Pandemic Influenza and the Mental Health Act 1983

Consultation on Proposed Changes to the Mental Health Act 1983 and its Associated Secondary Legislation

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Guidance

Document Purpose	Procedure - change
Gateway Reference	12268
Title	Pandemic Influenza and the Mental Health Act 1983
Author	Clive Marritt
Publication Date	10 September 2009
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, Directors of HR, Allied Health Professionals, GPs, Emergency Care Leads, Directors of Children's SSs, Mental health voluntary sector bodies (including service user organisations) and independent psychiatric hospitals
Circulation List	
Description	Consultation on temporary changes to the Mental Health Act 1983 that might be required in the event of severe staff shortages during, and in the aftermath of, an influenza pandemic.
Cross Ref	N/A
Superseded Docs	N/A
Action Required	Comments required on consultation proposals
Timing	**Wednesday 7 October 2009**
Contact Details	Clive Marritt Mental Health Legislation Department of Health, Wellington House, 133-155 Waterloo Road, London SE1 8UG 020 7972 4492
For Recipient's Use	

First published 10 September 2009
Published to DH website, in electronic PDF format only.

http://www.dh.gov.uk/consultations

Pandemic Influenza and the Mental Health Act 1983

Consultation on Proposed Changes to the Mental Health Act 1983 and its Associated Secondary Legislation

Prepared by Mental Health Legislation Team,

Mental Health Division,

Department of Health

Contents

Executive Summary

This document invites comments on proposals to make some temporary changes to the Mental Health Act 1983 ("the 1983 Act") and some of its associated secondary legislation in the event of severe staff shortages during, and in the aftermath of, an influenza pandemic. They would be made to ensure that mental health professionals could continue to operate the 1983 Act in the best interests of the health and safety of patients and for the protection of others in these exceptional circumstances.

In addition to consultation questions on specific proposals you are invited to say whether you agree that the overall package of proposed amendments to the 1983 Act is fair and reasonable and whether it would be effective and helpful in a period of severe staff shortage during an influenza pandemic. You are also invited to say in what circumstances you feel it would be appropriate for the Secretary of State to bring them into force.

We apologise for the shorter-than-usual consultation period in this instance. This is forced upon us by our need to be prepared to introduce amended legislation if necessary to cope with an expected increase in the number of people affected by the pandemic in the early autumn.

Comments on the content of the consultation document should be sent to the Department of Health's Mental Health Division:

E-mail: **pandemicandmentalhealth@dh.gsi.gov.uk;**

Or write to: Mental Health Legislation Team
Department of Health
Wellington House
133-155 Waterloo Road
London SE1 8UG

Comments are required by **Wednesday 7 October 2009**.

Pandemic Influenza and the Mental Health Act 1983

1. Introduction

1.1 This document invites comments on proposals to make some temporary changes to the Mental Health Act 1983 ("the 1983 Act") and some of its associated secondary legislation in the event of severe staff shortages during, and in the aftermath of, an influenza pandemic. They would be made to ensure that mental health professionals could continue to operate the 1983 Act in the best interests of the health and safety of patients and for the protection of others in these exceptional circumstances.

1.2 This consultation relates solely to England.

2. Pandemic Influenza

2.1 Influenza (flu) pandemics are natural phenomena, which occurred three times in the last century. Pandemics arise when a new influenza virus emerges and spreads rapidly across the world with widespread epidemics in many countries. The severity of pandemics varies. In the last century, there were three pandemics: the 'Spanish flu' of 1918-19, in which 20-40 million people worldwide died (with peak mortality rates in people aged 20-45), the 'Asian flu' of 1957-58 and the 'Hong Kong flu' of 1968-69. Whilst the later pandemics were much less severe, they also caused significant illness levels (mainly in the young and older people) and an estimated figure of between 1 million and 4 million deaths each.

2.2 The World Health Organisation announced a global pandemic of A(H1N1v) (swine flu) on 11 June 2009. However, there is still uncertainty about the speed and severity of the illness, the pattern of spread and the impact of the virus on the UK. In July 2009 we moved into the treatment phase across the entire UK .The National Pandemic Flu Service has been launched and antiviral collection points are operational . We continue to collect information on the impact and spread of the virus in order to inform our care and treatment of symptomatic individuals.

2.3 Staffing is a critical issue for all sectors. The current planning assumptions are for a 10-12% rate of absence from work in the general population in the peak weeks of the pandemic. We know that health and social care organisations have a high number of staff with childcare and other caring responsibilities so the percentage of their staff who are not at work could be higher. They may experience a staff absence rate of up to 25% at some stage because of sickness and caring responsibilities, particularly if many schools are closed. These are planning assumptions for the first wave of the A(H1N1v) pandemic. As further UK and international surveillance data emerges, we will seek both to refine and extend these planning assumptions.

2.4 The Department of Health has also made arrangements for the supply of sufficient A(H1N1v) swine flu vaccine for the population of the United Kingdom. The following groups will be the first to be vaccinated with H1N1 swine flu vaccine, in the following order, once the vaccine has been licensed:

2.4.1 Individuals aged between six months and up to 65 years in the current seasonal flu vaccine clinical at-risk groups;

2.4.2 All pregnant women, subject to licensing conditions on trimesters;
2.4.3 Household contacts of immuno-compromised individuals;
2.4.4 People aged 65 years and over in the current seasonal flu vaccine clinical at-risk groups.

2.5 Front line health and social care workers will be offered the vaccine at the same time as they are at increased risk of infection and of transmitting that infection to susceptible patients. No decision has been taken to embark on a mass vaccination campaign. The use of the vaccine in the wider healthy population will depend on the evolution of the pandemic as well as new and emerging clinical data on the use of the vaccine.

3. The Mental Health Act 1983

3.1 The 1983 Act sets out procedures for detaining patients in hospital where that is necessary for their own health or safety or for the protection of other people. Part 2 of the 1983 Act applies to patients who have not committed any kind of offence and Part 3 to those who are concerned in criminal proceedings. The 1983 Act also contains provisions under which people may be subject to guardianship or be discharged from detention onto supervised community treatment.

3.2 The primary purpose of the 1983 Act is to ensure that compulsory measures can be taken, where necessary and justified, to ensure that people who suffer from a mental disorder get the care and treatment they need. Because these provisions place people under compulsion (for example to receive treatment) the 1983 Act also contains a number of safeguards. These include, for example, a right to apply to the First-tier Tribunal for their discharge from detention or supervised community treatment and a right to a second opinion from a second opinion appointed doctor (SOAD) in relation to certain types of treatment.

4. Implications of Pandemic Influenza for the Mental Health Act 1983

4.1 An influenza pandemic might lead to a shortage of certain professionals needed to meet the requirements of the 1983 Act. To be ready to cope in this circumstance we need to consider whether any of its provisions could or should be changed during the pandemic and, if so, in what circumstances it would be acceptable to implement such changes. We also need to consider what transitional arrangements should be made to ensure a smooth transition back to normal procedures when the height of the pandemic is over.

4.2 The proposals in this document are informed by four key considerations:

4.2.1 Ensuring that the 1983 Act can continue to operate effectively to fulfil its primary purpose in times of severe staff shortage;

4.2.2 Keeping changes likely to be required to achieve this to a minimum;

4.2.3 Adhering to the guiding principles in the Code of Practice to the 1983 Act; and

4.2.4 Maintaining the compatibility of the 1983 Act with the European Convention on Human Rights.

4.3 With that in mind we are suggesting possible temporary amendments to the 1983 Act and some of its associated secondary legislation which could be used to allow mental health professionals more flexibility where staff absence levels during an influenza pandemic mean that the usual procedures under the 1983 Act cannot be followed. This may be confined to certain areas if some are much more seriously affected than others, but even in these extreme circumstances the intention would only be to give them more flexibility. The contingency legislation will not preclude the usual procedures from being followed where that is possible.

4.4 As we have seen with the present swine flu virus, its impact has affected different parts of the country at different times. It is our intention that the contingency measures would only be used if local circumstances make it necessary to do so, ie when health and social care services cannot function in their "normal" way. It is not possible to be precise about the level of staff absence that might make this necessary. This might be if the overall staff absence rate reached the level described at paragraph 2.3 above in some places. We cannot, however, rule out the possibility that a lower rate of staff absence, if sustained over a period of several weeks or over a wide area, for example, might also bring about a situation in which we would have to bring the contingency measures into force. These assumptions are informed by our understanding that the 1983 Act operated successfully in the winter of 2008-09, when overall sickness absences in the NHS in England were approximately 5% (a figure which does not include staff absences to care for sick relatives).

Consultation Question 1: These contingency measures are intended to enable the 1983 Act to continue to operate effectively during a period of severe staff shortage. In what circumstances do you feel it would be appropriate for the Secretary of State to bring them into force?

4.5 One key factor affecting the usefulness of the contingency measures will be the amount of additional information that will need to be collected. We will need details of the levels of staff absences from work to inform decisions about if and when to introduce and withdraw the contingency legislation. Arrangements will need to be put in place to report these details to key co-ordinators in strategic health authorities and, through them, to the Secretary of State.

4.6 We will also need information on the use made of the contingency provisions to evaluate their usefulness. We could collect information about this once the height of the pandemic is over. But as it would probably be most efficient to record the information at the time, it might be possible to put sufficiently robust arrangements in place to report on the use of the contingency measures whilst they are in force. If so, this would inform services locally for managerial purposes and the Secretary of State over decisions about whether to continue with some or all of the contingency measures and when to bring them to an end.

4.7 We therefore propose that mechanisms for recording and reporting the use of the contingency powers should be put in place. We are nevertheless concerned to ensure that any information gathering arrangements do not counteract the benefits of implementing the contingency measures to an unreasonable extent.

4.8 If the contingencies are implemented, we also propose to ask the Care Quality Commission to convene an oversight group with representation from national mental health service user and professional bodies to advise on progress and the need for ongoing contingency measures.

Consultation Question 2: Who should collect what information about the contingency measures? What arrangements should be made for this information to be passed on to (a) services locally, (b) the oversight group and (c) the Department of Health?

5. Detailed Proposals for Temporary Changes to the Mental Health Act 1983

5.1 In the event of significant staff shortages, we have identified a number of changes to facilitate the continued operation of the 1983 Act. They are intended to enable services to cope with significant staff shortages whilst maintaining safeguards for patients. We are satisfied that the proposals are compliant with the European Convention on Human Rights. They would remain in effect for no longer than necessary during and, where appropriate, in the aftermath of the pandemic.

5.2 The proposed contingency measures would be permissive. This means that they would give people operating the 1983 Act additional flexibility to make decisions whilst allowing the usual procedures under the 1983 Act to be followed wherever possible. We think this approach will enable the 1983 Act to continue to be operated where the flexibilities need to be used, whilst not forcing the build-up of avoidably large backlogs of work during the height of the influenza pandemic.

Consultation Question 3: Do you agree that these contingency measures should be permissive rather than obligatory - allowing practitioners to use them where circumstances make it necessary but allowing normal safeguards to continue to be adhered to whenever possible?

5.3 The proposals fall into three categories:

5.3.1 Reducing the number of doctors required to comply with a number of sections in the 1983 Act;

5.3.2 Extending or suspending time limits which apply to certain actions under some provisions in the 1983 Act; and

5.3.3 Allowing certain additional people to be approved to undertake some specific functions under the 1983 Act.

5.4 Reducing the Required Number of Doctors

5.4.1 In the majority of cases an approved mental health professional (AMHP) applies for the patient to be detained under either section 2 or section 3 of the 1983 Act on the written recommendation of two doctors, one of whom must be specially approved for the purpose under section 12 (“section 12 approved”).

5.4.2 We propose a temporary amendment so that an application by an AMHP for detention under sections 2 or 3 of the 1983 Act may be made on the recommendation of one section 12 approved doctor without the need for a second doctor’s agreement. The doctor need not have previous acquaintance with the patient. Such an application based on the recommendation of one doctor is only to be made by an AMHP. If the nearest relative makes an application, a recommendation from two doctors will still be required.

5.4.3 In common with the other proposed contingency measures, this provision will be permissive. This means that an application may be based on one recommendation only if the AMHP believes that there would otherwise be undesirable delay. It will remain possible, however, for two medical recommendations to be obtained. This will enable the best use to be made of medical time when doctors are in short supply whilst maintaining the important social care perspective of the AMHP. It will also ensure that at least two professional people who are independent of the patient agree before anyone can be detained under either of these sections.

Consultation Question 4: Do you agree that allowing just one medical recommendation on an application by an AMHP for someone to be detained under section 2 or 3 of the 1983 Act should be one of the contingency measures?

5.4.4 The proposed change in the number of medical recommendations required would not fit the current application forms for detention under sections 2 and 3 of the 1983 Act (forms A2 and A6 respectively). We could include two new forms in Schedule 1 to the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008. The forms would be numbered A2A and A6A respectively. They would be the same as the current forms A2 and A6 respectively, with the exceptions that their references to two registered medical practitioners would be amended to read one medical practitioner and the subsequent paragraph about previous acquaintance would be omitted; and an extra statement by the AMHP would be required to confirm that obtaining a second medical recommendation would cause undesirable delay. These new temporary forms would be made available on the Department of Health website. The alternative to producing them would be for AMHPs to adapt the current forms locally to record the relevant information.

Consultation Question 5: Would you prefer specially prepared forms A2A and A6A or would you rather adapt the current forms A2 and A6?

5.4.5 We similarly propose temporarily to reduce the number of medical reports required before the Secretary of State authorises a person's transfer from prison to hospital under section 47 or 48. Under these temporary arrangements, the Secretary of State would be able to authorise such a transfer on the recommendation of one section 12 approved doctor without the need for a second medical report. This will make it easier to ensure that people who would otherwise be prison can be detained in hospital instead where their needs require it.

Consultation Question 6: Do you agree that the proposed changes to the number of doctors involved in decisions to transfer people from prison to hospital under Part 3 of the 1983 Act should be part of the contingency measures?

5.5 Extending or Suspending Time Limits

5.5.1 Under section 58 of the 1983 Act a second opinion appointed doctor (SOAD) is generally required to approve the medication given without consent to someone detained in hospital after a period of three months. The approval of a SOAD is also generally required for medication given to someone on supervised community treatment (SCT) after one month. We propose that, during the height of the pandemic, the

obligation to obtain SOAD approval for medication should be suspended. This will not prevent SOAD opinions being given during the height of the pandemic but it will remove the normal requirements for them to be given to a specified timescale. This will remove a demand upon the time of these doctors, freeing them to undertake other functions.

5.5.2 The approval of a SOAD will still be required as normal in respect of electro-convulsive therapy (ECT) under section 58A.

Consultation Question 7: Do you agree that the suspension of the obligation to obtain SOAD opinions on medication should be part of the contingency measures?

5.5.3 We propose to suspend time limits for taking certain actions ordered by the courts under various sections in Part 3 of the 1983 Act during the height of the pandemic. This would allow for the possibility that longer periods may elapse before some steps could be taken. Among other things this would suspend the time limits for admission to hospital as ordered or directed by the court for reports (section 35) or treatment (section 36), admission under a hospital order (section 37), an interim hospital order (section 38), committal to the Crown Court (sections 43 and 44) or a hospital direction (section 45A). We also propose to suspend the time limits for conveying patients to hospitals in sections 40 and 45B.

Consultation Question 8: Do you agree that time limits on conveying people and admitting them to hospital under Part 3 should be suspended as part of the contingency measures?

5.5.4 We also propose to suspend time limits for acting on warrants issued by the Secretary of State for Justice which authorise transfers to hospital from prison under sections 47 and 48. This will save valuable time which might otherwise have to be devoted to re-applying for and re-issuing time-limited warrants, bearing in mind that it may be more difficult to effect transfers while the contingency measures are in force.

Consultation Question 9: Do you agree that the time limits on warrants for transferring people from prison to hospital should also be suspended as part of the contingency measures?

5.5.5 Under sections 35 and 36 of the 1983 Act, in certain circumstances, the courts can remand people to hospital for a report on their mental condition or for treatment. The courts can remand people for up to 28 days at a time, but for no more than 12 weeks in total. We propose that, while contingency measures are in force, courts should have the discretion to renew such remands beyond 12 weeks if they consider it appropriate.

Consultation Question 10: Do you agree that giving courts discretion to renew remands under the 1983 Act beyond the normal 12 week maximum should be part of the contingency measures?

5.6 Additional People to Undertake Specific Functions

5.6.1 Changes made by the Mental Health Act 2007 which took effect on 3 November 2008 introduced approved clinicians to broaden the range of professions from whose

ranks people could be drawn to undertake the tasks under the 1983 Act previously performed by a responsible medical officer (RMO).

5.6.2 To make up the shortfall during a period of severe staff shortage, we propose that strategic health authorities should be able to approve people to act temporarily as approved clinicians who have undertaken the role of the RMO and/or been approved to act as an approved clinician within the past three years. As not all of these former RMOs will have extensive expertise in mental health, we propose that strategic health authorities should only be able to approve them temporarily as approved clinicians if, when they last performed this role, they were also section 12 approved.

5.6.3 We propose that for the duration of the severe staff shortage strategic health authorities should be able to approve these people to undertake the role of the approved clinician temporarily without requiring the formal evidence of competency or the completion of the course for the initial training of approved clinicians set out in the Mental Health Act 1983 Approved Clinician (General) Directions 2008.

Consultation Question 11: Do you agree that strategic health authorities should be allowed the flexibility to approve former RMOs and former approved clinicians to be approved clinicians as part of the contingency measures?

5.6.4 We also propose that strategic health authorities should be able to approve temporarily as approved clinicians any doctors who are currently section 12 approved but who have not previously acted as RMOs or been approved to act as approved clinicians. We propose that for the duration of the severe staff shortage strategic health authorities should be able to approve these people to undertake the role of the approved clinician temporarily without requiring the formal evidence of competency or the completion of the course for the initial training of approved clinicians set out in the Mental Health Act 1983 Approved Clinician (General) Directions 2008.

Consultation Question 12: Do you agree that strategic health authorities should be allowed the flexibility to approve current section 12 doctors who have not previously acted as RMOs to be approved clinicians as part of the contingency measures?

5.6.5 The changes made by the Mental Health Act 2007 also introduced AMHPs to broaden the range of professions from whose ranks people could be drawn to undertake the tasks under the Act previously performed by approved social workers (ASWs). The rules governing the appointment of AMHPs are set out in the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008. Schedule 1 consists of a list of the professions from which AMHPs may be drawn. Schedule 2 lists the competencies which a member of a profession listed in Schedule 1 has to satisfy before being approved as an AMHP.

5.6.6 To make up the shortfall during a period of severe staff shortage, we propose that local authorities should be able to approve some former ASWs and AMHPs to act as temporary AMHPs. We propose that the people in question should either be practising members or previously practising members of a profession listed in Schedule 1 who have maintained their registration with their appropriate professional body; and have undertaken the role of the ASW and/or AMHP in the past three years.

5.6.7 We propose that for the duration of the severe staff shortage local authorities should be able to approve these people temporarily to undertake the role of the AMHP without requiring the formal evidence of competency or completion of the training requirements for AMHPs set out in the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008.

Consultation Question 13: Do you agree that local authorities should be allowed the flexibility to approve the former ASWs and AMHPs identified in paragraph 5.5.6 to be AMHPs as part of the contingency measures?

5.6.8 We propose that it will not be possible for anyone temporarily approved as either an approved clinician or AMHP under paragraphs 5.6.2 or 5.6.6 above to become automatically permanently approved as such once the severe staff shortage is over under the arrangements in the relevant directions or regulations as appropriate. In common with anyone coming fresh to either role they will be required to undergo the specified training and demonstrate that they satisfy the required competencies if they wish to continue in the role.

Consultation Question 14: Do you agree that the additional people temporarily approved to be approved clinicians or AMHPs as part of the contingency measures should not automatically continue in the role unless they satisfy the normal requirements once staff absence has reduced to a level which is closer to normal?

5.7 Reducing the Demands on Approved Mental Health Professionals

5.7.1 We have not felt able to recommend relieving AMHPs of any of their duties under the 1983 Act. We think it is important that they should continue to be available to consider whether applications for detention should be made. We would nevertheless welcome views on how helpful it would be to make temporary changes to other aspects of AMHPs' duties under the 1983 Act (for example their role in agreeing the extension of community treatment orders) that would free up their time and what such changes might be.

Consultation Question 15: Do you think that we should make changes to AMHPs' duties under the 1983 Act? If so, please suggest what these changes should be.

5.8 Transitional Arrangements

5.8.1 We propose to put transitional arrangements in place to facilitate a smooth return to operating under the normal provisions of the 1983 Act for SOAD second opinions. These will take effect once the level of staff absence has reduced to a level at which a gradual return to normality will be possible.

5.8.2 We need to allow a suitable period of time to clear any backlog of requests for SOAD second opinions which the proposal at item 5.5.1 can be expected to generate. We propose that this should be up to a three month transitional period.

Consultation Question 16: Do you agree that the proposed transitional arrangements for SOAD second opinions are reasonable?

5.8.3 We do not expect the pandemic to cause a large number of deaths amongst mental health professionals. But if that were to happen it could be necessary to allow temporarily approved AMHPs and approved clinicians to continue to fulfil these functions until a sufficient number of permanent replacements could be trained and approved in accordance with the normal rules.

Consultation Question 17: If there should be a large number of deaths, do you agree that the contingency measures for temporarily approved AMHPs and approved clinicians should remain in place until fully trained replacements can be approved?

6. Measures Considered but not Proposed

6.1 We considered but rejected the following options:

6.1.1 Extending the periods that people could be detained under section 4 (emergency detention in hospital for up to 72 hours on the basis of just one recommendation by a registered medical practitioner) of the 1983 Act or under sections 135 or 136 (removal to a place of safety for up to 72 hours). The easements in the number of medical recommendations required for detention under sections 2 and 3 should render time extensions here unnecessary.

6.1.2 Extending the periods that people could be detained under sections 2 or 3. These ideas were rejected on the grounds that the easements in the number of medical recommendations required for detention under sections 2 and 3 should render any time extensions here unnecessary.

6.1.3 Amending sections 5(2) (emergency detention of a hospital in-patient by a doctor or approved clinician for up to 72 hours) and/or 5(4) (emergency detention of a hospital in-patient by a nurse with special expertise in mental health or learning disability for up to 6 hours) to extend the periods of emergency detention they permit or the range of professionals who could make decisions under either provision. These ideas were also rejected on the grounds that the easements in the number of medical recommendations required for detention under sections 2 and 3 should render time extensions here unnecessary.

Consultation Question 18: Do you agree that the proposals set out in section 6 should not form part of the contingency measures? Or do you think some of them should be included?

7. The Consultation Process and How to Comment

How to Comment

7.1 We would be particularly grateful for your responses to our specific consultation questions but please feel free to offer any other comments you may wish to make.

7.2 Please send comments on the content of the consultation documents to:

pandemicandmentalhealth@dh.gsi.gov.uk or:

Mental Health Legislation Team
Department of Health
Wellington House
133-155 Waterloo Road
London SE1 8UG

Consultation Period

7.3 The consultation period closes on **Wednesday 7 October 2009.**

After the Consultation

7.4 We will evaluate the responses to the consultation exercise, revise the proposals wherever appropriate in the light of the comments and suggestions received and prepare contingency legislation for introduction if necessary.

Criteria for consultation

7.5 This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible; **
- be clear bout the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

** We are sorry that the speed required if we are to be ready to cope with a worsening of the influenza pandemic in the autumn means we are not able to adhere to the stipulation of a minimum of 12 weeks for this consultation.

7.6 The full text of the code of practice is on the Better Regulation website at:

Link to consultation Code of Practice

Comments on the consultation process itself

7.7 If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of Information

7.8 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

7.9 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

7.10 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

7.11 The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

7.12 The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

7.13 A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Department of Health
10 September 2009

ANNEX A

PANDEMIC INFLUENZA AND THE MENTAL HEALTH ACT 1983
CONSULTATION QUESTIONS

Consultation Question 1:
These contingency measures are intended to enable the 1983 Act to continue to operate effectively during a period of severe staff shortage. In what circumstances do you feel it would be appropriate for the Secretary of State to bring them into force?

Comments:

Consultation Question 2:
Who should collect what information about the contingency measures? What arrangements should be made for this information to be passed on to (a) services locally, (b) the oversight group and (c) the Department of Health?

Comments:

Consultation Question 3:
Do you agree that these contingency measures should be permissive rather than obligatory - allowing practitioners to use them where circumstances make it necessary but allowing normal safeguards to continue to be adhered to whenever possible?

Comments:

Consultation Question 4:
Do you agree that allowing just one medical recommendation on an application by an AMHP for someone to be detained under section 2 or 3 of the 1983 Act should be one of the contingency measures?

Comments:

Consultation Question 5:
Would you prefer specially prepared forms A2A and A6A or would you rather adapt the current forms A2 and A6?

Comments:

Consultation Question 6:
Do you agree that the proposed changes to the number of doctors involved in decisions to transfer people from prison to hospital under Part 3 of the 1983 Act should be part of the contingency measures?

Comments:

Consultation Question 7:
Do you agree that the suspension of the obligation to obtain SOAD opinions on medication should be part of the contingency measures?

Comments:

Consultation Question 8:
Do you agree that time limits on conveying people and admitting them to hospital under Part 3 should be suspended as part of the contingency measures?

Comments:

Consultation Question 9:
Do you agree that time limits on warrants for transferring people from prison to hospital should also be suspended as part of the contingency measures?

Comments:

Consultation Question 10:
Do you agree that giving courts discretion to renew remands under the 1983 Act beyond the normal 12 week maximum should be part of the contingency measures?

Comments:

Consultation Question 11:
Do you agree that strategic health authorities should be allowed the flexibility to approve former RMOs and former approved clinicians to be approved clinicians as part of the contingency measures?

Comments:

Consultation Question 12:
Do you agree that strategic health authorities should be allowed the flexibility to approve current section 12 doctors who have not previously acted as RMOs to be approved clinicians as part of the contingency measures?

Comments:

Consultation Question 13:
Do you agree that local authorities should be allowed the flexibility to approve the former ASWs and AMHPs identified in paragraph 5.5.6 to be AMHPs as part of the contingency measures?

Comments:

Consultation Question 14:
Do you agree that the additional people temporarily approved to be approved clinicians or AMHPs as part of the contingency measures should not automatically continue in the role unless they satisfy the normal requirements once staff absence has reduced to a level which is closer to normal?

Comments:

Consultation Question 15:
Do you think that we should make changes to AMHPs' duties under the 1983 Act? If so, please suggest what these changes should be.

Comments:

Consultation Question 16:
Do you agree that the proposed transitional arrangements for SOAD second opinions are reasonable?

Comments:

Consultation Question 17:
If there should be a large number of deaths, do you agree that the contingency measures for temporarily approved AMHPs and approved clinicians should remain in place until fully trained replacements can be approved?

Comments:

Consultation Question 18:
Do you agree that the proposals set out in section 6 should not form part of the contingency measures? Or do you think some of them should be included?

Comments:

ANNEX B

PANDEMIC INFLUENZA AND THE MENTAL HEALTH ACT 1983
PARTIAL IMPACT ASSESSMENT

B1. Because the proposals in this consultation document are intended to be brought in only in the event of, and for the duration of, a severe staff shortage during an influenza pandemic they will have little, if any, long-term impact of any kind.

B2. The contingency provisions proposed are designed to ensure that it will still be possible to for people who need to be detained under Mental Health Act 1983 (the 1983 Act) to receive the care and treatment they require in the event of a severe staff shortage. By reducing the number of mental health staff required to take specified decisions under the 1983 Act and enabling local authorities and strategic health authorities to approve additional staff to undertake certain defined roles, these contingency measures will largely preserve the effect of the 1983 Act in circumstances in which its operation could otherwise break down.

B3. Where provisions are suspended during the height of the influenza pandemic, for example those relating to second opinion appointed doctors, transitional arrangements when that period ends will ensure that any short-term impact on patients who were subject to the 1983 Act then will be redressed in an orderly way as quickly as possible. Any impact while the contingency measures are in force will be counterbalanced by the release of the staff resource to undertake other functions.

B4. The risk of failing to take contingency measures in these exceptional circumstances is that the operation of the 1983 Act may break down. This would mean that people would not be detained when they should be for the benefit of their own health and safety or for the protection of others. For people who have come into contact with the criminal justice system, failure to take these measures could result in people being kept in prison rather than being cared for or treated in a hospital environment. This adverse impact would affect both patients and the wider public.

B5. A few additional staff costs may be incurred where people are brought back into organisations, but not where current employees merely revert to a former role - probably only for a very short period when a high proportion of staff are off sick or caring for sick relatives. These costs should be small and the need to incur them will probably be unavoidable in the circumstances. If a significant number of mental health staff die in the pandemic there will be greater costs associated with keeping some of the temporarily approved AMHPs and approved clinicians in post for longer and there would be the extra costs of training a larger number of permanent replacements than would be needed in normal circumstances. Those costs would be caused by the pandemic, not by these proposals.

B6. Other potential financial implications will depend on which of the contingency provisions are used in practice and how often. These implications are expected to be small. In all cases where the number of medical opinions required is reduced from two to one there might be a small saving in locum costs which might otherwise have to be incurred. The cost to the Care Quality Commission of running the oversight group is likely to be small. There may also be a negligible cost of printing a few temporary forms.

B7. In addition to the human costs identified at paragraph B4 above, there may also be financial costs if we fail to adopt the contingency measures. Failures to detain people for their own health or safety could increase the costs of care and treatment where their conditions subsequently deteriorate further. Costs of these kinds may similarly be incurred where people who are in contact with the criminal justice system are detained in inappropriate settings. Accommodating people in prisons who should be held in a more clinically appropriate hospital setting would also place an additional financial cost on the prison service.

Equality Impact Assessment

B8. None of the contingency measures proposed affects the criteria to be satisfied before a person can be made subject to any of the provisions in the 1983 Act.

B9. There continues to be some concern that members of some groups, in particular if they come from minority ethnic backgrounds, are more likely to find themselves subject to compulsory measures under the Act than the population as a whole. We are not aware of any empirical evidence that they are more likely to be detained inappropriately. The underlying reasons for this are complex and these contingency measures do not seek to address them. But equally, these contingency measures are not expected to affect the proportions of people from different sections of the community who come under any of the 1983 Act's provisions.

B10. The consultation on the changes to the 1983 Act includes a proposal to ask the Care Quality Commission to convene an oversight group with representation from national mental health service user and professional bodies. This will advise on progress and the need for ongoing contingency measures. It will provide a forum for any concerns that stakeholder groups may have over the implementation of the temporary changes to the 1983 Act. How this group will work and details of its membership will be finalised in the light of any consultation comments about the role that this group should play.

Next Steps

B11. We will produce a final impact assessment when proposals are finalised in the light of comments received from this consultation exercise.

ANNEX C

PANDEMIC INFLUENZA AND THE MENTAL HEALTH ACT 1983 GLOSSARY

Application for admission to hospital

An application to the managers of a hospital for a patient to be detained there under Part 2 of the 1983 Act. As well as being the means of requesting a patient's detention, the application itself (when properly completed and submitted) becomes the legal authority on the basis of which the patient is detained.

An application may be made for admission under section 2 of the 1983 Act for the patient to be detained in hospital for up to 28 days to be assessed (or assessed and treated). An emergency application under section 4 is also a form of application for admission for assessment. An application may also be made for admission under section 3 of the 1983 Act for a patient to be detained in hospital for medical treatment.

Approved clinician

A mental health practitioner approved for the purposes of the 1983 Act by, or on behalf of, the Secretary of State in England. Certain decisions under the Act can be made only by approved clinicians. In particular, medical treatment cannot (in general) be given without a patient's consent unless an approved clinician is in charge of it.

Approved mental health professional (AMHP)

An AMHP is a social worker or other professional approved by a local social services authority (LSSA) to perform a variety of functions under the 1983 Act. Those functions include making applications for admission to hospital and agreeing that patients should become SCT patients.

Approved social worker (ASW)

Prior to 3 November 2008, most of the functions now carried out by an AMHP were carried out by an ASW. ASWs were approved by the LSSA as having appropriate competence in dealing with persons who are suffering from mental disorder.

Care Quality Commission (CQC)

The Care Quality Commission is the independent regulator for health and social services in England. It is charged (among other things) with keeping under review the operation of the 1983 Act in relation to detention and SCT. It is also responsible for appointing second opinion appointed doctors.

Community treatment order (CTO)

A CTO is an order made by a patient's responsible clinician under section 17A of the 1983 Act discharging a patient from detention in hospital, subject to the possibility of recall to hospital. A CTO is the means by which a patient becomes an SCT patient, and is the legal authority for the patient to be subject to SCT.

Local social services authority (LSSA)

A local authority which has responsibility for adult social services.

Responsible medical officer (RMO)

Prior to 3 November 2008, most of the functions now carried out by an approved clinician were carried out by a Responsible Medical Officer. This was the doctor who was in charge of the treatment for the patient. Normally the RMO would have been a consultant psychiatrist but other doctors could have undertaken the role.

Second opinion appointed doctor (SOAD)

A doctor appointed by the Care Quality Commission to provide an independent second medical opinion on whether it is appropriate for certain types of medical treatment for mental disorder to be given to patients under Part 4 and Part 4A of the 1983 Act. In normal circumstances certain treatments cannot be given unless the SOAD has issued a SOAD certificate approving their administration.

Section 12 approved doctor

A doctor approved by a strategic health authority on behalf of the Secretary of State for Health to carry out certain functions under the 1983 Act. At least one of the medical recommendations required to support an application for admission to hospital under Part 2 must be made by a section 12 approved doctor. Similarly, medical evidence required by courts or the Secretary of State under Part 3 must often come, at least in part, from a section 12 approved doctor.

All approved clinicians who are doctors are also treated as approved under section 12.

Strategic health authority (SHA)

The NHS body responsible for the strategic management of NHS services in a particular region of England. SHAs have certain functions under the 1983 Act, including the approval of section 12 approved doctors and approved clinicians on behalf of the Secretary of State for Health.

Supervised community treatment (SCT)

The scheme in the 1983 Act by which certain patients may be discharged from detention in hospital by their responsible clinician, subject to the possibility of recall to hospital for further medical treatment if necessary. SCT is put into effect by the making of a community treatment order (CTO). The CTO is the legal instrument, while SCT is the scheme in general.