired decision-making.

(3) **The law should be consistent with professional ethics.**
The Hippocratic oath of "first do no harm" should apply in this field of legislation as in any other medical intervention. A law which creates ethical conflicts for psychiatrists is damaging for the profession, for its reputation and for recruitment of new members. The use of compulsion can cause harm to patients. A law that is too broad will increase the use of compulsion in ways that are not in the interests of either patients or others. The original Bill was seriously defective in this regard but has been much improved in the House of Lords. The Bill still contains serious issues for psychiatrists – in particular with respect to the use of second opinion doctors under community treatment orders. We hope to see these issues addressed in the House of Commons.

(4) **Informal treatment, care and support should always to be preferred over compulsion when circumstances permit.**
Patient outcomes are improved when patients and their clinicians work together to promote recovery. Compulsory powers should be only used after other alternatives are exhausted. This is accepted by the government and is stated in the Code of Practice on Mental Health. We believe however that the government in its original Bill had lost sight of this goal.

(5) **The law should be practical.**
It should not be over-bureaucratic nor skew resources towards one group of patients at the expense of others. The over broad provisions for community treatment orders (CTOs) would have had this effect – as amended the Bill is more satisfactory. It should not impose, under different legislation, different or conflicting functions for the same group of patients. The Mental Health Act, as amended by this Bill still does not operate consistently with the Mental Capacity Act and needs further change.

(6) **Public protection is an important aspect of the law and the role of psychiatrists but it should not overshadow the main goal of promoting the health of patients**.
Indeed the two goals are not opposed. What promotes the wellbeing of patients will be beneficial for others as well. The media's obsession with reporting cases of mental health patients who become violent has seriously distorted the truth. Mental illness is not a predictor of violence against others for almost all diagnoses – depression, bipolar disorder, anxiety disorders being the most common. There is a slightly enhanced risk of violence associated with a diagnosis of schizophrenia but this insignificant compared with the relationship between

---

[3] The Department of Health's study of public attitudes to people with mental illness found that "levels of fear and intolerance of people with mental illness have tended to increase since 1993" and that "attitudes …have become less positive between 2000 and 2003" 3 The Social Exclusion Report 2004 found stigma to be the biggest problem people with mental health problems face as a group.

other conditions and violence – alcohol consumption being the main one. Overall, homicides by people with mental illness have remained constant over the last 2 decades while the total number of homicides has risen. According to recent Home Office statistics they constituted 3.7% of total homicides over the last decade.

2. Issues raised by compulsory powers – the dangers of over inclusive legislation

2.1 The power to detain patients has a profound significance for the doctor patient relationship. Merely having the legal authority, indeed responsibility, to force treatment on a non consenting patient can damage the therapeutic relationship. In no other branch of medicine is it possible to treat a patient who lacks capacity not because it is in the best interests of that patient but for the protection of another person. In no other branch of medicine is a doctor likely to be so feared by his/her patients.

2.2 The law of compulsion should be narrowly framed. Patient's health is best served (and where it is relevant the public safety as well) by a climate of trust between psychiatrist and patient. Where that is destroyed the patient is unlikely to come forward - leading to deterioration in his/her health and in time precipitating a crisis – which is self evidently unacceptable in terms of human suffering for patients and families and is costly of NHS resources.

2.3 Another reason for caution is that the use of the Act may do harm. While some patients whom we detain under the Mental Health Act clearly benefit from compulsory care and are grateful for having been protected at a time when their illness made them refuse the help they needed, others look back on their experience of being under compulsion as traumatic and damaging, or as leaving a "lingering sense of grievance"[4]. Large numbers of service users wrote to the Joint Scrutiny Committee on the Mental Health Bill 2004 to express that view.
" I fully accept that there are some individuals who do need compulsory treatment. However unless one has been through this experience it is quite impossible to express how degrading and terrifying it is".[5]

2.4 As a consequence service users may come to fear and distrust the doctors on whom they rely for help. In the context of the 'blame' culture, where every tragedy caused by a patient can potentially be attributed to a psychiatrist's misjudgement, psychiatrists often feel required to section patients, perhaps against their better judgement or the best interest of the patient. In its evidence to the Joint Scrutiny Committee on the draft Mental Health Bill the Royal College of Psychiatrists stated, *"Enabling people to feel able to seek help early, to talk about their fears and difficulties, without fearing scorn, humiliation or loss of status, freedom, job and friends is the best way to bring about improvement in their health".*

2.5 This is in no way to imply that psychiatrists dissent from the powers in the Mental Health Act or shirk the responsibilities they place upon us but merely to highlight the implications for mental health legislation. To maintain relationships between doctor and patient and improve patient outcomes the powers should be tightly confined and unambiguous, it should command the support of the professional groups and patients, there must be a proper balance between clinical discretion and patient safeguards, and between paternalism and respect for autonomy. While public protection is an important dimension of the psychiatrist's role it should not overshadow the main purpose which is the care, safety and wellbeing of the patient.

3. The original Bill

3.1 A major problem with the original Bill was that it was over-inclusive. It operated on the assumption that clinicians should be given the greatest powers possible and with the fewest restrictions in order that no one should escape its provisions. This is a serious error. For

---

4. "What I needed was an arm around my shoulder not a shot in the arm" Joint Committee on the Draft Mental Health Bill Vol II Evidence 736 Eric Stark

5. Memorandum from Victoria Hanson, Vol II Joint Committee on the Draft Mental Health Bill Evidence 735

reasons that we have already stated this is not in the best interests of patients and therefore does not command our support.
This would inevitably lead to a greater use of compulsory powers. The Bill broadened the definition of mental disorder for those treated under a treatment order[6]. It also

- removed exclusions[7] that have the purpose of limiting and more precisely defining the group of people who may be detained.
- abolished the 'treatability' test and. in so doing opened the possibility for detaining people for whom there is no therapeutic benefit.
- introduced community treatment orders (CTOs) but with such a low threshold for their application that almost every person who would now be discharged, (albeit in some cases under a supervised discharge provision[8]) could be eligible if the cautious clinician decides.
- failed to introduce any limits on the power to detain patients who were fully able to make decisions for themselves.

3.2 The cumulative effect of all these is a real likelihood that people may get trapped into a long term system of compulsory care. As Professor Richardson put it, the compulsory system could become like a lobster pot, easy to get into but difficult to get out9. As also pointed out by the Mental Health Act Commission compulsion increases stigma for patients.10 Its impact is likely to be felt most by those from ethnic minority groups who are already disproportionately subject to the Act11. It is damaging for patients' lives, and will undermine the effort of nurses, social workers and doctors to establish and maintain cooperative relationships with service users. A law which has the effect of adding to the numbers of patients under compulsion will also take away resources from voluntary patients – both in terms of bed space and professional's time in dealing with the procedural requirements of the Act. The College fears that mental health services will be directed away from those services which should reduce the need for compulsion such as early intervention, assertive outreach and other developments.

---

[6] Clauses 1-2

[7] Clause 3. The role of exclusions is to make clear what kind of behaviour, beliefs or life style should not be brought within compulsory powers although they may fall within the definition of mental disorder and may be contained in the diagnostic manuals used by psychiatrists. Exclusions also guard against people being swept into the Act when their sexual, cultural or social behaviour offends moral norms or is illegal and could be seen by some to reflect a disordered mental state but where there is no therapeutic health intervention for them. They are a feature of legislation in other countries including Scotland, New Zealand and the Australian states.

[8] The provisions for supervised discharge under section 25A –J which the Bill repeals however apply to a smaller number of discharged patients than will be eligible for a CTO.

[9] Joint Scrutiny Committee on Draft Mental Health Bill Vol 11 Evidence , 5

10 The Mental Health Act Commission reports, "Of all mental health patients, none are so stigmatised as those who receive treatment under compulsory powers, because of widespread ignorance and fear regarding the purpose and usual causes of detention under the Mental Health Act 1983." MHAC 9th Biennial Report p 72, Para 6.34

11 Findings from the first national census of psychiatric wards revealed African Caribbean's are 44% more likely to be detained under the 1983 Act. They are three times more likely to be admitted to psychiatric hospitals, 50% more likely to be put in seclusion and 29% more likely to be forcibly restrained than the rest of the population despite having the same rates of mental ill health as other ethnic groups. Commission for Healthcare Audit and Inspection (2005) Count Me In, Results of a national census of inpatients in mental health hospitals and facilities in England and Wales,; National Centre for Social Research (April 2002) EMPIRIC Report

4. Key issues in the Bill

Impaired decision making

4.1 The Mental Health Act authorises the detention of the patient in hospital for a period of time and requires him or her to submit to a course of treatment with which he or she disagrees. His or her views and wishes or indeed his or her 'best interest' are strictly speaking immaterial. This contrasts with the position for those with a physical illness. The legal position relating to physical treatment was recently spelt out by Dame Elizabeth Butler-Sloss in the case of Ms B (2002):
"A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death". Although the judge did not state it, this principle does not apply to the patient with a mental illness

4.2 Patients have different attitudes to dealing with their illness and to the drugs which may be prescribed for them. For some the side effects of these powerful and toxic chemicals are unacceptable and they may choose to cope with unpleasant symptoms rather than even more unpleasant side effects. This is not so different from the cancer patient who declines chemotherapy even though he knows it may hasten death.

4.3 If both people have a full capacity (that is a full understanding of their illness and the consequences of taking or not taking their medication) why should there be a difference? The difference in the law is based on a mixture of paternalism, prejudice, fear of mental illness and concern for the protection of others. The consequence for service users is profound. The Act should limit the right to act against patients' wishes to those patients whose ability to make decisions for themselves is impaired by their mental disorder.

4.4 **The likely health benefit "treatability":** The Bill removed the current treatability test and replaces it with a test of "appropriate treatment". While it is acknowledged that case law has led to a very broad interpretation of the current test[12], this creates the potential for people to be detained but receive no benefit beyond that of the containment itself. It is vital, as the Joint Committee on Human Rights recognised in a Report in 2002 that mental health legislation not be used as a form of preventive detention[13]. This is both a point of principle but also an essential practical point on the use of health resources. Legislation that takes away a person's liberty for no fault of their own must confer upon them a health benefit. The breadth of powers given to clinicians over what is "appropriate" treatment is amplified also by the fact that the Act expands the range of clinicians who can be in charge of a patient (responsible clinicians) and hence the range of treatments. For the first time a person may be detained for psychological treatment.

4.5 The aim of measures to expand the reach of the 1983 Act is, largely, to protect the public. The College fully accepts that there is a role for psychiatrists in this regard. However the public are not likely to be reassured by a measure that is unlikely to succeed, to give the few patients that are potentially dangerous more reason to avoid services than to engage with them[14].

---

[12] the treatability test can in any case be met in practice by claiming that treatment may extend'from cure to containment' (*Reid v Secretary of State for Scotland* [1999] 1 All ER 481.

[13] In the view of the JCHR, it is questionable whether the non-therapeutic detention of persons without conviction of an offence, on the grounds of "speculation about possible future behaviour and resulting risk to identified persons", will be compatible with the HRA. The JCHR noted in its report that explicit powers of preventive detention established by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 had been deemed compatible with the (ECHR) Article 5 by the Judicial Committee of the Privy Council, but pointed to the fact that these powers related only to restricted patients who have been convicted of serious offences and set no clear precedent for patients who have had no contact with the criminal justice system.

[14] The Michael Stone inquiry (resulting from the death of Lin and Megan Russell) found that, despite much intervention by services on his behalf, there were institutional and communication failures, including a lack of

Psychiatrists regularly undertake assessments of the level of risk a person poses to themselves or others in deciding whether to detain or discharge him or her. However the prediction of risk whether done by actuarial or clinical methods is at best an inexact science[15]. Safety can best be improved by making the service accessible and effective. Public safety in this area of medicine is no different from, for example, in relation to sexually transmitted disease. It is essential that prospective patients are not deterred from seeking help. Indeed, because suicide and other risks are largely assessed from information given by the patient, it is necessary for the person to feel able to talk freely. Fear that being open will lead to loss of liberty does not aid this process. Hence if mental health law is seen to be overly coercive it will lead to patient avoidance of mental health services and, paradoxically, an increase in risk both to the individual and the public.

4.6 **The House of Lords Amendment**. The amendment in the House of Lords reinstated a form of the treatability test but with a significant difference that would deal with the problem that the government had identified. The government had stated that the problem occurs with people who refuse to engage with psychological treatments (which unlike drug treatments cannot be imposed at will. The patient then claims s/he is untreatable and must be released. As a result of the amendment in the House of Lords a person in this situation remains treatable, and hence under compulsion, so long as there is treatment on offer from which they would be likely to benefit.

Community treatment orders (CTOs).

4.7 The Bill introduced a form of community treatment order. There are at present powers, especially through Section 17 leave or Section 25A-J supervised discharge[16], for professionals to retain a degree of control over patients whom they release into the community. These can be useful in providing a graduated return to home life and as a trial release in which the person's readiness for discharge can be tested. The power of supervised discharge was added to the 1983 Act in 1995. While it has not been widely used it too has been helpful in cases where the condition of a person's health and the degree of risk makes absolute discharge unwise. Its problem has been the lack of enforcement powers.

4.8 The College does not oppose a position in which patients may be under an enforceable CTO in the community. We accept that there may be a small number of patients who respond well to a CTO, who relapse and become ill when released from hospital and for whom the possible sanction of a return to hospital may be in their best interest and those of the community. But studies from abroad do not show CTOs to be the panacea the government makes them out to be[17]. Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale18.

---

appropriate inpatient services that contributed to his commission of the homicides. Nor did the more recent Barrett inquiry recommend a change in the law.

[15] Academic literature makes clear that to prevent one homicide it would be necessary to incarcerate many more - up to 2000 or even as high as 5000. Szmukler 2003, *Risk assessment: 'numbers' and 'values'* in Psychiatric Bulletin 27, 205-207.Munro & Rumgay: 2000. *Role of risk assessment in reducing homicides by people with mental illness*. British Journal of Psychiatry 176 116-120

[16] There is also a form of community supervision and treatment through conditional discharge (s 37 with a s 41 restriction order) and under the guardianship provisions.

[17] Throughout Australia, where community treatment orders were embraced in a major way, the failure of community care to deliver good outcomes for patients over the last decade has been revealed as a national scandal leading to two major national inquiries, re examination of the law and large injection of funds into hospital care and new community service provision National Senate Inquiry into Mental Health , Australian Federal Parliament, March 2006

[18] " Evidence that community treatment orders are effective in reducing relapse and readmission to hospital is limited. High quality community services are essential if there is to be a benefit but the better the services

4.9 Patients in the community have returned to lead their daily lives. They should be entitled to make decisions for themselves. These decisions may include, as it does for people with physical illnesses, a decision to dispense with the medication which medical practitioners prescribe for them. It has been found for instance that only 8% of patients with heart disease that is potentially fatal take the statins that they have been prescribed[19]. For mental health patients in particular this decision may be because of the side effects which they may understandably find less tolerable than the symptoms of their illness[20] .

4.10 **The House of Lords Amendment.** CTOs should be targeted at the very small group of revolving door patients who may benefit from them and whose danger to the public justifies keeping coercive powers over them. This should include also a test of impaired decision making capacity. We were pleased that the House of Lords passed an amendment to that effect.

4.11 There remains however a significant issue in relation to CTOs which causes the College great concern. The system for second opinion approved doctors to give a second opinion on medication after 3 months has been altered under the Bill for people on CTOs. Under the Bill the SOAD will be enabled to approve a course of medication in advance of the time at which it may become relevant. This is contrary to good medical practice and needs to be changed. Other changes to the Bill should deal with the assessment process for people placed on CTOs, safeguards for those who are recalled to hospital for medical treatment, and the role of the Tribunal in relation to conditions of compulsion.

Changes to Professional roles

5.1The College is fully supportive of multi-disciplinary working and respects the strengths of other disciplines working within the mental health field. However some anomalies are apparent in the proposed system under which consultants in other disciplines have overall responsibility for patients subject to compulsion. It must be ensured that decisions are taken by those with an appropriate level of training and experience for the decision to be taken.

5.2 For instance, the Government has determined that only registered medical practitioners are deemed to have the necessary training to make the initial recommendation that a patient meets the relevant conditions for compulsion. It is unclear how a psychologist or other person who is not medically qualified is able to satisfy the legal requirement of ensuring that the relevant conditions are still satisfied when the patient's section is to be renewed if they are unable to determine the presence or absence of these conditions in the first instance. This policy appears to rest on the erroneous assumption that the initial diagnosis is the most complex and difficult and that diagnoses and 'nature and degree' of mental disorder can be more easily resolved once a person's condition is stabilised.

Amendments to the Mental Capacity Act for 'Bournewood' patients

---

the less likely will be the need for community orders". Memorandum from Kings College London Vol II Joint Committee on the Draft Mental Health Bill Evidence 779

[19] Heart 2002 88 229-33.

[20] Parkinsonism, dystonia, akathisia, tardive dyskinesia, hypotension, hypothermia, hyperthermia, neuroleptic malignant syndrome (which may be fatal), drowsiness, apathy, agitation, excitement, insomnia, convulsions, dizziness, headache, gastro-intestinal disturbances, nasal congestion, dry mouth, blurred vision, difficulty with micturition, acute urinary retention, constipation, tachycardia, arrythmias, (including sudden death), menstrual disturbances, galactorrhoea, gynaecomastia, impotence, weight gain, agranulocytosis or leucopenia, (both of which may be fatal), photosensitization, contact sensitisation, rashes, jaundice, corneal and lens opacities, and pigmentation of the skin, cornea, conjunctiva and retina (which may cause blindness).

6.1 That the Mental Capacity Act and the Mental Health Act provide overlapping regimes for people with a mental disorder is well known. Some of these are the so called Bournewood patients, who lack the capacity to make their own decisions about their residence, their care and treatment.

6.2 Most 'Bournewood gap' patients have little cognitive functioning. They are likely to lack capacity in respect of almost all areas of their life and to require high levels of care and supervision. Many are patients who, but for their compliance with the proposals for their care, would be detained under the Mental health Act. Adequate measures for their protection should have a central place in mental capacity legislation.

6.3 Patients receive a lower standard of care and protection if they are detained under one statute rather than the other. For instance, Bournewood patients are likely to be receiving medication and treatment for either/both mental and physical conditions. Under Section 58 of the Mental Health Act there is a statutory second medical opinion procedure for medication beyond three months and for electro convulsive therapy (ECT). The same safeguard should be replicated here. Statutory second medical opinions should be also required for treatment for physical conditions for the same group of serious medical treatments that will be specified in Regulations under section 37(6) of the MCA. The second opinion doctor should be a specialist in the same field as the treatment proposed.

6.4 The professionals may be faced with difficult decisions as to which Act to use. The inconsistency between the two Acts and the dilemmas this presents to psychiatrists is highlighted by the position with regard to electro-convulsive therapy. A patient who lacks capacity to consent to ECT and who is detained may only be given it if authorised by the second opinion doctor. If however that patient were not detained the safeguard would not apply. The decision is being taken involving a treatment which carries a significant risk of harmful side effects. If a patient has been unable, because of incapacity, to weigh the risks and the possible benefits and give informed consent a second opinion should be mandatory whether or not the patient is detained.

The College hopes that these anomalies will be remedied as the Bill progresses through parliament.

7 An Act that is fit for purpose

The following are important additions to the Act. These have been accepted by the Expert Committee Report on the 1983 Act in 1998, the Joint Scrutiny Committee, the Milan Committee on which the Scottish Mental Health (Care and Treatment) Act is based. They are also exemplified in the legislation of Commonwealth jurisdictions. Some were accepted by government within the 2004 Bill. We consider them too important to be lost in this Bill.

Modern principles of care: patient choice

7.1 Patient choice and participation in their care and treatment are central tenets in the new NHS. Maximising personal autonomy is a basis of the Mental Capacity Act. Respect for these principles implies the following:

(a) patients' right to choose their nearest relative to support them. This Bill instead gives a patient a limited right to displace the legally imposed nearest relative by applying to the County Court on the grounds that the nearest relative is 'unsuitable'. This is an inappropriate basis for displacement that may damage family relationships.
(b) When a patient is admitted to hospital in the midst of a crisis, s/he will be the least able to speak for him or herself or to understand and negotiate with the health system. A mental health advocate is extremely helpful both for the patient and for the professionals to give the patient a voice.
(c) The use of advance statements that set out both what a patient wishes to occur and what treatment s/he refuses in the event of being detained and lacking capacity, are gaining currency as useful and empowering tools for service users. These should, wherever possible, be respected under the Mental Health Act.

Protection for children and young people

7.2 Child and adolescent mental health problems are characterised by complexity, severity and often multiple co-existing diagnoses. The equal provision for the assessment and treatment of mentally disordered minors is made more complex by the issues of parental rights and responsibilities and assessment of competence of a growing child (with particular reference to "Gillick' competence)

7.3 Clinical provision is hampered by such a significant resource shortfall that many Mental Health Act assessments of minors are undertaken by psychiatrists specialising in adult services. About one third of young people detained under the MHA 1983 are commonly detained on adult wards. This is unacceptable. Amendments adopted in the House of Lords to require at least one medical assessment prior to use of the Act to be by a doctor specialising in the assessment and treatment of children and adolescents and to require children to be accommodated in age appropriate accommodation are most welcome. Remaining issues of concern involve that

- All young people deemed to be competent to consent should also be deemed competent to refuse treatment.
- Special protection should be provided for young people who may be subject to electro-convulsive therapy.

The Royal College of Psychiatrists
28th March 2007

For further information please contact Agnes Wheatcroft, Public Affairs Officer, the Royal College of Psychiatrists.

Telephone: 020 7235 2351

E-mail: awheatcroft@rcpsych.ac.uk