Pandemic Influenza and the Mental Health Act 1983

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

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Pandemic Influenza and the Mental Health Act 1983

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

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Executive summary

This document sets out the Government's response to the consultation 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, for example, an influenza pandemic which has a severe and prolonged impact on services. They would be introduced 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 commentators were invited to say whether they agreed that the overall package of proposed amendments to the 1983 Act was fair and reasonable and whether it would be effective and helpful in such extreme circumstances. They were also invited to say in what circumstances they felt it would be appropriate for the Secretary of State to bring them into force.

In the light of consultation comments we have concluded that all of the temporary amendments to the 1983 Act that were proposed in the consultation would be an appropriate part of a package of contingency measures, if needed. We have also included some further amendments to section 5 of the 1983 Act in response to consultation comments. The full list of potential temporary amendments which would require legislative changes is at Annex C.

These measures would only be brought into force in the event of, for example, a pandemic which has severe and prolonged impact on services. At that time a decision would be made as to whether all or only some of these measures would be needed.

1. The consultation on pandemic influenza and the Mental Health Act 1983: a summary.

1.1 Between 10 September and 7 October 2009 the Department of Health consulted on "Pandemic Influenza and the Mental Health Act 1983"[1] on proposals for temporary changes to the Mental Health Act 1983 (the 1983 Act) in the event of an influenza pandemic which had a severe impact on health and social care services. It received 120 sets of comments. This document sets out the Government's formal response to the consultation.

1.2 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 made subject to guardianship or discharged from detention onto supervised community treatment.

1.3 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 a right to apply to the First-tier Tribunal for their discharge from detention, guardianship 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.

1.4 The consultation document invited comments on possible temporary changes to the 1983 Act and some of its associated secondary legislation

1 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103756.pdf

which could be brought into force in, for example, the face of staff shortages where a pandemic has a severe and prolonged impact on services. The changes 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.

1.5 The consultation also sought views about the circumstances in which it might be appropriate to implement some or all of these measures and the information required to establish that that point had been reached.

2. Consultation process

2.1 The consultation took place over a four-week period between 10 September and 7 October 2009. This was shorter than the Department would ideally have liked but it was felt important to get people's views in time to inform the possible need to implement temporary changes during the H1N1 2009 swine flu pandemic in autumn 2009. The consultation sought comments on a range of specific proposed temporary amendments to the 1983 Act and the circumstances in which it would be appropriate to implement them. It also asked for suggestions as to what information it would be reasonable to collect to inform decisions to implement and withdraw the temporary changes and how that information should be communicated to local and national decision-makers.

2.2 The consultation was aimed at anyone with an interest in the suggested changes to the 1983 Act. The Department used standard communications channels to alert all the relevant NHS bodies and social services authorities. E-mails were sent to a wide range of voluntary sector and academic bodies who had previously been invited to comment on the draft Code or Practice and draft secondary legislation produced in the light of the Mental Health Act 2007.

3. Who commented?

3.1 The Department received 120 sets of comments. Where the information about the commentator was given (98 responses), the greatest number came from NHS bodies (about 60 per cent) and local authorities (over 10 per cent). Other comments came from professional bodies, voluntary sector bodies, and approved mental health professionals (AMHPs) and NHS professionals (some individuals and some groups). There were also comments from individuals or bodies who described their perspective as service user, carer, legal, independent provider, criminal justice or secure service. A list of commentators is at Annex A.

Table 1: Details of commentators

Category of commentator	% of respondents
NHS body	51
Local authority	14
Professional body	9
Voluntary sector body	7
Service user small group/individual	4
Legal body or individual lawyer	4
NHS professional small group or individual	4
Approved mental health professional (AMHP) – small group or individual	3
Independent Provider	2
Criminal justice or secure service	1
Carer – small group or individual	1

4. What they said

4.1 Some people commented on all 18 of the consultation questions. Others only commented on those points in which they had particular interest or where they had specialist expertise or personal experience. Some raised issues or made comments that were not directly related to the consultation questions, in particular in relation to the First-tier Tribunal. We have not been able to address every comment in this document but we have carefully considered all points made.

4.2 The replies revealed widespread acknowledgement that it is sensible to prepare temporary changes to the 1983 Act which could be brought into effect in the event of a pandemic which had a severe impact on health and social care services. They emphasised that the conditions in which the introduction of these measures would appropriate would have to be exceptionally bad – in particular that local services should take all the business continuity and management action that could be taken within the current legislative framework first. Only then should a decision be made to bring changes to the 1983 Act into effect. There was also general agreement that if any changes were to be made they should not be kept in place for longer than necessary.

4.3 The consultation comments have provided valuable insights into how a range of people think it would be appropriate to amend the 1983 Act in the event of a severe and prolonged pandemic. The Government is very grateful for the range of ideas suggested, the thoughtfulness of comments (both for and against some of the proposals) and the caring and the conscientious attitudes that were revealed where respondents gave reasons for some of their reservations, caveats or disagreements.

5. Next steps

5.1 It did not prove necessary to introduce any changes in 2009/10 to enable services to cope with the H1N1 2009 swine flu pandemic as its impact was not as severe as originally feared. Therefore the consultation comments have enabled us to finalise the range of measures that might be needed in the event of any future pandemic. These include a few additional temporary amendments to the 1983 Act which we were persuaded could also be of value in allowing its effective continued operation. The changes would only be introduced if it became absolutely necessary. At that time a decision would be made as to whether all or only some of these measures would be needed.

6. Comments and Government responses on the individual consultation questions

6.1 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?

6.1.1 78 per cent of commentators addressed this issue.

6.1.2 There was widespread acknowledgement that in extreme circumstances contingency measures could well be appropriate. Many commentators, including the Mental Health Foundation, placed their supportive comments on later questions in the context of an expectation that these measures would only be introduced as a last resort. This reflected a view held strongly by a high proportion of commentators that the procedures and safeguards in the Act exist for good reasons and should only be changed, even temporarily, in the most difficult of circumstances.

6.1.3 A few commentators were opposed to introducing virtually all of the suggested amendments to the 1983 Act. This view was most strongly articulated by the Hertfordshire Joint Commissioning Team who felt that "…at present all operational organisations within Hertfordshire have enough resource and appropriate policy safeguards to allow us to meet the requirements of the [1983 Act] without the need to use some of the contingencies detailed…"

6.1.4 Some commentators wanted a fixed percentage staff absence figure to be stipulated and expressed firm opinions about what percentage constituted a last resort. However, their suggested percentages varied. Some commentators suggested a level of ten or twelve per cent as a reasonable starting point, a few suggested more and only one less. Some

suggested the subtly different idea that there should be fixed criteria, which does not necessarily mean a set percentage of staff absence.

6.1.5 About 20 per cent of those who commented specifically said that the need for contingency measures should be dependent on local circumstances, recognising some places could reach breaking point before any fixed trigger figure was reached. Bradford Metropolitan District Council commented, “sickness absence percentages are not necessarily comparable from one area to another. For example, a relatively modest sickness absence figure can be more critical in one area where the underlying numbers of staff in post are low due to staff vacancies etc.”

6.1.6 Approximately 10 per cent of those who commented made the point that the number of staff away was less important than whether key people were affected – especially in smaller authorities. The Isle of Wight NHS Primary Care Trust said that in smaller units “the absence of a few key staff members could cause problems in operating the Mental Health Act”.

6.1.7 One commentator made the point that there have been staff absence crises in the past without any need to amend the 1983 Act and that any level at which some or all of these contingency measures were introduced would have to be greater than that which the service had previously coped.

6.1.8 A few commentators said that the contingency changes should be time limited and kept under regular review. A couple specifically said that Strategic Health Authority (SHA) agreement should be required before any local body could institute the contingency changes.

6.1.9 Only one commentator felt that the contingency measures should only be triggered when sufficiently bad conditions had been reached in all parts of the country. Considerably more (26 per cent) related an acceptable trigger to conditions in a particular locality. A couple specifically said that authority to use the contingency measures should be introduced nationally but decisions on actually activating them should be made locally.

The Royal College of Psychiatrists' introduction to their comments on individual consultation questions included a position statement that the changes "…should be the minimum reduction for the briefest time, consistent with maintaining the service". They went on to respond to this question saying, "the College agrees that any change should depend on local circumstances and that it is not possible to give a precise figure as to the level of absence or non-availability of staff that should trigger enaction of the emergency powers."

Government Response

6.1.10 Although individual views varied considerably, the overall tenor of the responses has given us a good idea about the circumstances in which it would have been reasonable to introduce temporary changes to the 1983 Act, had they been necessary, during the 2009/10 swine flu pandemic.

6.1.11 Several consultation comments sought a precise steer on when the emergency measures might be brought into force but views on what a reasonable level of staff absence would be varied between seven per cent and 50 per cent. Several commentators made the sensible point that the same level of staff absence would have different effects in different places.

6.1.12 Overall, these responses indicate that it is unlikely to be helpful, or indeed practical, to specify a particular level of staff absence as the trigger point for introducing some or all of the emergency changes to the 1983 Act. Clearly staff absences would have to be so severe that services are no longer able to function without the proposed temporary changes before we would countenance asking Parliament to agree to bring them into force.

6.1.13 During any pandemic we would expect local services to take all the business continuity and management action that could be taken within the current legislative framework as per the "Swine Flu H1N1 Updated Guidance

for Mental Health Services in England", Department of Health, November 2009)[2].

6.1.14 We also agree with the view that temporary changes to the 1983 Act would need to be brought into force in response to local circumstances as soon as the first services can show that they need to have them in place. To delay once those circumstances have been reached is to risk failing to bring the temporary legislation into force until the service had broken down in too many places or, worse, after the need for it had passed. Ultimately the Secretary of State will have to make a judgement about when (or if) to introduce the changes.

6.1.15 We agree again with those commentators who thought that the contingency changes, if ever introduced, should be kept under regular review. The consultation document included a proposal to ask the Care Quality Commission (CQC) "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." That remains a sensible approach.

6.2 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?

6.2.1 68 per cent of commentators addressed this issue.

6.2.2 Because of the broad range of arrangements for information gathering in different places there was a range of suggestions offered in reply to this question.

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2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109172

6.2.3 Many of the commentators felt that their local Mental Health Act Administrators would be best placed to collate information about the use made of the contingency measures. There was a general desire to avoid requiring more data to be gathered than absolutely necessary and amongst those who commented on the reporting channels there was a preference for the using (as far as possible) the same ones as for other pandemic-related information, in particular in relation to reporting of staff absences. It was acknowledged that a different route would be required to get information to the CQC oversight group.

Government Response

6.2.4 Information would be required centrally to answer three questions – whether the severity of staff absences is so great that emergency measures should be introduced or (if introduced already) should remain in force; how much use has been made of each of the emergency measures; and where. In particular, Ministers would need to be able to provide sufficient detail to Parliament to inform its legislative decisions.

6.2.5 The need for information on pressures and resilience in all NHS services during an emergency will also take into account the principle of minimising the data reporting burden (where possible) and using existing systems where appropriate.

6.2.6 In addition to the general data giving an indication of the degree of strain on service provision, bringing emergency changes to primary legislation into force will also generate a need for information on the use made of the various easements. During an emergency it might not be easy to get accurate information quickly on the uses made of the contingency measures but we need to put a system in place to pass as much information as possible to the proposed CQC oversight group and to the Department. This would require Mental Health Act Administrators locally to collect and collate the information required and pass it up through agreed channels.

6.2.7 The Ministry of Justice would respond to any requests for information on actions taken under temporary amendments to Part 3 of the 1983 Act made by the proposed CQC oversight group.

6.3 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?

6.3.1 77 per cent of commentators addressed this issue. Of these 87 per cent were in favour and 6 per cent against. The remaining respondents were either unsure or could see cons as well as pros.

6.3.2 The principal drawback expressed by those who were not in favour was that they felt it would give individual practitioners too much discretion. A couple of commentators felt that a permissive approach would cause confusion.

6.3.3 A far larger number took the view that a permissive approach would enable the flexibilities to be used where necessary whilst giving scope for the usual practice to continue to be followed wherever possible.

Government Response

6.3.4 We agree with the great majority of commentators who said that any temporary changes should be permissive.

6.4 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?

6.4.1 91 per cent of commentators addressed this issue. This demonstrates a very high level of interest in this consultation proposal. The responses were nearly two to one in favour of the proposal. This reflects strong support from NHS bodies from whom the majority of the consultation comments originated and who would have a major role in managing mental health services in the event of a future pandemic.

6.4.2 13 per cent of commentators expressed reservations about the single recommendation in the case of detentions under section 3. This idea was particularly unpopular amongst AMHPs and local authorities some of whom put an argument that AMHPs value having a second medical opinion. It was suggested that a single recommendation and the suspension of the SOAD requirement taken together would constitute too great an erosion of patient safeguards.

6.4.3 The main point made against a single medical recommendation for section 3 is that it affects a patient for a far longer period than section 2 does. Some commentators said that the initial point of detention for as long as six months (and with subsequent renewals, ultimately, in many cases for far longer) was such a significant step that the second opinion should still be required. Manchester Mental Health and Social Care Trust commented, “Given that section 3 provides authority for treatment of up to six months and for renewal periods of up to twelve months, it is felt that the proposal to involve only one doctor, with no requirement for previous acquaintance, would be a disproportionate measure.”

6.4.4 Some commentators who recognised that a single medical recommendation might be necessary for section 3 suggested that the second recommendation should be sought as soon as possible after the height of the pandemic had passed. Manchester Mental Health and Social Care Trust also suggested, “Given the consideration of least restriction in any use of the Mental Health Act, perhaps a temporary limit should be placed on section 3 so that the basis of detention for treatment is for a shorter period e.g. 3 months

rather than 6 months, so that the patient has the added safeguard of a second medical examination at the earliest possible opportunity."

6.4.5 10 per cent of comments on this question were in favour of extending the period during which people could be held under section 4 (doctor's emergency power of admission for assessment) rather than reduce the number of medical recommendations for sections 2 or 3. Camden and Islington NHS Foundation Trust, for example, said, "In our view it would be more appropriate to encourage the use of section 4, if necessary extending the time limit from 72 hours (3 days) to 5 days…..In practice, even if only one doctor could attend an assessment in the community, the likelihood of another doctor not being available once the patient was admitted is limited."

Government Response

6.4.6 We recognise that there were some strong arguments against the single medical recommendation, especially in relation to detention under section 3. We accept that this is a major step which many people find uncomfortable. We would not implement it lightly. It is important to ensure, however, that in times of a severe impact on health and social care services, people should come under compulsion to receive care and treatment in the same way that they would have done in normal circumstances.

6.4.7 When (for example) many staff are absent the possibility that a second medical recommendation cannot be obtained cannot be ruled out. Removing this option, therefore, could easily lead to some people not being detained even though they should (and in normal circumstances would) have been - to the detriment of their health and safety and/or that of others.

6.4.8 We have considered carefully whether it would be sensible to require a second medical recommendation once the height of the pandemic had passed in cases where someone had been detained under section 3 on the strength of a single recommendation. However, some time would inevitably have passed between the two recommendations. The second

recommendation would either be given by the responsible clinician (who already has the responsibility to discharge anyone who no longer satisfies the criteria for detention) or else would be, in effect, a review of the responsible clinician's decision not to discharge. This would give a second recommendation an effect it would not normally have. There are also other safeguards which would remain in place, such as the rights to an independent mental health advocate, to request a hospital managers' hearing or to apply to a First-tier Tribunal.

6.4.9 The consultation document suggested (see paragraph 6.1.1) that easements in the number of medical recommendations required for admission under sections 2 and 3 should render a time extension for emergency admission under section 4 unnecessary. Whilst such an extension could be considered as an additional emergency measure, on balance we do not think it would be appropriate. The single medical recommendation would allow clinicians to treat patients without consent under section 2 or 3 in the same way as they would in normal circumstances. As it does not give clinicians authority to treat without consent, extending the period for which patients may be detained under section 4 would result in them being detained for longer without any possibility of receiving treatment.

6.4.10 We understood the sentiment behind the suggestion of restricting detention under section 3 to three months. By bringing forward the renewal date by three months this could, however, increase the burden on key staff at a time when services were still recovering from the height of the pandemic. It would also mean that the usual cycle of review and renewal of detention would be disrupted, which could cause later confusion. For these reasons we are not inclined to adopt this suggestion.

6.4.11 Our policy intention would be to maintain, as far as possible during a severe and prolonged pandemic, the effect that the 1983 Act would normally have had. In line with this we have concluded that we should retain the option of a single medical recommendation for both sections 2 and 3.

6.5 Consultation Question 5:

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

6.5.1 69 per cent of commentators addressed this issue. Forms A2 and A6 are used to record applications by an approved mental health professional for admission for assessment under section 2 or treatment under section 3 respectively. Forms A2A and A6A would be the same as their respective current forms, except that:

- References to two registered medical practitioners would be amended to read one medical practitioner;
- Subsequent paragraphs about previous acquaintance with the patient would be omitted; and
- An extra statement by the AMHP would be inserted to confirm that obtaining a second medical recommendation would have caused undesirable delay.

6.5.2 The alternative to producing them would be for AMHPs to adapt the current forms locally to record the relevant information.

6.5.3 The answers given in response to this question need to be seen in the context of the answers to question four. Some commentators expressed views either for or against having specially prepared forms A2A and A6A despite having expressed concerns about or opposition to the proposal for a single medical recommendation. In total 25 per cent said they would prefer to adapt the current forms but 66 per cent preferred specially prepared forms A2A and A6A. The remainder did not express a view.

6.5.4 The risk of causing confusion was cited in support of both using specially prepared forms A2A and A6A and amending the current ones. The other principal reason for preferring to adapt current forms was to avoid being unable to detain someone because of potential problems in distributing the

specially prepared forms. The view was also expressed that specially prepared forms would lead to a waste of paper.

Government Response

6.5.5 In view of the greater weight of support for specially prepared forms A2A and A6A, the Department will prepare these for use in the event of temporary changes to the 1983 being required. These new temporary forms would be made available, as necessary, on the Department of Health website.

6.6 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?

6.6.1 67 per cent of commentators addressed this question. Of these, 66 per cent were in favour and 22 per cent against. The remaining 12 per cent did not express a clear preference. A few specific suggestions were nevertheless proffered by some commentators.

6.6.2 For example, one nurse suggested that the second recommendation could come from a member of another mental health profession.

6.6.3 Another person expressed the view that any proposed transfer authorised on the strength of just one registered medical practitioner's report should be reviewed if the transfer had not happened by the time the emergency powers ended.

6.6.4 Another commentator was concerned that change should not affect this user group disproportionately. Two commentators suggested that there should be a review involving a second doctor after a set period.

Government Response

6.6.5 Given the weight of support for the proposal to reduce temporarily 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, we have concluded that this proposal should form part of the package of potential temporary changes to the 1983 Act. 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 in prison can be detained in hospital instead where their needs require it.

6.6.6 A transfer warrant issued on the strength of one medical report would lapse if it had not been acted upon by the time the emergency powers ended.

6.6.7 We do not share the anxiety that this change might affect this user group disproportionately. In particular, it is consistent with other proposed temporary amendments to the number of medical recommendations required for detention in hospital under sections 2 and 3. As all these proposals would be permissive the Ministry of Justice would continue to expect two recommendations wherever that would be feasible without endangering the health of the prisoner to be transferred.

6.6.8 The suggestion that there should be a review involving a second doctor after a set period raises similar issues to the proposal for a later second medical recommendation for admission under section 3. We note that people who are subject to transfer directions have an immediate right to apply to the First-tier Tribunal. We also feel that any disagreement on the second doctor's part could result in the patient being returned to prison - which would be bound to be unsettling for someone about whose mental health there would at the very least be some doubt.

6.6.9 We agree with two commentators who said that if there were to be only one medical recommendation, it should come from a doctor who works at the receiving hospital.

6.6.10 We also agree with the commentator who said that there should be a record of all transfers under sections 47 and 48 directed on a single medical opinion. This person thought that the record of using the contingency power should be available for audit. The Mental Health Act Administrator at the receiving hospital could collect, collate and pass on details of the number of people transferred, in the same way as with any other record of the use of the temporary changes. The Ministry of Justice would also keep a record of every single opinion transfer authorised and would respond to requests for information from CQC's oversight group. This would give an indication of the difference between the number of transfers authorised the number that actually took place.

6.6.11 We agree with one commentator who argued that if a transfer would happen at end of sentence, two opinions should be required. In the light of the outcome of the TF case (*R (oao TF) v Secretary of State for Justice 2008 EWCA Civ 1457*) the Ministry of Justice rarely transfer anyone towards the end of their prison sentence and would adopt an administrative safeguard of not doing so on the basis of a single medical recommendation in such cases during the height of an pandemic.

6.7 Consultation Question 7:

Do you agree that the suspension of the obligation to obtain second opinion appointed doctor (SOAD) opinions on medication should be part of the contingency measures?

6.7.1 71 per cent of commentators addressed this issue.

6.7.2 The tenor of the responses to this consultation question was a recognition that something would need to be done to reduce the obligation to obtain SOAD opinions but views about quite what were mixed. The largest single group of commentators (35 per cent) agreed that we were correct to

include them in the contingency proposals. One of these was CQC, which is responsible for the SOAD service. A further eight per cent were far less enthusiastic but nevertheless supportive. Some 13 per cent made neutral responses and another 13 per cent flatly disagreed.

6.7.3 Nearly 40 per cent of those who commented, however, offered specific suggestions which fell into one of three categories:

6.7.3.1 Extending the time limit for SOAD opinions rather than suspending the requirement (16 per cent);

6.7.3.2 Suspending the SOAD requirement for supervised community treatment (SCT) patients only; and

6.7.3.3 Allowing other mental health professionals (either senior staff from other professions or doctors from other internal teams) to give second opinions (18 per cent).

Government Response

6.7.4 After careful consideration we have concluded that the contingency package should include the measure on SOADs set out in the consultation.

6.7.5 We acknowledge that suspension of the obligation to obtain SOAD opinions has further-reaching implications than extending the time limit for obtaining them. In particular it would lift the SOAD requirement for those patients who had already passed the (extended) time limit as well as those who have yet to reach it. Simply extending it would mean that people who had already been detained for longer than the extended limit would continue to require SOAD certificates every time their medication was changed whilst those detained for between three months and the new extended limit would not. Whilst this would retain a safeguard for the longer-term patients, at a

time when SOADs could be in such short supply that they could not meet even this more limited demand, it could result in a legal barrier preventing patients from receiving potentially beneficial alternative treatments (or making them continue with inappropriate ones). Suspension of the obligation, on the other hand, has the advantage of ensuring that the same, easily understood conditions apply to all.

6.7.6 We agree, of course, that the SOAD function is important. But we note that a key reason for the proposal to suspend it would be to free up scarce medical time for even higher priority work. The more scope we include to reduce the obligation to undertake SOAD activity, the more we hope to be able to limit the need to make use of some of the other temporary changes (including, of course, recourse to use of the single medical recommendation).

6.7.7 Because the change would be permissive, CQC would still be able to send SOADs out to give second opinions wherever possible. It will be in their interests to do so as, even allowing for a period of transition back to normal, the smaller the backlog of SOAD visits the easier it will be to clear it once the height of the pandemic has passed. Suspension of the obligation rather than extension of the period would also leave CQC free to decide the correct clinical priorities for deploying such SOAD resource as would still be available.

6.7.8 The problem with suspending the SOAD requirement only for SCT patients is practical. If the SOAD system is under strain under normal conditions, in the event of a severe staff shortage just suspending the SCT component of the function may not be sufficient, as there are far more visits to detained patients than to SCT patients.

6.7.9 Suggestions that people other than the SOADs already appointed by CQC should be permitted to undertake the SOAD role in an emergency were made by 18 per cent of those who commented on this question. A further 12 per cent supported the idea of allowing members of other mental health professions to act as temporary SOADs. These were

interesting ideas. In practice, however, we feel that it would be difficult to recruit temporary SOADs and provide them with the necessary training. It also seemed to us that in these extreme situations any suitable people are likely to be heavily burdened coping with their normal duties. On balance we feel it would be preferable not to make changes to the 1983 Act that would divert some of these staff from their more familiar duties into a role with which they would be unfamiliar.

6.8 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?

6.8.1 71 per cent of commentators addressed this issue. The replies to this question supported the proposal by about two to one. For eight commentators the main criticism was the proposal to suspend rather than extend the timescale.

Government Response

6.8.2 The emergency changes would only be in force for a finite period. Any unimplemented order would automatically lapse when the emergency provision ceased to have effect. Given we cannot know for sure how long any emergency would last, suspension, rather than a new time limit, will be more likely to avoid situations in which people have to be re-sentenced because a bed simply cannot be found in time.

6.8.3 We agree with three commentators who said there should be monitoring of delayed cases. We would expect the Mental Health Act Administrator at the receiving hospital to collect and collate this information in the same way as with any other record of the use of the temporary changes locally and pass it on through the channels outlined at paragraph 6.2.6.

6.9 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?

6.9.1 67 per cent of commentators addressed this issue. They supported the proposal by about two to one. For six commentators the main criticism was the proposal to suspend rather than extend the time limits.

6.9.2 Opinions varied on the amount of use that would be made of this easement – some, such as the Mental Health Act Development Lead at Northumberland, Tyne and Wear NHS Trust, were supportive in principle but not certain how much use would be made of it whilst others, such as NHS West Essex, felt sure that it would be save valuable time.

Government Response

6.9.3 In view of the large preponderance of support for this proposal it will be one of the measures we would consider implementing in the event of a future influenza pandemic.

6.9.4 Along with the other emergency changes, provision allowing prisoners to be transferred to hospital on the strength of a single medical report would only be in force for a finite period. A warrant for this purpose which had no time limit would automatically lapse when the emergency provision ceased to have effect. The Secretary of State would have to issue a fresh warrant before the transfer could go ahead.

6.9.5 We agree with the commentator who said that there should be a record of all transfer warrants issued without any time limits. The Ministry of Justice would in particular keep a record of all those transfers that are not effected within 14 days of the date of the warrant. The Ministry of Justice

would also respond to any requests for information from CQC's oversight group.

6.10 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?

6.10.1 67.5 per cent of commentators addressed this issue. Several commentators took a neutral stance but those who expressed a view supported the proposal by considerably more than two to one.

6.10.2 Opinions varied on the use that would be made of this easement. As with the proposal on suspending time limits on warrants for transferring people from prison to hospital, some were not certain that it would save a great deal of staff time.

6.10.3 Seven commentators felt that the proposal should stipulate a maximum period rather than giving the courts carte blanche to remand people for undefined longer periods.

6.10.4 One commentator made the point that any decision to remand someone to hospital should be contestable. Several people made the point that the use of this provision should be monitored.

6.10.5 The Tees, Esk and Wear Valleys NHS Foundation Trust said: "consideration should be given to allowing the courts to remand people for longer than 28 days at a time as well as for longer than 12 weeks in total. Assuming the courts will also be affected by staff shortages, the practicalities of having hearings every 28 days during an emergency situation may be unsustainable."

Government Response

6.10.6 In the light of responses, we have concluded that extending the twelve-week maximum should form part of the package of potential temporary changes to the 1983 Act.

6.10.7 We agree that the suggestion that we should temporarily extend the maximum length of each period of remand beyond 28 days could reduce pressures on the court but have concluded that as subsequent remands are usually dealt with in the absence of the defendant, the amount of time saved by this proposal would not justify a temporary amendment to the 1983 Act. The primary purpose of extending the cumulative period of remand would be to ensure that offenders who ought to be in hospital would not have to be moved to prison simply because a report on their mental condition could not be completed in time, or because the necessary arrangements could not be made for their future care before the end of the maximum period of remand.

6.10.8 Any decision to remand a person to hospital is contestable by the remanded patient under section 35(8) or 36(7) of the 1983 Act. Nothing in the consultation proposals will change that.

6.10.9 The Mental Health Act Administrator at the hospital to which the patient is remanded would be best-placed to collect and collate information on the use of this measure in the same way as with any other record of the use of the temporary changes locally and pass it on through the agreed channels outlined at paragraph 6.2.6.

6.11 Consultation Question 11:

Do you agree that strategic health authorities[3] should be allowed the flexibility to approve former RMOs and former approved clinicians to be approved clinicians as part of the contingency measures?

[3] Subject to the approval of Parliament, the Health and Social Care Bill 2011 will abolish strategic health authorities. Decisions have yet to be taken about which body will then become responsible for approving approved clinicians.

6.11.1 77 per cent of commentators addressed this issue.

6.11.2 The general tenor of the replies to this question was supportive although approximately half of those who commented believed that for the proposals to be effective most, if not all, of the professionals to be drafted in would require some background or refresher training. The numbers favouring this measure amounted to some 74 per cent of those commenting whilst a further 10 per cent took a more neutral stance.

6.11.3 Several specific suggestions were made:

- Do not let temporary approved clinicians make single recommendations for detention under sections 2 or 3;
- Promote specialist registrars;
- Ensure that any temporary approved clinicians receive adequate professional supervision; and
- Include people who had been responsible medical officers (RMOs) within the past five years rather than three.

Government Response

6.11.4 The Government agrees with the majority of those who commented in support of this measure. At a time of severe staff shortage it would make sense to authorise people who have recently done the same or a very similar job to do it again.

6.11.5 This change can be brought into force by making temporary amendments to the Mental Health Act 1983 Approved Clinician (General) Directions 2008. The power to make these directions already exists in the 1983 Act which would not need to be amended. Although no Parliamentary scrutiny would be required it would of course only be introduced as part of the

wider package of measures discussed in this document which would, of course, be subject to Parliamentary approval.

6.11.6 We take the point that the people appointed would need training on the issues which may have changed since they last performed the same or a similar role. Such training would have to be made available as part of local agencies' preparedness planning for dealing with future pandemics and/or any other widespread emergency.

6.11.7 We do not think it would be necessary to amend the 1983 Act to prevent temporarily approved clinicians making single recommendations for detention under sections 2 or 3 or for transfers from prison to hospital under sections 47 or 48. Under the contingency arrangements the only temporary approved clinicians who would be allowed to give single medical recommendations would be those who were members of the medical profession. On their appointment they would automatically become section 12 approved. Bodies responsible for approving them – currently SHAs - would have a responsibility to satisfy themselves that a doctor would be competent to make medical recommendations before they approved them to be a temporary approved clinician. There will be no question of temporary approved clinicians from any other profession making single recommendations for detention under sections 2 or 3 or for transfers from prison to hospital under sections 47 or 48.

6.11.8 Similarly, we do not think that changes to legislation would be necessary in respect of specialist registrars, because they can already be approved in the ordinary way. The current directions require evidence of competence and membership of a specified profession - one of which is the medical profession. They make no reference to grade.

6.11.9 Several commentators suggested that approving bodies should be permitted to approve people as temporary approved clinicians who had been RMOs within the past five years rather than three. One reason for specifying three years is that it would ensure that their qualifying experience

would not be too far out-of-date. It would also make it a shorter period into the future before the only people who could qualify would be former approved clinicians, which will make the preparatory training issue progressively easier to address. We have therefore concluded that we should not deviate from the consultation proposal in this way, at least for the time being. We will, however, keep this under review as, with the passage of time, people who could be approved would all be former approved clinicians. This might make a longer period since they last practiced more generally acceptable in future. We would make a final judgement on this point in the light of the circumstances when the time came.

6.11.10 We note that several commentators were concerned to ensure that any temporary approved clinicians receive adequate professional supervision. We acknowledge that this will be important. It will need to be addressed in local services' future pandemic preparedness planning.

6.12 Consultation Question 12:

Do you agree that strategic health authorities[4] 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?

6.12.1 68 per cent of commentators addressed this issue.

6.12.2 66 per cent of those who commented on this question (including the Royal College of Psychiatrists) were broadly supportive. Many expressed caveats, in particular that the people who might be appointed should receive some preparatory training and be appropriately professionally supervised. Some people expressed a view that people who had not previously had any experience of being an approved clinician should only be given temporary appointments if efforts to recruit former RMOs and approved clinicians had not identified sufficient people to cover the shortfall.

[4] Subject to the approval of Parliament, the Health and Social Care Bill 2011 will abolish strategic health authorities. Decisions have yet to be taken about which body will then become responsible for approving approved clinicians.

6.12.3 Some commentators suggested that this should be limited to section 12 approved doctors who specialise in psychiatry. The principal practical effect of this suggestion would be to exclude a number of section 12 approved general practitioners.

6.12.4 Another suggestion was that junior doctors who have only completed a basic section 12 course should not be appointed as temporary approved clinicians.

6.12.5 A third suggestion was that former section 12 approved doctors who have not been RMOs should be drafted in as well as ones currently practicing.

Government Response

6.12.6 We agree anyone appointed under this easement should be properly prepared and professionally supervised. Approving bodies should have confidence in the ability and suitability of any section 12 approved doctors they saw fit to approve temporarily as approved clinicians.

6.12.7 The suggestion that the only section 12 approved doctors who should be recruited as temporary approved clinicians should already be psychiatrists would reduce the number of additional people who might be called upon and would reduce the flexibility envisaged in the proposal. We would not want to prevent SHAs from approving any competent people to act as temporary approved clinicians if they feel that this would be helpful in their local circumstances.

6.12.8 The suggestion that junior doctors who have only completed a basic section 12 course should not be appointed as temporary approved clinicians would also reduce the number of people who could be asked to act as temporary approved clinicians. We feel that competence should be the main issue for approving bodies to consider here. The proposal would not

remove from approving bodies the responsibility to approve only those people whom they are satisfied would be competent to take on the role. Again we would not want to deprive them of a potentially helpful flexibility here.

6.12.9 We are grateful for the suggestion that former section 12 approved doctors who have not been RMOs should be recruited as well as ones currently practicing. We feel that this is very much in the spirit of the consultation proposals. We note that if we were to agree to this idea the doctors in question would need preparatory training. But on balance we feel that people who had neither been RMOs in the past nor were currently section 12 approved would probably be a step too far removed from the approved clinician role to be brought in safely.

6.13 Consultation Question 13:

Do you agree that local authorities should be allowed the flexibility to approve the former ASWs and AMHPs identified in paragraph 5.6.6 to be AMHPs as part of the contingency measures?

6.13.1 75 per cent of commentators addressed this issue.

6.13.2 There were very few objections in principle to the proposals for temporary AMHPs but a lot of commentators felt that former ASWs would need detailed training on the changes made by the 2007 Act.

6.13.3 Some commentators suggested that local authorities should take on people as temporary AMHPs who had been approved social workers (ASWs) within the past five years rather than three.

Government Response

6.13.4 We agree with the majority of commentators who supported the principle of approving some people to be temporary AMHPs. We have also noted the large number of comments about the need for appropriate training for former ASWs on the changes brought in by the 2007 Act. The questions

of identifying suitable people and providing them with appropriate refresher or update training will need to be an important feature of local authorities' work on preparedness for future pandemics. Nevertheless, at a time of severe staff shortage we believe that it makes sense to approve people who have recently done the same or a very similar job to do it again.

6.13.5 This change could be brought into force by making temporary amendments to the current regulations[5]. The power to make and amend these regulations already exists in the 1983 Act. Amended regulations would have to be laid before Parliament and would not become law if Parliament objected (a process called negative resolution). These amendments would be made in concert with other measures discussed in this document which could not be introduced without an affirmative vote in Parliament.

6.13.6 Some commentators suggested that local authorities should be permitted to approve people as temporary AMHPs who had been ASWs within the past five years rather than three. As with the similar suggestion with respect to former RMOs, we considered this carefully. One reason for specifying three years is that it would ensure that their qualifying experience would not be too far out-of-date. It would also make it a shorter period into the future before the only people who can qualify are former AMHPs rather than ASWs, which would make the preparatory training issue progressively easier to address. We have therefore concluded that we should not deviate from the consultation proposal in this way, at least for the time being. We will, however, keep this under review as, with the passage of time, people who could be approved will all be former AMHPs. This might make a longer period since they last practiced more generally acceptable in future. We would make a final judgement on this point in the light of the circumstances when the time came.

[5] The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008.

6.14 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?

6.14.1 74 per cent of commentators addressed this issue.

6.14.2 There was virtually unanimous support for this proposal.

Government Response

6.14.3 The Government agrees that this proposal should be part of the package of contingency measures.

6.15 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.

6.15.1 66 per cent of commentators addressed this issue.

6.15.2 The general tenor of these responses was that changes to the duties of AMHPs should not be made. Of those who said more than a straight "no" the majority expressed the view that local managerial changes should be made to non-statutory duties undertaken by AMHPs to free up sufficient time for statutory duties under the 1983 Act. A few also said that doing that together with the consultation proposal to recruit temporary AMHPs for the emergency period should render any adjustments to AMHP duties unnecessary. Several constructive suggestions were put forward, however, and these are discussed below.

Government Response

6.15.3 We are aware that a pandemic is likely to put extra stress on AMHPs. However, as the consultation document acknowledged, it is difficult to see where changes could be made to the role of AMHPs which would have a significant benefit but not depart unreasonably from the usual operation of the1983 Act or inappropriately weaken safeguards.

6.15.4 One suggestion was to allow the patient's care co-ordinator or another mental health professional with personal knowledge of the patient to agree to the renewal of a CTO where an AMHP is not available to do so. One proponent of this idea thought that this might lead to better outcomes for some patients. At present an AMHP has to complete Part 2 of form CTO7, so accepting this idea would require a new form CTO7A and amendments to Hospital, Guardianship and Treatment regulation 13(6) and section 20A(8) of the 1983 Act. This proposal would also have entailed specifying in the emergency legislation which professionals could stand in for the AMHP.

6.15.5 Another suggestion was to allow other mental health professionals to replace the AMHP in section 136 assessments.

6.15.6 We see two problems common to both of these suggestions. In a time of severe staff shortage the other mental health professionals would be likely to be over-stretched coping with the demands of their usual roles. Moreover, if they were to be appointed as temporary AMHPs they would be taking on a role with which they had no previous professional familiarity. This would require rather more contingency training than would be required to update and refresh former ASWs and AMHPs.

6.15.7 We are reluctant to agree to a suggestion that we could permit CTO renewals without involving a second professional at all. None of the consultation proposals would leave a decision of this importance to just one professional.

6.15.8 There was a suggestion that the AMHP's duty to assess people removed by the police to a place of safety under section 136 should be suspended, where the patient is willing to consent to informal admission or to agree to some other care plan. This would leave a duty on an AMHP to interview only those people held under section 136 for whom formal admission seemed necessary. It presupposes, however, that the people who should and should not be detained in hospital could be accurately identified in advance of the AMHP interview. We feel that this suggestion would run the risk of people not being admitted to hospital when they would have been in more normal circumstances – exactly the result that the temporary changes would be intended to avoid.

6.15.9 Another suggestion was to suspend the requirement to get the nearest relative's agreement to detention under section 3, in order to reduce the need for local authorities to take action to displace them under section 29. We agree that this would make the process of detention under section 3 easier. However, section 11(4) (b) already allows for a patient to be detained under section 3 without consultation with the nearest relative if it appears to the AMHP that "such consultation is not reasonably practicable or would involve unreasonable delay." As the number of medical recommendations required would be reduced from two to one, we feel that suspending the nearest relative's role as well would be to take away one safeguard too many.

6.15.10 A further idea was to amend the section 13(4) requirement to inform the nearest relative in writing of a decision not to apply for a patient to be detained with a requirement to tell the nearest relative orally. It seems to us that, as the decision and the reasons for it would have to be recorded anyway, it is not clear how much AMHP time, if any, this suggestion would save.

6.15.11 Some commentators suggested that the section 14 requirement for an AMHP to make a social circumstances report when application is made under Part 2 of the 1983 Act by the nearest relative could be suspended. But as section 14 already contains the words "as soon as practicable" we have

concluded that there is no need to amend the current legislation in order to allow the preparation of these reports to be deferred at the height of a pandemic.

6.15.12 In the light of this we have concluded that there are no additional contingency measures that it would be appropriate to introduce to ease the statutory duties of AMHPs. On balance we felt that management action to rearrange AMHPs' workloads to allow them to focus on statutory duties, including this one, was the most appropriate approach here.

6.16 Consultation Question 16:

Do you agree that the proposed transitional arrangements for SOAD second opinions are reasonable?

6.16.1 64 per cent commentators addressed this issue.

6.16.2 About 80 per cent of those who commented supported this proposal for a three-month transitional period. This included some (including Mind) who disagreed with the idea of suspending the SOAD system at the height of a pandemic but thought that if that were to happen then the transitional proposal would be reasonable. The remainder of the comments were approximately equally distributed between those who disagreed and those who expressed no view. We noted that Harrogate Service Users expressed the view that "the rights of the patient must be maintained at all times".

6.16.3 Some of those who were broadly supportive nevertheless offered comments on the proposal. The most common observation (made by about 10 per cent of those who agreed in principle with having a transitional period in the light of the backlog of cases requiring SOAD opinions at the time of the consultation) was that three months would not be long enough.

6.16.4 Leicestershire Partnership NHS Foundation Trust suggested that we should rely upon the provisions for administering immediately necessary treatment in the absence of a SOAD opinion that are in the 1983 Act already. Leeds Partnership NHS Foundation Trust suggested that CQC should set up a system for prioritising SOAD requests.

Government Response

6.16.5 We agree with the vast majority of those who commented who were supportive of this proposal. We note the reservations expressed by a substantial minority that the three-month period proposed would not be long enough. This view may be coloured by the current difficulties in keeping up with the demand for SOAD opinions. CQC are working to resolve these problems. This does, however, need to be balanced with the concern that we should not to suspend a patient's right to a SOAD opinion unless absolutely necessary. We believe this will ultimately have to be a matter for judgement at the time – whenever it comes - because it will depend on the degree to which SOADs will still be able to provide opinions in the normal way during and in the aftermath of the pandemic. For the time being we think that a three-month transitional period would be likely to strike the right balance.

6.16.6 Our view is that whilst reliance on section 62 to give treatment in the absence of a second opinion will be appropriate in circumstances specific to some individual cases at any time, the suspension of the obligation to obtain a SOAD certificate would resolve any uncertainty that might otherwise arise in individual cases at the height of a pandemic.

6.16.7 The question of prioritising SOAD visits at the height of a pandemic would be an operational matter for CQC.

6.17 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?

6.17.1 69 per cent commentators addressed this issue.

6.17.2 Of those who commented on this proposal only six per cent disagreed. A group of AMHPs based at Wirral Department of Adult Social Services disagreed because they felt that "after the emergency some form of assessment of competence should take place." Another six per cent gave neutral responses. Everyone else accepted that this measure could be necessary and should not be ruled out. Several supportive commentators added caveats about monitoring the situation to ensure that the emergency provisions would remain in place for no longer that absolutely necessary.

Government Response

6.17.3 Obviously we share the hope of several commentators that circumstances will never get so bad that the ongoing need for temporary AMHPs or approved clinicians asked about in this question would arise. Nevertheless it is important that we should be prepared for the eventuality and we agree with the vast majority of commentators who supported the proposal.

6.17.4 If these changes should need to remain in force for longer than the others, this could be achieved by the simple expedient of not revoking temporary amendments to the current Mental Health Act 1983 Approved Clinician (General) Directions 2008 and the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008.

6.18 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?

6.18.1 66 per cent of commentators addressed these issues. The possible measures the consultation document originally suggested should not be included in any package of temporary changes were:

- 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);
- Extending the periods for which people could be detained under sections 2 or 3; and
- 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.

6.18.2 The largest number of responses to this consultation question supported their exclusion from the contingency proposals. In total 60 per cent (including some who disagreed with us implementing any measures in the first place) agreed that these measures should not be pursued. Some 39 per cent of commentators, however, thought we should include one or more of the measures the consultation document originally proposed to exclude. A few offered additional ideas.

Government Response

6.18.3 In the light of consultation comments we have decided to include a few further changes to the 1983 Act in the overall set of potential contingency measures.

6.18.4 Several commentators said that section 5(2) created a “pinch point” on a Monday under normal circumstances and suggested we ought to include an extension of the time limit should be included in the package of

proposals. This rationale seemed sensible so we have concluded that we should extend the time period to 120 hours (i.e. 5 days rather than 3).

6.18.5 We also propose that the contingency measures should include allowing any approved clinician or registered medical practitioner to detain under section 5(2) rather than just the one in charge of the case. At present the person in charge can nominate one other person – either a registered medical practitioner or an approved clinician – to act for him in his absence. This proposal would allow any such practitioner, not just one who has been specifically nominated, to detain the person.

6.18.6 Third, we have been persuaded by a number of comments that we should consider extending the time allowed in section 5(4) (nurse's emergency holding power) from 6 hours to 12 hours. Several respondents commented that it would be helpful to extend this in a circumstance in which doctors and approved clinicians might be less immediately available. This would offer greater flexibility if a shortage of doctors and approved clinicians means that not all urgent decisions to detain could be taken straight away.

6.18.7 Allowing any approved clinician or registered medical practitioner to detain under section 5(2) rather than just the one in charge of the case would require a change to Hospital, Guardianship and Treatment regulation 4(1) (g) and a modification to Form H1. As we have decided to prepare forms A2A and A6A for single medical recommendation detentions under sections 2 and 3, for consistency we would produce a new form H1A for this situation.

6.18.8 We accept that extending the periods of emergency detention allowed under sections 5(2) and 5(4) does change the effect of the 1983 Act in relation to some patients who are already in hospital in that it prolongs the period during which they can be detained without any authority to treat. However, we are persuaded by the pragmatic arguments put forward that these additional measures would offer helpful additional flexibility at a time of severe staff shortage.

7. Other Issues

Tribunals

7.1 Several commentators, including the Royal College of Psychiatrists, noted that the consultation proposals made no reference to how the Tribunal would be able to cope. This was because the consultation related specifically to changes that might be made to the 1983 Act.

7.2 The Mental Health Tribunal falls within the pandemic flu plan for the Ministry of Justice. Within this plan is a pandemic flu group which monitors the impact of pandemic flu and takes necessary action across the ministry where necessary to ensure an appropriate response and minimise impact. Each Tribunals Service site including Arnhem House, where the Mental Health Tribunal is based, has both a Crisis Management Plan and Business Continuity / Recovery Plan for dealing with a range of incidents that may affect the operations of their teams.

7.3 For any incident a crisis management team is convened and it is responsible for assessing and responding to any business continuity related matter; this would include the impact of a pandemic should one be confirmed. As part of the planning process, the Mental Health Tribunal has assessed and identified priority areas of work within its operations, and this would enable resources - including staff and tribunal personnel - to be focused on priority areas should incidents occur. In addition, the Mental Health Tribunal would have the ability to call upon administrative staff and resources from other areas of the Tribunals Service when required to ensure operations continue and that priority areas of work were unaffected.

7.4 The Tribunals Service therefore believes that it has robust arrangements in place to enable any pandemic influenza outbreak to be closely monitored to allow senior administrators to make informed decisions on how to maintain an appropriate level of service.

Human Rights

7.5 A few people who commented on the consultation queried whether some of the proposals might impinge on the human rights of people with mental disorders. For example the Law Society thought that the proposal to suspend the time limits on warrants for transferring people from prison to hospital might lead to circumstances giving rise to a claim under Article 3 of the European Convention on Human Rights (ECHR)[6] and the Mental Health Alliance reported that some of their member organisations were suggesting that it was possible that the proposals on single medical recommendations and the suspension of SOAD requirements could breach it too. The Equality and Human Rights Commission expressed the view that these two changes, in particular, would be proportionate in Human Rights Act terms only insofar as they are strictly necessary and are subject to strict limits of situation and duration.

7.6 Maintaining the compatibility of the 1983 Act with the ECHR is essential. Given that these proposals would only be brought into force in the kind of circumstances referred to by the Equality and Human Rights Commission, we are content that they are ECHR-compatible.

Indemnity

7.7 Indemnity and contractual arrangements for temporary approved clinicians were also mentioned. All approved clinicians are approved by SHAs but it is important to note that SHAs do not currently have any indemnity provision through Clinical Negligence Scheme for Trusts (CNST) for clinical incidents[7]. People with current contracts of employment with an NHS Trust, NHS Foundation Trust or Primary Care Trust would be covered by the CNST, which is administered by the NHS Litigation Authority. Others could also be

[6] "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."
[7] A clinical incident refers to any adverse event, medication error or other incident which either did have or could have had a negative impact on patient care.

covered by this Scheme under the terms of a temporary contract of employment with one of these Trusts.

7.8 If, however, clinicians work under a contract for services with the NHS body they would need to ensure they have made their own indemnity arrangements. For example, many GPs are independent contractors who are required to have adequate indemnity cover against liability arising from the provision of clinical services under the terms of their primary medical services contract. Indemnity and contractual arrangements are among the issues which would need to be settled before an NHS Trust, NHS Foundation Trust or Primary Care Trust could permit them to act as temporary approved clinicians.

8. Conclusion

8.1 We are grateful to everyone who took time to respond to the consultation. Overall, the responses received demonstrate a general but not universal acceptance that it would be wise to have contingency changes to the 1983 Act ready to be brought into force, if necessary, where a pandemic has a severe and prolonged impact on services.

8.2 In the light of consultation comments we have concluded that all of the temporary amendments to the 1983 Act that were proposed in the consultation would be an appropriate part of a package of contingency measures, if needed.

8.3 We have been persuaded by arguments put by some commentators to include a few further amendments to section 5 of the 1983 Act.

8.4 These measures would only be brought into force in the event of, for example, a pandemic which has severe and prolonged impact on services. At that time a decision would be made as to whether all or only some of these measures would be needed.

Annex A – List of commentators

Commentators who indicated that they were happy for their information to be shared included:

1. AMHP Leads Network
2. Administrative, Justice and Tribunal Council
3. Association of Directors of Adult Social Services (ADASS)
4. Avon and Wiltshire Mental Health Partnership NHS Trust
5. Barnsley Clients Alliance
6. Bedfordshire and Luton Partnership NHS Trust
7. Birmingham City Council
8. Birmingham and Solihull Mental Health Foundation Trust
9. Birmingham East and North PCT
10. Bradford District Care Trust
11. Bradford Metropolitan District Council
12. British Psychological Society
13. Buckinghamshire County Council
14. Camden and Islington NHS Foundation Trust
15. Care Principles Ltd
16. Care Quality Commission
17. Care UK
18 Mrs E Carman
19. Central and North West London NHS Foundation Trust
20. Cheshire and Wirral NHS Foundation Trust
21. Cheshire West and Chester Council
22. Eve Clark
23. College of Occupational Therapists
24. G J Cooper
25. Coventry City Council and Coventry and Warwickshire Partnership NHS Trust
26. Cumbria Mental Health Group
27. Cwm Taff Local Health Board Wales
28. Devon and Torbay AMHPs
29. Devon Partnership NHS Trust
30. Dudley and Walsall Mental Health Partnership NHS Trust
31. Durham County Council
32. Emergency Social Services Association
33. Equality and Human Rights Commission
34. Stuart Field
35. Linda Fields
36. Focus on Mental Health, Hastings
37. Dr Sara Forman
38. Gloucestershire County Council
39. Hampshire NHS in conjunction with Hampshire County Council
40. Hampshire Partnership NHS Foundation Trust
41. Harrogate and District NHS Foundation Trust
42. Hereford PCT

43. Hertfordshire County Council in conjunction with Hertfordshire PCTs and Hertfordshire Partnership NHS Foundation Trust
44. Humber Mental Health Teaching NHS Trust
45. Isle of Wight NHS Primary Care Trust
46. Kent & Medway NHS and Social Care Partnership Trust
47. Kirklees Council
48. Dr P Kumar
49. Lancashire Care NHS Foundation Trust
50 Lancashire County Council
51. Dr M Launer
52. Law Society
53. London Borough of Richmond
54. Leeds Council
55. Leeds Partnership NHS Foundation Trust (2)[8]
56. Leicestershire Partnership NHS Foundation Trust
57. Liberty
58. Lincolnshire Partnership NHS Foundation Trust (2)[8]
59. Manchester Mental Health and Social Care Trust
60. Matrix Training Associates
61. MAGIC (Mental Awareness Group Input Committee) Harrogate
62. Mental Health Foundation
63. Mind
64. NEERAP North East England Registration Panel
65. Newcastle City Council
66. NHS Cheshire West and Chester Council
67. NHS Coventry
68. NHS East Lancashire
69. NHS East Midlands
70. NHS London
71. NHS Northants
72. NHS Plymouth
73. NHS West Essex
74. North East Lincolnshire Care Trust Plus
75. North East London NHS Foundation Trust
76. North Essex Partnership NHS Foundation Trust
77. Northumberland, Tyne and Wear NHS Trust (2)[8]
78. Nottinghamshire Healthcare NHS Trust
79. Oxfordshire & Buckinghamshire Mental Health NHS Trust (3)[8]
80. Oxleas NHS Foundation Trust
81. Pennine Care NHS Foundation Trust
82. Portsmouth City Teaching PCT
83. Rethink
84. Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust (2)[8]
85. Royal College of General Practitioners
86. Royal College of Nursing
87. Royal College of Psychiatrists

[8] Where there is more than one response from people in the same organisation, the number of responses is shown in brackets.

88. Sainsbury Centre for Mental Health
89. South Essex Partnership NHS Foundation Trust
90. South London and Maudsley NHS Foundation Trust
91. South Staffordshire and Shropshire Healthcare NHS Foundation Trust (2)[9]
92. South Tyneside MBC AMHPs
93. South West London and St George's Mental Health NHS Trust
94. South West Yorkshire Partnership NHS Foundation Trust
95. St Andrew's Healthcare
96. Staffordshire County Council
97. Suffolk County Council
98. Suffolk Mental Health Partnership NHS Trust (2)[5]
99. Sussex Partnership NHS Foundation Trust
100. Sussex Police
101. Dr R L Symonds
102 Tees, Esk and Wear Valleys NHS Foundation Trust
103 The Princess Royal Trust for Carers
104 The Westminster Society for People with Learning Disabilities
105 West London NHS Mental Health Trust
106 West Norfolk Mind
107 West Sussex County Council
108 Whitley Bay CMHT
109 Wirral DASS
110 Wirral MBC
111 Fiona Woods
112 Worcestershire Mental Health Partnership NHS Trust

[9] Where there is more than one response from people in the same organisation, the number of responses is shown in brackets.

Annex B: Numerical analysis of comments on individual consultation questions

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?

Answer	Never	Neutral	In Extreme Circumstances	
			Prescribed	Not prescribed
Percentage[10]	4.5	15.5	29	51

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?

We have not attempted to categorise the wide range of answers received.

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?

Answer	Yes	Neutral	No
Percentage	87	7	6

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?

Answer	Yes	Yes with comment	Neutral	No with comment	No
Percentage	31	30	7	15.5	16.5

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

Answer	Yes	Neutral	No
Percentage	66	9	25

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?

Answer	Yes	Neutral	No
Percentage	66	12	22

[10] Percentages quoted in Annex B are percentages of the number of comments on each question

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

Answer	Yes	Yes with comment	Neutral	No with suggestion	No
Percentage	35	8	13	31	13

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?

Answer	Yes	Yes with comment	Neutral	No
Percentage	44	14	13	29

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?

Answer	Yes	Yes with comment	Neutral	No with suggestion	No
Percentage	45	9	19	5	22

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?

Answer	Yes	Yes with comment	Neutral	No
Percentage	49	11	16	24

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?

Answer	Yes	Yes with comment	Neutral	No with suggestion	No
Percentage	26	48	10	14	2

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?

Answer	Yes	Yes with comment	Neutral	No with suggestion	No
Percentage	29	38	8.5	19.5	5

Question 13: Do you agree that local authorities should be allowed the flexibility to approve the former ASWs and AMHPs identified in paragraph 5.6.6 to be AMHPs as part of the contingency measures?

Answer	Yes	Yes with comment	Neutral	No with suggestion	No
Percentage	21	54	3	19	3

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?

Answer	Yes	Yes with comment	Neutral	No with suggestion	No
Percentage	100	0	0	0	0

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.

Answer	No change	Neutral	Suggestion offered
Percentage	58	10	32

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

Answer	Yes	Yes with comment	Neutral	No
Percentage	68	15	9	8

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?

Answer	Yes	Yes with caveat	No comment	No
Percentage	67	21	6	6

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?

Answer	Leave out	Neutral	Include some
Percentage	56	7	37

Question 18 (cont.): Suggestions from those who disagreed:

Answer	Extend Time for Section 4	Extend Time for Section 5(2)	Extend Time for Section 5(4)	Broaden Professions for Section 5(2)	Broaden Professions for Section 5(4)	Other
Number in favour[11]	8	9	13	2	1	8

[11] Percentages not used here as several commentators made more than one suggestion.

Annex C – Final list of proposals requiring legislative changes

C1. Allowing just one medical recommendation on an application by an AMHP for someone to be detained under sections 2 or 3 of the 1983 Act.

C2. To facilitate C1 above, preparing special forms A2A and A6A for use by a doctor making a single medical recommendation.

C3. Changing the number of doctors involved in decisions to transfer people from prison to hospital under Part 3 of the 1983 Act.

C4. Suspending the obligation to obtain SOAD opinions on medication.

C5. Suspending time limits on conveying people and admitting them to hospital under Part 3.

C6. Suspending time limits on warrants for transferring people from prison to hospital.

C7. Giving courts discretion to renew remands under the 1983 Act beyond the normal 12 week maximum.

C8. Allowing SHAs the flexibility to approve former RMOs and former approved clinicians to be temporary approved clinicians.

C9. Allowing SHAs the flexibility to approve current section 12 doctors who have not previously acted as RMOs to be temporary approved clinicians

C10. Allowing local social services authorities the flexibility to approve former ASWs and former AMHPs to be temporary AMHPs.

C11. Seeking a three-month transitional period for SOAD second opinions.

C12. If there should be a large number of staff deaths, keeping the contingency measures for temporarily approved AMHPs and approved clinicians in place until fully trained replacements can be approved.

C13. Extending the periods of emergency detention permitted under section 5(2) (emergency detention of a hospital in-patient by a doctor or approved clinician) from up to 72 hours to up to 120 hours.

C14. Extending the periods of emergency detention permitted under section 5(4) (emergency detention of a hospital in-patient by a nurse with special expertise in mental health or learning disability) from up to 6 hours to up to 12 hours.

C15. Allowing any approved clinician or registered medical practitioner to detain a hospital in-patient under section 5(2) rather than just the one in charge of the case.

C16. To facilitate C15 above, preparing special form H1A for use by an approved clinician or doctor who is not in charge of the case.

Annex D – Glossary of terms

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)

CQC 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.

Emergency holding powers

There are two emergency holding powers under section 5 of the 1983 Act which allow a doctor or a nurse to prevent a current in-patient from leaving hospital before an application for detention under either section 2 or section 3 can be completed. The doctor's power under section 5(2) is valid for up to 72 hours and could be extended to five days under emergency provisions. The nurse's power under section 5(4) is valid for up to six hours and could be extended to twelve hours under the emergency provisions.

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 (RMO). 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 CQC 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 an SHA 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 CTO. The CTO is the legal instrument, while SCT is the scheme in general.

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