The Law Society

Review of the Mental Health 1983 Code of Practice
Pre-consultation Engagement

November 2013

Introduction

The Law Society of England and Wales is the independent professional body, established for solicitors in 1825, that works globally to support and represent its 166,000 members, promoting the highest professional standards and the rule of law.

This response has been prepared by the Society's Mental Health and Disability Committee. The Committee is made up of lawyers practising in the fields of disability discrimination, mental health, mental capacity and community care for claimants and respondents and includes members from other professions and organisations in the field.

The Society agrees that the current Code of Practice to the Mental Health Act 1983 ('the Code') is ripe for revision. This is crucial in order to ensure the Act and subsequent legislation, most importantly the Mental Capacity Act 2005 (MCA 2005) are in practice capable of ensuring the safety and protection of those it was aimed to assist. The engagement paper correctly identifies that serious lessons about the current effectiveness of safeguards must be learnt from Winterbourne View. This is therefore a valuable opportunity to ensure that professionals are provided with clarity as to best practice and importantly, that service users and their carers are aware of what they should expect from mental health services and professionals. We expect to see a more digestible and accessible Code for this purpose.

Importantly, since the last version of the Code in 2008 the UK has ratified the UN Convention on the Rights of Persons with Disabilities (UNCRPD). We are keen that the revised Code reflects the UNCRPD's supportive approach to decision making and emphasis on the presence of effective access to safeguards such as advocacy and independent reviews of treatment and detention.

Also, the Equality Act 2010 requires health trusts and NHS bodies commissioned to provide services for detained patients to comply with the public sector duty (section 149) in relation to planning services and devising policies for people who are detained under the Mental Health Act 1983. This includes having due regard to the need to remove or minimise disadvantages suffered by persons who share a relevant protected characteristic.

They must also make reasonable adjustments to their provisions, criteria and practices to accommodate people with mental health conditions (section 20).It is important that staff and policy makers are adequately trained and understand their obligations under the Equality Act and the Code should play its part in this.

Below we detail our general comments on those aspects of the Code upon which we have the expertise to comment and which have been identified to require substantial revision. This is followed by discussion of other areas of the Code we believe also require urgent revision.

1. Advocacy, wishes expressed in advance and legal representation

Advocacy

The Code should emphasise the need for the complete independence of advocacy services from providers of care. This may require explicit guidance on what independence means in this context. Advocacy services cannot and should not be commissioned by independent hospitals as the danger of conflicts of interest that ultimately damage the wellbeing of patients is high. The Code should make this clear.

In practice there are sometimes difficulties in advocates gaining access to detained patients in the place where they are actually detained and this was a particular hallmark of the advocate experience at Winterbourne View. The experience of our members suggest that advocates sometimes have considerable difficulty in accessing wards, perhaps where a complaint has been raised. Staff should be advised in the Code to allow reasonable access to advocates to the immediate place of detention and this may mean they need to be trained in the role of the advocate.

Consideration should also be given to the review of the provisions on how a patient who lacks capacity to request access to IMHA might still be provided with one. This may be resolved by the operation of a system where appointments are recommended by default[1]. A person may be able to withdraw but if an appointment is made it guarantees knowledge of, and access to this important service.

When people are subject to CTOs it is much harder for them to have access to advocacy services and yet often these are the patients who really need advocacy, as they may be isolated and may lack capacity to make some decisions about their care. This is particularly around issues of medication in the community.

Currently, section 2.11 of the Code provides guidance on the factual and legal grounds for detention and use of CTOs. In Chapter 20 the Code confirms the need to inform a patient about the availability of advocacy as soon as a patient goes on to a CTO. This information should also be provided whenever a CTO is renewed and perhaps, this should also include the need to provide information about IMHAs in addition to other information.

Given the provisions in 23.37 and following, it would be helpful for this part of the Code to state that patients should be informed of their right to have an advocate present (by the responsible clinician) when medical treatment is being discussed.

Wishes in advance

For patients who are detained one of the key issues is the fact that, save in emergencies, ECT cannot be given to a patient who lacks capacity if the patient has made an advance decision refusing ECT. It is quite hard to find this in the Code at present. It would be helpful if this could be made more prominent.

It would also be useful to have a template of an advance statement for people to view. This might provide greater clarity as to the nature of advance decisions and encourage take up.

[1] http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/58406.htm

Legal Representation

The Code currently provides no guidance or signposting to assist access to legal representation. It would be useful for the Code to spell out in more detail exactly what information should be given to the patient about their rights and how best to access to legal representation i.e an up to date list of all the solicitors /firms with legal aid contracts in the area and their contact details.

It would be helpful for there to be new pro forma letters about access to lawyers that attaches a list of current providers. This would mean amending the existing paragraph 32.5 or paragraph 2.18. Additionally, guidance on facilitating private and confidential communication between patients and their legal representatives and/or advocates is also necessary and this should include telephone communication.

The Code should also specify that it is presumed that legal representatives will have access to **all** medical notes and records as they cannot represent their clients adequately without access to these. We are aware that currently there are serious problems in accessing the full medical history of patients (electronic and paper files). A paragraph to this effect might also include an observation that legal representatives will need to review/check conditions of detention such as seclusion, restraint and medication. See also our comments on working with the Tribunal.

2. The use of physical restraint, mechanical restraint, medication and seclusion

The UN Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment has for the first time published a report in February 2013 which identifies the State's obligations to regulate, control and supervise health-care practices with a view to preventing mistreatment under any context.

In order to safeguard against mistreatment every provider needs to give adequate staff training on non-discriminatory practices and human rights as well as having robust complaints procedures that are easily accessible to patients and their families. It also requires that those people who are in a psychiatric hospital have adequate access to physical health care if they need it.[2]

Physical Restraint

The starting point is that restraint itself is not treatment and it can amount to a breach of Article 3 if used disproportionately and unnecessarily in a healthcare setting – see Bures v Czech Republic[3] . This needs to be made explicit in the Code and Chapter 15 needs to be reviewed in the light of this, especially in times of austerity where under

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[2] *http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf*

[3] http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-113812#{"itemid":["001-113812"]}

staffing may lead to increased use of restraint. Guidance should refer to the need for adequate staffing levels.

One of the difficulties is the plethora of guidance from various sources about methods and standards to be followed if restraint is used. We believe it would be of great benefit to staff if the guidance could be distilled into practical points about the use of restraint which should always emphasise that the use of restraint is an option of last resort.

We would also suggest that the Code states that if restraint is to be used, individuals should be given access to an IMHA. This is a recommendation of the Serious Case Review at Winterbourne View.

We are also aware of issues that have been highlighted by the CQC and other organisations regarding asking police to deal with challenging behaviour on inpatient wards and the use of tasers by the police. This should be addressed in Chapter 15.

Medication

Since the 2008 Code of Practice there have been a number of cases dealing with medication without consent most recently the case of *X v Finland*[4]. As such, it would be helpful to move the general points in paragraph 23.37 up to the beginning of the Chapter to promote the rights of patients and to include more detail on the requirements of Article 8 ECHR.

Chapter 23 is really quite hard to follow and it might benefit from illustrations or separating all the provisions relating to medication from other treatments.

The different statuses of patients subject to the Mental Health Act could be designated as follows:

- Compliant capacitated
- Compliant incapacitated
- Non – compliant capacitated
- Non –compliant incapacitated

This might be a way to better illustrate the different legal positions that can exist.

With regard to Chapter 24 and SOADs, research by Professor Phil Fennell's suggests that they do not often differ in their views. Their particular attention should be drawn to the requirements of Article 8 (see *X v Finland)*) and the protection that they provide, particularly for patients who lack capacity, and the need to scrutinise the treatment plan. For anyone who is assessed to lack capacity and is meeting a SOAD, support of an IMHA should be recommended.

Chapter 6 on 'the appropriate medical treatment test for mental disorders' is quite a lengthy and confusing chapter. There should be reference to medicating within BNF limits in the context of what is appropriate treatment. Additionally the guidance should

[4] http://www.bailii.org/eu/cases/ECHR/2012/1371.html

give greater weight to the patient's concerns and views than currently in the light of the UNCRPD.

The Guidance could usefully refer to the comments in *DL-H v Devonshire Partnership NHS Trust and the Secretary of State for Justice*[5] and *DL-H v Partnerships in Care and Secretary of State for Justice*[6]:

"NICE has issued Clinical Guidance No 77 on Antisocial Personality Disorder: Treatment, Management and Prevention. As it recognises: 'This guideline draws on the best available evidence. However, there are significant limitations to the evidence base, notably a relatively small number of randomised controlled trials (RCTs) of interventions with few outcomes in common.' Central to the Guidance is the patient's involvement: 'Treatment and care should take into account people's needs and preferences. People with antisocial personality disorder should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.'

32. This presents a problem when patients refuse to engage in treatment. Some may argue that there is no treatment available. Whether or not they adopt this tactic, Dr Parker told the tribunal that historically patients who are not discharged by a tribunal thereafter accept treatment.

33. This presents a danger for tribunals. It arises from the way that medical treatment is defined in section 145. That definition is sufficiently broad to include attempts by nursing staff to encourage the patient to engage by taking what the NICE Guidance calls 'a positive and rewarding approach [which] is more likely to be successful than a punitive approach in engaging and retaining people in treatment.' This is not difficult to satisfy. That produces the danger that a patient for whom no appropriate treatment is available may be contained for public safety rather than detained for treatment. The solution lies in the tribunal's duty to ensure that the conditions for continued detention are satisfied. The tribunal must investigate behind assertions, generalisations and standard phrases. By focusing on specific questions, it will ensure that it makes an individualised assessment for the particular patient. What precisely is the treatment that can be provided? What discernible benefit may it have on this patient? Is that benefit related to the patient's mental disorder or to some unrelated problem? Is the patient truly resistant to engagement? The tribunal's reasons then need only reflect what it did in the inquisitorial and decision-making stages.

34. In this case, the tribunal merely recorded: 'We accept the opinion of Dr Parker that continued treatment in hospital provides alleviation or prevention of a deterioration in his condition. Appropriate medical treatment is available on C Ward with the hope that he will begin to engage in treatment.' That is too general to deal with the issue and it ignores evidence to the contrary. It begged the question of whether the patient could be persuaded to engage. It is correct that Dr Parker set out in two reports details of the treatment that was available for the patient. Their effectiveness would depend on the patient's co-operation. On this, the patient's staff nurse gave evidence that the patient was hostile to the nurses and that there was no nursing input unless he asked for it. The nurse doubted whether the patient was getting any benefit from being on his ward. The tribunal did not refer to that evidence"

[5] [2010] UKUT 102 (AAC)

[6] [2013] UKUT 500 AAC

Seclusion

As a result of the outcome of the case of *Munjaz v United Kingdom*[7] hospitals may mistakenly believe that they do not have to follow the detailed guidance about seclusion. It would therefore be helpful to spell out clearly that this guidance should be followed and that this is the template for any use of seclusion unless there can be justification from departing from it.

The Code should also acknowledge that the Equality Act duty to make reasonable adjustments applies to seclusion. Access to an IMHA should be underlined in this context if prolonged seclusion is to be used as a last resort.

3. Decisions to hold and detain people, in police custody or hospital, and how reviews of detention take place

It would be helpful to head up the guidance in Chapter 10 with a statement about the importance of the guiding principles of the Code and joint working. This is because the impact of entry by warrant and the involvement of police is potentially extremely distressing and discriminatory. It is the experience of our members that people are unnecessarily traumatised by entry into their home when concerns could have been resolved without resorting to a warrant.

Police stations continue to be over used as a place of safety under section 136, despite the Guidance which stipulates that it is a location of last resort. It should be pointed out that HealthTrust's should be providing adequate healthcare locations for places of safety. Keeping a person in a cell without access to mental health care can be a breach of Article 3. Following the judgment in *MS v UK*[8] we believe time limits should be set in the Code limiting the period that a person can spend in police custody if detained under section 136 out of the total 72 hours allowed. In our opinion 24 hours is the absolute maximum. Full recognition should be had of the recent report from the Care Quality Commission and HMIP in this regard[9]. The Royal College of Psychiatrists have section 135 commissioning guidance which states that an assessment of the detainee should be made within 3 hours.

4. How Community Treatment Orders (CTOs) work

The 2008 version of the Code was introduced at a time when the provisions introducing community treatment orders had just been introduced, in November 2008, by virtue of the MHA 2007. Therefore, while it sets out the statutory arrangements and the intended purpose of the provisions, it is not informed by experience of how these operate in practice. There are a number of issues which it would in particular be useful to address:

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[7] http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-112198#{"itemid":["001-112198"]}

[8] http://www.bailii.org/eu/cases/ECHR/2012/804.html

[9] http://www.hmic.gov.uk/media/a-criminal-use-of-police-cells-20130620.pdf

Para 28.5 of the code confirms that CTOs are principally aimed at preventing the "revolving door" scenario and the prevention of harm which could arise from relapse. This option is said to be suitable where swift, compulsory recall is likely to be necessary. Anecdotal evidence suggests however that operating the recall provisions under s17A is no swifter or less burdensome than procuring a section 3 for a discharged patient, raising a query regarding the "necessity" for the power of recall to be available in case of relapse (under s17A(5)(d)).

Further, the study, "Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial" (March 26, 2013), found no difference in subsequent hospital re-admissions between those discharged and those subject to CTOs.

The CQC review, Monitoring the Mental Health Act in 2011/2012, confirms one issue that has arisen – that there is lack of clarity around when a CTO will have served its purpose and when and how patients will be discharged. Given that it will be considered effective where a patient is settled and engaged with treatment, the review states "this creates something of a double-bind in terms of discharge criteria, as it is not clear how a patient could ever demonstrate that they were ready to remain in the community without being subject to a CTO".

In addition, Chapters 23 and 24 are unclear about the operation of the treatment provisions in the MHA in relation to community patients. In particular, whilst it discusses the purpose of the conditions that may be imposed under s17A (under 25.29 to 25.35: to ensure that the patient receives medical treatment for mental disorder; prevent a risk of harm to the patient's health or safety; protect other people) it is not made clear whether it is possible to use conditions to compel treatment (although this appears not to be the case from the table under Chapter 23).

Anecdotally, there is some misunderstanding amongst patients that they remain under compulsion whilst on a CTO and will be recalled automatically if they do not consent to treatment. The CQC review also confirmed that the consequences of breach, and criteria for recall, were unclear: ie. That a patient will not be recalled for breach of conditions alone (other than the mandatory conditions to submit to examination), without evidence of risk of harm (17E(1)). Some more detailed explanation of the legal powers, and some examples from practice, would be useful.

5. How the Code applies to children and young people

Chapter 36 of Code of practice to the Mental Health Act 1983 ("the MHA Code") provides essential information to mental health professionals on the legal framework for the admission and treatment of children and young people in need of psychiatric inpatient care. In the past this has been a neglected area. For example the Report of the Expert Committee on the Review of the Mental Health Act 1983 (November 1999) noted that 'the law relating to the treatment of children suffering from mental disorder is in need of clarification" and that it created "a climate of uncertainty". Although some positive changes in relation to children and young people were introduced by the Mental Health Act 2007, such as the age appropriate environment duty (section 131A), significant uncertainties remain. As the MHA Code notes, "the legal framework governing the admission to hospital and treatment of children is complex". While on the whole Chapter 36 of the MHA Code provides very helpful guidance for professionals, some parts are insufficiently explained and/or are out of date – four key areas of concern are set out below.

Deprivation of Liberty

Although the text of the MHA Code does not explicitly state that parents can authorise the deprivation of liberty of their child, this is implied (see for example the discussion in paragraphs 36.25 and 36.26). It is also made clear in the flow chart "Informal treatment of 16 and 17 year olds".

The MHA Code will need to be revised to make clear that parental consent cannot authorise deprivation of liberty in the light of *RK v BCC and others*[10].

The overwhelmed young person

The MHA Code refers to situations where a young person "has capacity but does not consent (for whatever reason, including being overwhelmed by the implications of the decision)…"(36.23) and "has capacity to consent (as defined by the MCA) but for some other reason is not capable of consenting, for example because they are overwhelmed by the implications of the decision" (36.37). There is no reference to the authority for these statements. Furthermore, stating that a young person has capacity under the MCA but is not capable of consenting is confusing.

The concept of the "overwhelmed" young person and its implications for decision-making therefore requires further explanation.

The zone of parental control

This is a new concept introduced by the MHA Code. Making clear that there will be limits to the kind of decisions that parents can make in relation to their child is an important point (for example, as the Court of Appeal decision noted above, parents cannot authorise the detention of their child). However there are problems with the "zone of parental control".

Although the MHA Code states that the "zone of parental control" derives largely from the jurisprudence of the European Court of Human Rights, the only case it cites is that of *Nielsen v Denmark* 1989, a case dating back over 20 years and one that "far from limiting parental authority, recognised that it extended to allowing a 12-year old child to be locked up for several months in a closed psychiatric ward" (Brenda Hale, Mental Health Law, 5th edition, Sweet and Maxwell 2010 p.92). As another commentator suggests, this zone "is an attempt to encapsulate the idea enunciated in 1969 by Lord Denning in *Hewer v Bryant"* where Lord Denning referred to parental control as being a "dwindling right" which "starts with a right of control and ends with little more than advice"[11] The revised MHA Code should provide further explanation of the source, meaning and application of this concept.

[10] *[2011] EWCA Civ 1305*

[11] (Phil Fennell, Mental Health Law and Practice, 2nd edition, Jordans 2011, p. 417).

Assessing Gillick competence

For children under 16, professionals will be required to assess whether they are competent to make decisions concerning their admission and treatment. Whereas for those aged 16 and over, the MCA 2005 and its accompanying Code of Practice provide extensive guidance on assessing a person's capacity, there is very little guidance on assessing "Gillick competence". The revised MHA Code should include such guidance.

One approach would be to refer to section 3 of the MCA 2005 which sets out when a person is unable to make a decision. These factors can be a useful means of assessing a child's ability to decide even though the reason for a child not being able to make a decision may be due to a lack of maturity rather than "an impairment of, or disturbance in the function of the mind or brain" as set out in section 2 of the MCA 2005.[12]

8. How the Mental Health Act works, and could work better, with the Mental Capacity Act and Deprivation of Liberty Safeguards

The interface issues with the MHA 1983 and decision making as to the least restrictive regime which should operate for the incapacitated, compliant patient is a difficult area for decision makers and tribunals considering appeals against MHA detention. Charles J has provided some recent guidance in the recent case heard in the Upper Tribunal in the case of *AM v SLAM and DH*[13].

Applying AM, AMHPs may well find themselves having to choose between admission of an incapacitated compliant patient under the MHA or DOLS and this involves them in making a fact-sensitive judgment as to which would provide the best and least restrictive route to ensure that the treatment and/or assessment required can be given.

What this case reveals is the complexity of the overlapping regimes for deprivation of liberty and the difficulties faced by Approved Mental Health Professionals and doctors in applying the law. The Code can and should give more practical guidance to professionals on how best to decide on the most appropriate regime.

9. How the Mental Health Tribunal works and could be better understood

This section will require consideration of the judgment in *MH v UK*[14]. Full compliance with the judgment may require amendments to s. 68 MHA. In the meantime amendments to the could be made to Chapter 30 to provide for an assessment of the patient's capacity to decide whether to apply to a Tribunal in all section 2 and 3 cases and a referral in the case of those without capacity.

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[12] See the discussion in Richard Jones, Mental Health Act Manual, 16th edition, Sweet and Maxwell, 536)

[13] [2013] UKUT 0365 (AAC)

[14] http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-113812#{"itemid":["001-113812"]}

Paragraphs 32.7 and 32.8 deal with making patient records available to legal representatives and independent psychiatrists. This does not address the widespread difficulty in ensuring that representatives and experts gain access to all records given that these may be stored in a variety of ways, for example paper or electronic records. One of our members was recently alerted to an issue in one London Trust where a consultant was very concerned about the piecemeal approach to disclosure which could result in material emerging in reports that the patient's representative had not seen because they have only been given sight of part of the records. This is a relatively recent problem, but it is a growing problem for the Tribunal judiciary as well as representatives, as more Trusts rely on electronic records. Guidance within the Code could be very helpful.

The Code should also advise hospital staff of the need to ensure applications are forwarded to the Tribunal Service immediately if these are given by the patient to staff. This concern follows the decisions in *Modaresi v SSH*[15] (where patient was considered to have missed a deadline because the Trust did not send in the application on time.

In that case Lady Hale referred in clear terms to the Code:

The Mental Health Act 1983 Code of Practice (Department of Health, 2008) reminds hospitals that patients must be told, both orally and in writing, of their right to apply to the tribunal and how to do so (para 2.17). This is a statutory duty under section 132(1) of the Act. The Code also advises that hospital managers should ensure that patients are offered assistance to make an application to the tribunal (para 2.18). It would be helpful if the Code were also to advise that the hospital should ensure that tribunal applications which are given to hospital staff are transmitted to the tribunal without delay. A detained patient is in no position to ensure that her application reaches the tribunal unless the hospital affords her the facilities for it to do so.

We would also recommend an enhanced role for IMHAs in ensuring access for detained patients to the Tribunal. The Code could and should emphasise the role of IMHAs in explaining the patient's rights and helping them to exercise them. In this regard we support the recommendation of the Commons Health Committee that:

"…… the IMHA service becomes an opt-out rather than an opt-in service. This measure would help address the difficulties patients face in accessing advocacy and eliminate some of the practical problems clinicians face in making patients aware of their right to request an IMHA."[16]

The Code was drafted before the Tribunal Courts and Enforcement Act 2007 (TCEA) "bedded in" and only refers to the proposed new structure and the existence of an Upper Tribunal. This could usefully be updated. The Tribunal service has far more practice notes and guidance than it had before the TCEA. The Code refers to these at para 32.39 but could usefully direct readers to the practice directions at appropriate parts of the text and consider whether the Code is inconsistent with the relevant practice direction. For example, the Code gives guidance on report-writing at paragraph 32.10-32.22 but does not refer to the Tribunal's practice note (which is being updated) and which tells report-writers exactly what matters need to be addressed. Paragraph 32.17 states that report-writers should follow the Tribunal's guidance if they want part of their reports not to be disclosed to patients but does not summarise the guidance or explain that it is in the Tribunal Rules.

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[15] http://www.supremecourt.gov.uk/decided-cases/docs/UKSC_2012_0069_Judgment.pdf

[16] http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/58406.htm

Paragraphs 32.33-32.35 deal with appropriate accommodation for Tribunals. Again the Tribunal has a practice note about this and this could be referred to. The paragraphs in the Code do not refer specifically to the room being safe (i.e available exits) and this should be included. There have been incidents of assaults and attempted assaults in Tribunal rooms that are not suitable for the purpose, which underlines the need for clear guidance.

We have mentioned earlier that more information could be given in the Code to assist access to legal representation. The Code could say more about the role of legal representatives at paragraph 2.18 where it deals with providing information about how to contact a suitably qualified legal representative and more importantly at paragraph 32.5. It may also be prudent to advise all those who read the Code about the professional responsibilities of legal representatives. This could usefully refer to the Law Society's accreditation scheme for representatives and also our practice note on representation before the Tribunal.

Other areas of the Code where significant changes are required

(a) "The nearest relative and the unmarried father

We are aware that there is some uncertainty amongst mental health professionals about the meaning of section 26(2) MHA 1983. Section 26 of the MHA 1983 sets out who will be the Nearest Relative of the patient at the relevant time. Section 26(2) states:

"In deducing relationships for the purposes of this section, any relationship of the half-blood shall be treated as a relationship of the whole blood, and an illegitimate person shall be treated as the legitimate child of:

[(a) his mother, and

(b) if his father has parental responsibility for him within the meaning of section 3 of the Children Act 1989, his father."

The literal interpretation is that this provision is relevant to individuals of all ages, i.e not just to those aged under 18. If section 26(2) applies to patients who are 18 years or older, as well as those under 18, then all unmarried fathers will be excluded from being the adult patient's Nearest Relative whether or not they had parental responsibility when the patient was under 18. This is because parental responsibility ends at 18. This seems to be the view taken by Brenda Hale. Noting in Mental Health Law (5th edition, page 85), that PR ends at 18, she asks: *"..so does this mean that the relationship also comes to an end for this purpose?*" She goes on to state: "*This is an outdated exception to the general rule in the Family Law Reform Act 1987 (s1(1)) that relationships are to be construed without regard to whether or not a person's parents were married to each other*."

A different view is offered by David Hewitt.[17] Please also see the views of Professor Richard Jones on this question.[18]

Given the importance of this issue (for example, if the nearest relative is incorrectly identified for a section 3 admission, this impacts upon the validity of the detention), clarity on the correct interpretation of this provision is needed. While it may be that this

[17] see http://www.solicitorsjournal.com/comment/illegitimate-concern

[18] Mental Health Act Manual, 16th Edition pg.191, Professor Richard Jones

is an issue that ultimately needs to be addressed through legislative reform, the Code could at least ensure consistency in approach by setting out its interpretation of this provision, with an explanation for that interpretation.

(b) Section 20 of the MHA 1983

Section 20 provides that a patient's detention under section 3 can be renewed if the patient's Responsible Clinician ("RC") furnishes a report stating that the conditions for renewal are met. The RC must consult with another person professionally concerned with the patient's treatment (who belongs to a different profession to that of the RC) and obtain that person's written agreement that the conditions for renewal are met.

The Code provides guidance on renewal of detention but there is no mention of how the procedure for renewal should be undertaken in independent hospitals. In particular, there is no suggestion that the second professional should not be an employee of the independent hospital. The Report of the NHS Review of commissioning of care and treatment at Winterbourne View commented:

"In a situation such as Winterbourne View, where both professionals involved in the medical care might be employees, the potential for a conflict of interest arises."
The report recommended that the Department of Health's Review should include "whether the guidance surrounding the Mental Health Act contains adequate safeguards against conflicts of interest arising".

We believe that it is essential that the revised Code provides specific guidance on avoidance of such conflicts.