Contemporary Themes

Mental Health Act 1983

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An initial look into the past is necessary to gather together the threads which have been intertwined to form the new Mental Health Act and the setting in which it will operate. Throughout the history of mental health legislation the aims have been to provide hospitals or other institutions for the mentally disordered, to provide some system of public supervision over the standards of care in such institutions, to legislate for the conditions under which patients can be compulsorily detained, and to protect the sane against unwarranted detention.

Background

EIGHTEENTH AND NINETEENTH CENTURY LEGISLATION

At the beginning of the eighteenth century there was no such thing as mental health legislation and indeed no clear recognition of what constituted insanity. Those who were mad and destitute became the responsibility of the parish under the poor law. Those who were mad and criminal were subject to the penal laws and until 1800 there was no defence of insanity which led to hospital care. Those who were mad and itinerant were subject to the vagrancy laws because it was an offence to wander into another parish and become that parish's responsibility. There were no real institutions for the insane other than the Bethlem in London, which had been established since 1377. Pauper lunatics were sent to prison or workhouses, while the more affluent were put in private madhouses paid for by their relatives; these were profit making institutions with a vested interest in keeping as many people there for as long as possible.

The first time that the mad were recognised by special legislation was by the Vagrancy Act of 1744, which provided for the detention on the order of magistrates of dangerous "furiously mad" lunatics. Most ended up in prison.

By this time numerous private madhouses had been established and public concern over poor standards of care was widespread. Few madhouses were visited by doctors, and the staff were all untrained attendants. The 1774 Madhouses Act provided for licensing by the local public authority and notification of the admission of patients and for a system of visits and inspection by doctors, but only in London—these being known as the metropolitan commissioners in lunacy. The Madhouses Act, however, worked badly and by the late eighteenth century the treatment of the mentally abnormal was again in the public mind, partly because of several notorious cases of wrongful detention in madhouses and partly because of the insanity of King George III. In 1792 one of the first asylums designed to provide humane care—the Retreat in York—was established. The following year saw that major landmark in the history of psychiatry, the unchaining of the insane in the Bicetre Hospital in Paris by Pinel.

In 1800 the first piece of legislation designed specifically for mentally abnormal offenders—the first Criminal Lunatics Act—was passed. Thereafter the new breed of criminal lunatics accumulated in the Bethlem and elsewhere leading Parliament to recognise the need for a special national institution for their care. The result was the passing of the 1860 Criminal Lunatics Act and the opening of Broadmoor.

Meanwhile concern about the institutional care of pauper lunatics led to the 1808 County Asylums Act, which provided county asylums for them. These were the forerunners of our national system of mental hospitals. Humane treatment was, however, not often provided, and mechanical restraint was common, perhaps partly because the Act provided for severe penalties for keepers who allowed patients to escape.

During the next 50 years Britain was in the throes of the industrial revolution and social conditions generally were being improved as a result of the efforts of the reform movement. The founding of newspapers led to increased public awareness and a more active interest in parliament. The first textbooks on psychiatry were being written but conditions in the county asylums had not improved at all.

COMMISSIONERS IN LUNACY

In an attempt to raise standards the 1845 Lunatics Act established procedures for admission and certification by a lay magistrate and an inspectorate known as the commissioners in lunacy, whose powers extended those of the metropolitan commissioners in lunacy—namely, of inspection, licensing, and reporting. The legal and medical commissioners were given powers to visit each hospital every few months to inspect all buildings, to inquire about each patient under restraint, to inspect all records, and to discharge patients on their own authority. The new provisions for certification maintained the difference between pauper and private patients; the reasons why are interesting. For private patients the reception order was usually signed by a relative but for pauper patients a magistrate would determine whether or not the patient should be admitted to an asylum rather than to the workhouse. The magistrate was acting here not in the defence of the liberty of the subject but as an instrument of public policy to ensure that suitable patients were given the benefit of what was thought to be their best chance of good treatment and cure. County asylums still tended to take acute curable patients, whereas those with chronic mental disorders would end up in workhouses. The 1845 Act was not, however, very successful in this respect as many remained in workhouses, especially those with mental handicap and dementia. Arguments continued between the commissioners in lunacy and the poor law guardians over the

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treatment of pauper lunatics and in 1874 for the first time the government accepted financial responsibility for the treatment of those with mental disorder by providing financial incentives so that pauper lunatics could be treated in county asylums.

LEGISLATION 1890-1930

In the 1880s there were widely publicised cases of wrongful detention and public concern was heightened by novels such as Wilkie Collins's *Woman in White* leading to the 1890 Lunacy Act. This Act included a complicated range of legal procedures designed to prevent the admission and detention of sane patients. Magistrates were empowered to make reception orders with responsibility for examining the evidence for and against making an order and the validity of medical certificates. There was also new provision for the renewal of detention orders which had to be sent to the commissioners. This legislation provided specifically for lunatics rather than the mentally deficient, who had their own Act in 1913 which classified them into idiots, imbeciles, the feeble minded, and moral imbeciles. It also authorised the provision of institutions for the mentally deficient, separate from the lunatic asylums, and these two Acts between them provided a comprehensive legal and administrative machinery for lunatics and the mentally deficient.

At the beginning of this century Kraepelin had reached the sixth edition of his textbook on psychiatry, Freud was developing his theory of the unconscious and the technique of psychoanalysis, and Adolf Meyer was promoting the psychobiological approach to the patient. Henry Maudsley had founded the Maudsley Hospital, which in 1915 was specially allowed by Act of parliament to admit voluntary patients. By the 1920s the emphasis on legal certification procedures under the 1890 Act had led to a decline in standards of care and treatment in the county asylums. Public attitudes changed to favour treating the mentally disordered as far as possible in the same way as patients with physical disorders to combat the stigma attached to certification.

The Mental Treatment Act of 1930 made it possible for patients to be admitted on a more or less informal basis in certain circumstances without certification. One category was that of the "temporary" patient who required treatment for not longer than a year, after which he had to be certified or discharged. The other class was that of "voluntary" patients who had to be willing to be admitted and capable of signing and understanding the importance of an application form. Terminology changed too: "asylums" became "mental hospitals" and "lunatics" became "persons of unsound mind." Patients could, however, still be admitted only to mental hospitals, which remained separate from hospitals for the physically ill, even with the advent of the National Health Service in 1948 when psychiatric hospitals were handed over to the Ministry of Health. The foundation of the NHS and the career grade of consultant psychiatrist together with improved financial resources did, however, lead to the development of psychological treatments, social work, and rehabilitation. By this time specific treatments had been limited to insulin coma therapy, electroconvulsive therapy, and leucotomy, but in the 1950s the phenothiazines and antidepressant drugs were being introduced and with them the hope that psychiatric patients could now be cured.

THE PERCY COMMISSION

All this led to the setting up in 1954 of a royal commission on the law relating to mental illness and mental deficiency, which undertook a thorough review of every aspect of mental health legislation. The Percy commission's report recommended that mental patients should be treated as far as possible in the same way as those with physical disorders. It recommended that compulsory treatment should be used as sparingly as possible but that in certain circumstances detention was warranted: "When an illness affects the patient's power of judgment and appreciation of his own condition there is a specially strong argument for saying that his own interests demand that a decision whether or not to accept medical care should not be left entirely to his own distorted or defective judgment."

THE 1959 ACT

The commission's report formed the basis of the Mental Health Act 1959 which was regarded at home and abroad as a most enlightened piece of progressive legislation, heralding a new era in the care of the mentally disordered. In the 1959 Act certification by magistrates was abolished on the basis that decisions on compulsory admission should be a medical matter; mental hospitals were no longer separated from others; and mental patients were allowed to enter any hospital or nursing home as defined in the Act, to accept or reject treatment, and to leave hospital of their own free will. The bulk of the 1959 Act constitutes a range of safeguards to protect the civil liberties of patients including detailed conditions under which patients can be detained, have their detention renewed, and appeal to mental health review tribunals.

Mentally abnormal offenders—Under the 1959 Act special provisions were made for mentally abnormal offenders: criminal lunatic asylums such as Broadmoor were renamed special hospitals, were put under the management of the Department of Health and Social Security, and were permitted for the first time to admit patients on transfer from other hospitals without going through the courts. Since then legislation on mentally abnormal offenders has included the 1957 Homicide Act, which introduced the defence of diminished responsibility for those charged with murder, and the Criminal Procedure (Insanity) Act 1964, which provides for hospital treatment for those found "unfit to plead" and "not guilty by reason of insanity."

CHANGES SINCE 1959

Since 1959 public attitudes have changed considerably, as manifested by the civil rights movement and a growing tendency to challenge medical opinion. Treatment methods have changed and the organisation of the health services has moved towards multidisciplinary teams with nurses, psychologists, and social workers.

Public concern over the standards of care in psychiatric hospitals has been fired by allegations of neglect and ill treatment in the string of public inquiries in the 1970s. In 1969 mentally handicapped patients in Ely Hospital were found to have been neglected and ill treated by incompetent staff. The report on Ely was followed by those on Farleigh and the Whittingham Hospital in 1972, where allegations of severe ill treatment, inadequate medical and nursing care, defective management policy, and suppression of complaints were found to be true. In South Ockendon in 1974 allegations of cruelty and inadequate medical and nursing care were again substantiated and in 1976 public attention focused on the issue of consent to treatment with electroconvulsive therapy after the publication of the St Augustine's report. The report on Normansfield in 1978 described the consultant psychiatrist there as "intolerant, abusive, and tyrannical," the standard of nursing care as "extremely low," the administration poor at every level. In 1980 the Boynton report on Rampton Hospital described it as having been "in a backwater and the main currents of thought about the care of mental patients have passed it by."

The Board of Control, which had replaced the commissioners of lunacy in 1930, had been disbanded in 1960 leaving nobody with a statutory duty to visit hospitals and monitor standards of care. The Hospital Advisory Service was set up by Richard Crossman in 1969 after publication of the report of the com-

mittee of inquiry into conditions at Ely Hospital. Since 1976 the service has operated through multidisciplinary teams with the social work service of the DHSS, one of whose teams is for mental illness hospitals. Their purpose is to encourage and disseminate good practice and new and constructive ideas and to act as local catalysts to stimulate local solutions to local problems. The service is not, however, empowered to investigate individual complaints or to comment on matters of clinical judgment and has quite different responsibilities from the proposed Mental Health Act Commission. Hospitals for the mentally handicapped are visited by the national development team, who recently described seven Surrey hospitals as "the most deprived we have ever seen" with dangerously low staffing levels, poor environmental standards, and widespread neglect of building maintenance. It is not surprising that morale among psychiatric staff in NHS hospitals is at a low ebb.

Nevertheless, in the past 23 years psychiatrists have successfully implemented the spirit of the 1959 Act, as evidenced by the fact that at present 90% of all admissions to mental illness hospitals are voluntary as are 97% of admissions to hospitals for the mentally handicapped. The "open door" philosophy has led to a dramatic reduction in long stay patients. Treatment methods have improved but perhaps reached the point where no new dramatic innovations are likely.

In the early 1970s bodies such as the Royal College of Psychiatrists and the National Association for Mental Health decided that the working of the 1959 Act should be reviewed. In 1974 a report by the college said that the Act was working well but recommended certain changes. In 1976 and 1977 Larry Gostin of MIND published his two books, *A Human Condition*, which contained more severe criticisms of the operation of the Act and proposed radical changes in patients' rights. In 1975 the Butler Committee published a report recommending several changes in the law concerning mentally abnormal offenders, and in 1976 the Labour government published a consultative Green Paper which was followed in 1978 by a White Paper with the government's proposals for changes.

CONTROVERSIAL ISSUES

Perhaps the two most controversial areas were those concerning consent to treatment and the reinstitution of a form of commission. The latter had been advocated by the Royal College of Psychiatrists along the lines of the Scottish Mental Welfare Commission but the proposal was rejected in the 1978 White Paper. In response to claims that the 1959 Act was unclear on whether detained patients could refuse treatment the government proposed that second opinions should be given for treatments which were "irreversible, hazardous, or not fully established" and that this second opinion should be given by a multidisciplinary panel including social workers, lawyers, and lay people as well as psychiatrists. The types of treatment in question were not defined but were taken to refer to certainly psychosurgery and probably electroconvulsive therapy but not to the use of ordinary medication. The proposals for second opinions by multidisciplinary panels were strongly opposed by the college and the rest of the medical profession.

MENTAL HEALTH (AMENDMENT) BILL

In November 1981 the Conservative government published a new White Paper on the same day as the first version of the Mental Health (Amendment) Bill. Psychiatrists were pleased to see that the government accepted the proposal to establish a Mental Health Act Commission but disappointed that the new proposals on consent to treatment, particularly as "the administration of medicine by any means" was included. Because of concern over the effects on patient care of the government's proposals a campaign was launched to persuade members of parliament to think again. It was argued that without more realistic and practical methods of treating patients without their consent, patients would suffer more and psychiatrists would be admitting them to hospital for detention rather than for treatment.

A general feeling of uneasiness with the Bill was perhaps responsible for its being dealt with in the House of Commons by means of a special standing committee, a select committee which took evidence, both written and oral, and cross examined witnesses before considering the Bill clause by clause. The committee sat in public 22 times between April and June 1982 and took evidence from the Home Office, the Lord Chancellor's Department, chairmen of mental health review tribunals, social workers, psychologists, nurses, MIND, the National Schizophrenia Fellowship, the Royal College of Psychiatrists, and representatives of special hospitals. The Bill returned to parliament in October 1982 and received the Royal Assent at the end of that month becoming the Mental Health (Amendment) Act 1982. Since then parliamentary draughtsmen have incorporated the new Amendment Act into a Consolidation Act. The Mental Health Bill 1983 was published in January and the Mental Health Act 1983 comes into effect on 30 September 1983. (The Act applies to England and Wales only; Scotland has its own legislation and the Mental Health (Amendment) (Scotland) Bill received the Royal Assent before the dissolution of parliament. It introduces changes which are broadly similar to those taking place in England.)

Provisions of the new Act

MENTAL IMPAIRMENT

One of the controversial provisions of the new Mental Health Act is the change in terminology from "mental subnormality" to "mental impairment." There was general agreement with the government's proposals in the Bill that "mental subnormality" was an outdated term and that "mental handicap" was preferable. Nevertheless, in the House of Lords, after pressure from MENCAP, it was decided that the term should become "mental impairment" so as not to confuse those mentally subnormal patients who do not become compulsorily detained with those who do. Even now the public hardly understand the difference between mental illness and mental handicap and the new term is likely to cause confusion with dementia and other organic brain disorders. Even more worrying is the new definition, which has been changed to "a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning [the current wording for mental subnormality] and is associated with abnormally aggressive or seriously irresponsible conduct." This is, of course, taken from the definition of psychopathic disorder and is likely to cause prejudice against the mentally handicapped. It will probably also be the case that some mentally handicapped patients who fail to meet the definition, but who are currently detained in their own interests, will not be able to be admitted to hospital. The government's answer is that such vulnerability ought not to be a basis for compulsory detention, but it remains to be seen how many patients or their relatives will suffer, how many patients will be sent to prison instead of being admitted to hospital, and how many mentally handicapped patients will not receive treatment because of their inability to give full valid consent.

PSYCHOPATHIC DISORDER

The age limits for detention of non-offenders suffering from mental impairment or psychopathic disorder have been abolished

as have the words "requires or is susceptible to treatment" from the definition of psychopathic disorder. Instead, at admission and renewal of detention (and this applies to both psychopathic disorder and mental impairment) there will be a criterion that treatment "is likely to alleviate or prevent a deterioration" of the patient's condition. At present patients cannot be detained by reason only of promiscuity or other immoral conduct, and this will be further amplified by referring to "sexual deviancy or dependence on alcohol or drugs."

APPROVED SOCIAL WORKERS

In October 1984 mental welfare officers will be replaced by approved social workers, who will be appointed by local social services authorities as having appropriate competence in dealing with people with mental disorders. Before making an application for admission these new approved social workers will be required to interview the patient and satisfy themselves that detention in hospital is the most appropriate way of providing the care and treatment that the patient needs.

ADMISSION

Emergency admission—The use of section 29 of the 1959 Act as the means of admitting a patient to hospital has been criticised owing to its overuse. It, of course, requires only one doctor making the medical recommendation whereas the 1959 Act envisaged that section 25 would be the normal method of admission, as it requires two doctors and affords better safeguards for the patient. Section 29 is to be changed so that the application must be made by the nearest relative (rather than any relative) or by an approved social worker rather than a mental welfare officer. The patient will have to have been seen and admitted within 24 hours instead of three days at present. The list of nearest relatives has been enlarged to include cohabitees (who may be of the same sex as the patient) if they have lived together for five years.

Admission for assessment—Admission for observation under section 25 of the 1959 Act is now to be called admission for assessment and will last for 28 days as before, but it will be made clear that assessment includes treatment. Despite protests from psychiatrists and those representing patients' relatives, patients under section 25 are to be allowed an appeal to a mental health review tribunal within the first 14 days after admission. It was argued that instead of a tribunal reactivating the turmoil surrounding the admission it could have been possible for the patient to have his case heard by the managers of the hospital, who already have the power to discharge him if they consider him improperly detained. The government has relented to some degree on this issue and it seems possible that the chairmen of tribunals might in these cases be able to make flexible arrangements for the hearings.

Holding power for nurses—Some nurses have been worried about their legal position if they prevent an informal patient leaving hospital because the nurse considers the patient suicidal or dangerous. To answer this, a new "holding power" has been introduced for nurses. Registered mental nurses and subnormality nurses will have the power to detain an informal patient in hospital for up to six hours to enable a doctor to be found to sign a section 30 order.

Patients' statement of rights—When patients are compulsorily admitted to hospital the managers will be required to give them information on their rights—including those concerned with appeals to tribunals and their right to refuse treatment—and about the Mental Health Act Commission. Voluntary inpatients have been given voting rights. Patients are generally to be allowed unfettered correspondence, though special hospitals retain rights to inspect and withhold mail in some circumstances, subject to notification and appeal.

RENEWAL OF DETENTION

Periods of detention for patients under sections 26 and 60 of the 1959 Act have been halved. Detention will now have to be renewed after six months, after a further six months, and thereafter annually. The criteria for renewal will still be that the patient continues to suffer from mental disorder and that detention is necessary for the health or safety of the patient or for the protection of others.

The "treatability" criterion will apply at renewal of detention for patients categorised as having psychopathic disorder or mental impairment, the words being "alleviation or prevention of deterioration" of their condition, which may ensure that patients who are not considered treatable being either not admitted or not having their detention renewed. For patients with mental illness or severe mental impairment there are alternative criteria—namely, that if discharged the patient would be unlikely to be able to care for himself, to obtain the care he needs, or to guard himself against serious exploitation.

OFFENDER PATIENTS

No hospital will be forced to admit an offender patient, though regional health authorities may be required to inform courts of what facilities can be provided for particular patients. The wording of restriction orders is to be changed to make it clear that the purpose is to protect the public from serious harm, and another innovation is that doctors will have to send annual reports on restricted patients to the Home Secretary. At present of course the Home Secretary has to authorise the transfer or discharge from hospital of a restricted patient and he has the right to refuse the advice of a mental health review tribunal hearing on a restricted patient. Under the new Act a tribunal will have the power to order the discharge of a restricted patient if it considers the patient to be no longer dangerous or no longer suffering from mental disorder. The psychiatric profession has accepted the inevitability of this and is somewhat reassured by the enhancing of tribunals in such cases, where the chairman will now be a senior judge.

MENTAL HEALTH REVIEW TRIBUNALS

Patients admitted for treatment will be able to appeal to a tribunal during their first six months, their second six months, and then annually. Patients on a hospital order (whether or not with a restriction order) will be able to appeal during the second six months after their admission and thereafter annually. If patients do not avail themselves of the right to a tribunal in the first six months in which they are so entitled their case will be automatically referred to a tribunal by the hospital managers, as it will be if they have not asked for a hearing in any three year period.

Tribunals are given greater powers and will be able to order delayed discharge of a patient or to recommend granting of leave of absence or transfer to another hospital. There is also a new type of legal aid for representation at tribunals called ABWOR, assistance by way of representation. The result of all this will possibly be an increase in the number of tribunals from less than 1000 a year at present to about 5000.

AFTERCARE FOR DETAINED PATIENTS

Local health authorities and social services are required to provide "aftercare" for detained patients when they leave hospital, but what effect this will have remains to be seen because "aftercare" is not defined. It may be interpreted as providing care in a day hospital or outpatient clinic rather than in hostels: there is no provision for new resources.

NEW REMANDS TO HOSPITAL

There are new powers for remands to hospital and for making interim hospital orders. Under these proposals courts will have the power to remand someone charged with an imprisonable offence to a psychiatric hospital (and that can include a special hospital) either for treatment or for assessment and reports. These remands will be for a month at a time up to a maximum of three months and should improve the position of those who are presently admitted to hospital as "unfit to plead" cases, who are thereafter detained under the same conditions as if they were on a hospital order and restriction order without limit of time, without having their guilt properly determined in court. Remands for treatment, however, will not include those awaiting trial on a charge of murder.

There is also a provision for making interim hospital orders after conviction to see whether the making of a hospital order would be the appropriate disposal. These interim orders can last for up to six months and should provide part of the answer for determining the treatability of psychopaths. It is not known when these new provisions will come into effect but it will not be before September 1983.

TRANSFERRED PRISONERS AND PROTECTION OF STAFF

There is a change which affects prisoners transferred to hospital under sections 72 and 74 of the 1959 Act. At present restrictions on discharge last until the patient's prison sentence expires. Under the new Act the restrictions end at the time of the earliest date of release had the patient stayed in prison and earned full remission.

Section 141 of the 1959 Act, which affords protection to staff for acts performed in pursuance of the law, has been amended so that civil proceedings will require the leave of the High Court and criminal proceedings the consent of the Director of Public Prosecutions. The terms "substantial ground" and "bad faith" have been removed, and the Secretary of State and health authorities will no longer be able to seek protection under this section.

MENTAL HEALTH ACT COMMISSION

The new commission will have general protective functions for detained patients and may be asked by the Secretary of State to keep under review the care and treatment of voluntary patients. It is to be set up as a special health authority which will, therefore, be responsible to the Secretary of State but independent of him and will be required to publish a biennial report which will be laid before parliament. The 70 part time members will be doctors, nurses, psychologists, social workers, lawyers, and lay people. Teams will probably visit each psychiatric hospital once or twice a year and each of the special hospitals once a month. On their visits they will make themselves available to detained patients who wish to see them, ensure that staff are helping patients to understand their legal position and their rights, look at patients' records of admission and renewal of detention and those relating to treatment, and ensure that detained patients are satisfied with the handling of any complaints they make. The commission will appoint independent doctors and others to give opinions on consent to treatment and will also be responsible for preparing an advisory code of practice for the guidance of doctors and hospital staff on the admission of patients and their medical treatment.

CODE OF PRACTICE

The code will specify certain forms of treatment which, in the opinion of the Secretary of State, give rise to special concern and should not be given unless the patient has consented and a second medical opinion has been given in writing by an independent doctor appointed by the Secretary of State. The forms of medical treatment specified in the code will be in addition to other forms of treatment which will be specified by regulations made by the Secretary of State for treatments requiring either consent and a second opinion or treatments requiring consent or a second opinion.

CONSENT TO TREATMENT

These proposals on "consent to treatment" were the subject of intense lobbying from all sides during the passage of the Mental Health (Amendment) Bill. The particular issues were which forms of treatment should be subjected to which procedures, who should give second opinions on consent, and whether or not treatment should be given. On the one hand some psychiatrists thought that they must be free to give treatment, certainly medication, to any patient whenever they considered that appropriate and would refuse to accept responsibility for the patient if the second opinion did not agree with the treatment proposed. On the other hand, certain members of parliament expressed the view that in no circumstances whatsoever should a patient be forced to have treatment against his will. The middle ground recognised that patients must be protected from psychiatrists who might be careless or even unscrupulous in their prescribing habits but equally realised that many severely psychotic or mentally handicapped patients would, because of their mental disorder, be quite unable to consent (understand the nature, purpose, and likely effect of the treatment in question) and be caught in a Catch-22 situation. They could not have the treatment unless they understood why they needed it, but because of the mental disorder they were unable to recognise the need until they had been treated.

Eventually the government scrapped its original proposals and a compromise package passed into law. Psychiatrists won the battle that only doctors could give a second opinion but their opponents were successful in having introduced a non-medical element in deciding whether the patient was capable of consenting and had consented. All in all psychiatrists gained major concessions which should prove of benefit to patients, their relatives, and all concerned in the psychiatric services.

TREATMENTS IN REGULATIONS

Besides the advisory procedures for any treatments named in the code of practice, other forms of treatment will fall into two main categories which will be specified in regulations made by the Secretary of State. All treatments are specifically those for mental disorders. When second opinions are necessary, the doctor giving the opinion is required to consult two people professionally concerned with the patient's treatment, of whom one will be a nurse and the other neither a doctor nor a nurse. The second opinion may refer to a "plan" of treatment rather than an individual course. The new sections apply to patients admitted for assessment, treatment, and on hospital orders, and to transferred prisoners. They do not apply to those on three day orders: for them and for voluntary patients common law rights and duties apply.

Consent and second opinion—One section of the new Act refers to treatments requiring consent and a concurring second opinion. For these treatments a panel of three people, one a doctor, will be appointed by the Mental Health Act Commission to see the patient. The two non-medical people will certify that the patient is capable of consenting and has consented; the doctor will certify that the treatment can be given. The treatments included here are psychosurgery and probably hormone implants. This section also applies to voluntary patients (see below).

Consent or second opinion—The regulations will also specify

which treatments require consent or a second opinion. For these treatments, if the patient does not consent or is incapable of consenting, a concurring second opinion from a commission doctor will have to be obtained. The treatments here include electroconvulsive therapy and medication but only if medication is continued for more than three months since it was started: in the first three month period the issue of consent does not arise. Where medication is continued without consent after three months the patient's doctor will be required at each renewal of detention (or at any time if asked to do so by the Secretary of State) to submit a report to him on the treatment of the patient and on the patient's condition.

Urgent treatment—None of the above applies to any treatment necessary to save the patient's life. Any treatment, provided that it is not irreversible or hazardous, may be given to prevent a serious deterioration in the patient's condition, to prevent him behaving violently or being a danger to himself or others, or to alleviate serious suffering by the patient. In all these circumstances the issue of consent does not arise.

EXTENSION TO VOLUNTARY PATIENTS

In the final stages of the passage of the Bill through parliament, without discussion or consultation, the clause concerning treatment requiring consent and a second opinion was extended to voluntary patients. This means that any patient asking for certain treatments will not be allowed to have them until he has undergone the procedure of having his case examined by at least five other people. This applies at present only to psychosurgery and hormone implants but in future other governments might possibly include electroconvulsive therapy or even phenothiazines. These provisions apply not only to inpatients but also to outpatients and even those who are not under the care of a psychiatrist. Gone is the basic principle of treating voluntary psychiatric patients like those with any other physical disorder and there is now the reintroduction of certification of voluntary patients.

Conclusion

Under this new Act patients may have better rights than before, but with no new resources and the current constraints on the National Health Service these rights may prove to be meaningless and patients may be worse off in terms of getting the treatment they need.

My history of mental health legislation draws largely on the works quoted below of Kathleen Jones and Nigel Walker. While I acknowledge my indebtedness to them both the views expressed are my own and are not necessarily those of the DHSS. Finally, I cannot here hope to represent accurately or comprehensively the provisions of the new Mental Health Act.

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Letters to a Young Doctor

Postgraduate education in general practice

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The system of postgraduate education in general practice overlaps the hospital system described in the previous article (21 May, p 1635), but general practice also has an identifiable system of its own. This is befitting since about a third of all doctors are general practitioners and have their own special requirements. The chief officer is the regional adviser in general practice, appointed by the university. He works closely with the postgraduate dean and in some sense is "on the staff" of the dean. He has, however, much autonomy. He is accountable to the general practice advisory committee. This consists of general practitioner principals and trainees from all around the region as well as university representatives, especially those of a university department of general practice, and the local faculty.

The general practice advisory committee, on the advice of the regional adviser, appoints course organisers and trainers. These are the adviser's "officers" throughout the region. The trainers are the essential teachers. They are carefully selected for their interest and skills in education. Their practices are inspected for their suitability by the adviser, and they have to agree to undertake sessions that consider educational methods, including assessment of themselves, their practices, and their trainees. Only a proportion of principals in general practice in any one region are so selected. This is fortunate. The teachers are willing and learn their craft. In hospitals every doctor seems to think that he is ordained to teach, though sometimes he has little idea of what this requires. Only rarely do any of them formally learn something of the techniques of teaching.

Course organisers have general oversight of a small group of trainers and trainees, keeping them up to the mark educationally. The regional adviser works through them and through any associate advisers appointed to help him. These various helpers are needed since the region is geographically widespread, and there may be about 300 trainees working in it at any one time. One third of them may be in practices on a one teacher to one pupil basis, and all must be kept in touch. The other two thirds are in hospitals and they too must be kept in touch with the system. There must be negotiations with the consultants to

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